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SUCCESSFUL AGEING IN LONG-TERM CARE: INTERNATIONAL COMPARISON AND LESSON LEARNING

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Successful ageing in long-term care: International comparison and lesson learning

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Abstract

Quality of life is one of the main concerns in long-term care amongst ageing populations in many countries. This problem is historically unique and increases the demand for research material. This thesis looks at how different societies promote or fail to promote successful ageing of long-term care of older people, and considers how countries may learn from one another in their search for solutions. The three countries studied (England, the Netherlands and Taiwan) correspond to Esping-Anderson's three types of welfare system (Esping-Anderson, 1990). In addition, the Asian-European dimension has been employed as it is a neglected one.

Data sources included conceptual, empirical and statistical documents on long-term care of older people. Moreover, this research used identical qualitative cross-national research methods on three levels in each country: national, county and municipal. A total of 142 interviews were carried out in 2004. This aim of this study was broadly to rank the three welfare systems where there were clear differences but to qualify this by pointing out the complexities and difficulties of mixed economy comparisons.

The overall conclusion is that the Netherlands provides higher quality care to older people, thus confirming Esping-Andersen's finding about the superiority of social democratic systems. In reviewing current policies and research in needs and successful ageing, this qualitative comparative study has focused on *needs, social inclusion, power and autonomy, care resources* as well as *partnership* as crucial concepts in care systems and discovered good practice in each and lessons to be learnt.

Key words: Comparative social policy and practice, successful ageing, long-term care, older people, England, the Netherlands, Taiwan, social inclusion, power and autonomy, resources, partnership.

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To my father, Shanshi Chen who supports and guides me to who I have became.

In memory of my mum, Chingshai Chen (1939-2005) who first helped me to understand and care for older people and my brother, Hsienyen Chen (1963-2007) who encouraged and accompanied me through uncountable working nights in Loughborough from Taiwan.

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Contents

Part Three: Empirical research : A comparative perspective

List of Figures

List of Tables

List of Photos

Part One

Introduction

CHAPTER ONE

Background, Focus, Aims and Objectives

1.1 Introduction

The thesis is primarily concerned with the extent to which successful ageing is achieved for vulnerable older people who need long-term care in different countries. My original concern for older people arose through the voluntary experience of visiting older people in Taiwan. As a result, in 1997, I came to England - which I considered at the time to be probably one of the better welfare states - and completed a master dissertation on social work for older people in England and Taiwan. My concern for older people's well-being continued to grow while working as a social worker for older people in English Social Services Departments (it has been called Health and Social Care in some local authorities since 2006). Often, I wondered whether there were other ways of providing long-term care for older people other than simply meeting their most basic human needs (Ware et al, 2003). I therefore, undertook this cross-national study as a self-funded, part-time PhD project. Because of my age (28), I accept that I may not be the best person to interpret and comment on older people's care experience. However, through work and study in the area of long-term care of older people, I have continued to develop both my academic and practical knowledge in this field.

Throughout the study I have been acutely aware of the vulnerable position in which older people, and to some degree their carers and assessors/professionals who might have felt compelled to participate in this study I have been cognizant of these two concerns throughout the entire doctoral journey. I believe my uneasiness with both positions helped rather than hindered the research process. At every step I constantly reflected on how I was being analytically positioned by the texts, and also how I positioned others regardless of whether the texts were the published literature or the transcripts generated by the research participants. I also acknowledge the potential power differential that might have existed between myself and older participants, as well as other groups of interviewees.

This chapter provides some background information for this thesis. It begins with an overview of the study's engagement with existing comparative social policy and the long-term care of older people. It then outlines the argument to be developed, sets out the aims of the study and concludes with an overview of the chapters that will follow.

1.2 Background to the study

During the initial planning for this study, literature searches were conducted using seven relevant electronic databases[1], four international organisation websites[2], and nine national governmental websites[3]. Recent copies of a small number of key journals were also hand searched. The review focused on perceptions of the long-term care of older people and the management of front-line practice with regard to social care services and other support arrangements, including services provided by the public, private, formal/voluntary and informal sectors and different forms of user-directed support. As long-term care is an extremely diverse concept and a broad area of study, research from a range of disciplines, including social policy, sociology, psychology and gerontology was searched and included in these studies. However, while there is no denying the importance of care for people with mental health problems, this was too large an area to be taken on in this study.

It was clear that care services for older people had been compared intensively during the 1990s. The European Community had been active in promoting comparative research (e.g. Jamieson, 1991; Zaidi et al, 2006a, 2006b). Unlike other descriptive care provision reports, the projects analysed home care services in their historical, ideological, economical and political context. The World Health Organisation (WHO) also produced a series of publications on the topic (e.g. 2000, 2002a, 2002b, 2003). The reports began to include not only developed but developing countries. Within

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[1] These were Google Scholars, National Central Library Taiwan (NCL), Metablib University of Loughborough, IBSS, University library of Utrecht, the Netherlands Institute for Health Services Research (NIVEL) and the Netherlands Institute for Care and Welfare (NIZW).

[2] United Nation, OECD, World Health Organisation and EUROPA (including Eurostat).

[3] Department of Health, Commissioning of Social Care Inspection and Adult Commissioning in England. Ministry of Health, Welfare and Sport as well as Innovatiepartner in Zorg en Welzijn in the Netherlands. Ministry of the Interior, Ministry of Economic Affairs, Council of Labour Affair, and Department of Health in Taiwan.

the area of comparative research on the care for older people, the role of international organisations has been significant with the Organisation for Economic Cooperation and Development (OECD) also raising the issue as a major social policy challenge for member countries (e.g. OECD 1994, 1997, 1999a, 1999b, 2003, 2006a). These publications included comparative research and discussion on institutional and community base care, health and social care, informal care, pension and housing policies. This research aimed to promote flexible and affordable care between different sectors. Most of the reports mentioned above looked at the cost and/or care provision of long-term care systems. Other studies focused more specifically on the funding of care programmes, on family carers, on gender issues in care or on workforce and care relationships (e.g. Glendinning and McLaughlin, 1993; Le Bris, 1993; Tester, 1996; Glendinning et al, 1997, 2004; Ungerson, 1995, 2004; 2005; Österle, 2001). Furthermore, comparative studies also started to take the East into account when addressing welfare system issues (e.g. Gould, 1993; Goodman et al, 1998a; Aspalter, 2001, 2002; Walker and Wong, 2005) or focus on ageing from a global perspective (e.g. Wilson, 2000; Hermalin, 2002).

The above research activities implied there was a growing interest in cross-national learning in the field of care for older people, as welfare systems were facing or preparing for the ageing of their populations and looking abroad for policies to adopt. Many of these studies included detailed perspectives on the economics, politics, and cultural dynamics of national long-term care systems. From these studies we learned that despite the lack of fully reliable data it was evident that, for countries facing similar pressures (i.e. population ageing, funding limitation, shrinking numbers of in/formal carers), their responses were dissimilar. Most of the comparative work focused primarily on English speaking or European countries. Deinstitutionalisation and community care had been adopted as a policy preference in many parts of Europe but individual countries still had very distinctive provisions of their own. This showed that national institutional and cultural transitions were influential in care for older people. Many Northern European countries had reduced their provision of institutional care in contrast with those in Southern Europe. Also home care provision differed considerably between European nations, but support for informal care was becoming an important policy issue everywhere.

Many of these studies however faced difficulties: firstly, there was a lack of fully reliable detailed data to make valid comparisons. Secondly, there was considerable variation in the different systems - the definitions of long-term care, the terminology of

service support, the operation of the care services and especially the division of responsibilities between health and social care. Thirdly, there was rarely a conceptual and analytical framework for the comparative study of long-term care issues. Fourthly, there was little in the way of East/West comparison.

1.3 The key focus of the arguments present in this thesis

This design for the current study was stimulated in the initial stages of preparation by reading the literature mentioned above. Firstly, it was decided to attempt an in-depth understanding of the existing policy in three countries and the nature of variations between them. Secondly, the selected countries studied needed to be comparable. Thirdly, the comparative criteria needed to be tightened. The countries chosen were England, the Netherlands and Taiwan. They were selected for the following reasons:

- All of them were industrialized countries.

- All of them were facing similar pressure in meeting the care needs of older people and had actively been implementing long-term care policies of older people.

- Although the three countries differed in population (England 49.1 millions, The Netherlands 16.6 millions and Taiwan 22.8 millions), and size (130,000 sg km, 42,000 sg.km and 36,000 sg.km in England, the Netherlands and Taiwan respectively), the differences were not as great as those of countries compared in some other studies (such as United State, Canada, United Kingdom and Sweden in Matcha (2003)).

- Up to a point, each of them represented one of the different types of welfare regime as classified by Esping-Andersen (for a discussion see in Chapter two).

- There was a need for an East West comparison (for further justification see Chapter four and five).

Esping-Andersen concluded there were three types of welfare system in his 1990 study. He used a *quantitative* approach to compare and rank *social security* expenditure by the *state* applying the overall concept of *decommodification*. What has been done in this study is to take the idea of welfare systems or regimes and compare the long term *care of older people* using a *qualitative* approach to explore the *mixed economy of social care* using the overarching concept of *successful ageing*. The three welfare systems covered correspond to Esping-Andersen's three major types (social democratic, conservative-corporatist and liberal). In addition, the *Asian-European* dimension was employed as it was a neglected one. An important aim of the thesis was to consider how the countries studied could improve their long-term care policies and practices. In order to do so, this study was broadly to rank different aspects of the three welfare systems where there were clear differences but to qualify this by pointing out the complexities and difficulties of mixed economy of welfare comparisons.

Moreover, there was no intention to suggest the wholesale adoption of national conditions, values, culture and existing health and care policies, but by reviewing current policies and research to pull out the important issues of *needs, social inclusion, care resources, power and autonomy as well as partnership and system integration* as crucial concepts in examining care systems and to discover good practice in each. What was seen as significant was largely shaped by professional backgrounds. The area of care for older people is, like others, marked by a continuous interaction of groups with different types of knowledge, sensitivities and interests. The knowledge of experts in the field is different from that of politicians. While social scientists are used to dealing with a wide range of empirical data, they may lack an awareness of the new problems and challenges tackled daily by administrators, professionals and politicians. Consequently, this research included a broad spectrum of interests: practitioners, professionals, administrators, politicians, as well as older people themselves and their formal/informal carers. It has striven to analyze and describe the present as well as to identify policy challenges for the future.

1.4 Study aims

Using a comparative approach to issues of long-term care, the concept of *successful ageing* (borrowed from gerontological studies – see Chapter three) seemed to bring a degree of unity to the social policy concepts used in the fieldwork. When linked with aspects of Esping-Andersen's work, this resulted in the following research aims:

- To understand and evaluate current systems of care. The study concentrated not just upon one, but all levels of the care system. This was done by focusing on the views of local service users and radiating out to those participants who were relevant to the care of the older people studied.

- To discover how long-term care of older people was provided in different countries and how their needs and interests were being identified and met.

- To obtain a better understanding of the implications of long-term care for different welfare systems and to identify the factors that influenced the successful ageing of individuals being cared for.

- To assess the impact of policy upon the provision of long-term care services in different countries.

1.5 The structure of the thesis

Following the introduction this study is divided into three parts. *Part Two* is an examination of the existing literature. In Chapter two, an account is given of the framework of rules and regulations, rights, institutions and resources concerning services for older people. On the one hand it was noticed how the three countries had different traditions, interests and ideas about care. On the other hand, there were some shared developments and challenges. In all three countries economic, political and demographic pressures meant that care of the older people was at the forefront of social policy change. In Chapter three, a framework, which could then be used to evaluate different policies and practices in long-term care across countries, was developed. The framework has two aspects. One is a theoretical framework from gerontology and theories of needs, where it is suggested there are at least three

components (care needs, social inclusion and power and autonomy) which must be addressed for successful ageing to take place. The other aspect of the framework concerns policy development and service delivery. Certain elements (such as partnership and resources) within the delivery of the services need to be present if successful ageing is to be promoted. It is important to note that all the concepts are 'inter-linked'.

Part Three consists of empirical work conducted between 2004 and 2005. Chapters four and five, explain how the qualitative cross-national comparison was conducted and describes the groups of interviewees who participated in the study. The following five chapters (six to ten) go on to explore the 'views' of various participants in the three care systems studied. Each chapter explores how far long-term care addresses one or more of the key elements of successful ageing identified in Part One: needs (Chapter six), social inclusion (Chapter seven), and power and autonomy (Chapter eight). This study also explores how each country achieves the aim of successful ageing in long-term care by examining their resources (Chapter nine), and partnership arrangements (Chapter ten). Specific points for future practice are signalled in the concluding notes of each chapter.

Part Four, the concluding Chapter draws together practical issues, and explores the 'lessons to be learnt' from the cross-national findings that might (a) form the basis of further research and (b) be considered by government policy-makers. Similarities and differences between the countries are discussed.

In the following chapters, the focus will shift to an outline of the long-term care system for older people in England, the Netherlands and Taiwan. However, before progressing to Chapter two, I wish to reiterate that although not all the findings from this small qualitative study are generaliseable, there are, nevertheless, a number of key messages that can contribute to future policy development. Throughout the duration of this project, policy in this area has continually been changing in all three countries to try to modernise and improve their care systems. What this study tries to do is to offer a partial and highly contextual account of long-term care systems, an account that offers a multitude of diverse, complex and 'difficult to research' issues.

Part Two

Literature assessment

CHAPTER TWO

Welfare and Long-Term Care Systems

2.1 Introduction

This chapter consists of an examination of the literature on the welfare and long-term care systems of the three countries studied. The age group most likely to need welfare services in any country is those aged 65 and over (Jackbzone, 1999). Part of the reason for this is that from this age onwards, populations tend to experience poverty, isolation following the death of partners, personal disabilities and so on. Throughout the developed world, countries are facing the challenge of developing long-term care systems and policies that will meet the basic needs of the disabled elderly - at the same time trying to achieve good quality and economical care provision by finding a balance between the state and family. This chapter will initially involve an examination of each country's welfare system and the global issues that are having an impact on policy. This will be followed by an exploration of the political and service responses to the long-term care of older people in the three countries. Comparisons will be made between demographic characteristics, labour market participation, the cultural and political differences shaping policy objectives, economic constraints and long-term care services. The statistical data for this chapter have been collected from supra-national institutions (i.e. WHO, OECD, Eurostat) and national governments (i.e. England: Office for National Statistics, Netherlands: Statistic Netherlands, Taiwan: Executive Yuan/Department). While such indicators need to be treated with care because of a lack of consistent data (for further discussion see in Chapter four), they, nevertheless, supply us with a basic understanding of social, political and economic circumstances.

2.2 Welfare systems and globalisation

It is not possible to understand the long-term care of older people in our three countries without exploring the background in which care takes place, since policy concerning the long-term care of old people is part of the welfare system as a whole.

One of the key authors in this area is Esping-Andersen who has devised a typology of welfare state regimes (Esping-Andersen, 1990). Esping-Andersen distinguished between 'three worlds of welfare capitalism' within member countries of the Organisation for Economic Co-operation and Development (OECD): social-democratic, conservative/corporatist and liberal. The core of his analysis is the notion of 'decommodification', which he argues is an indication of good welfare provision. Decommodification 'occurs when a service is rendered as a matter of right, when a person can maintain a livelihood without reliance on the market' (Esping-Andersen, 1990, p 3). His definition of the three regimes can be briefly summarised as follows:

- The social democratic system provides universal welfare provision as well as having a strong decommodification and redistribution element.

- The conservative/corporatist welfare system supports the idea of class and status differentials and minimal redistribution. The benefit and welfare provision in this system is status-differentiated.

- Finally, the liberal model encourages a strong market oriented welfare system for the middle and upper class, has minimal decommodification and provides a residual safety net for the poor.

Esping-Andersen's analysis has contributed significantly to our understanding of differences between welfare states, in particular by demonstrating the way welfare regimes reflect different interests, priorities and paths of development. However, his three welfare regimes have also attracted considerable criticism and debate (see in Cass, 1990; Shaver, 1992; Lewis, 1993; Orloff, 1993). In a later paper about Japan, Esping-Andersen questioned how far his ideal types of welfare regime might apply fully to all existing societies (Esping-Andersen, 1997). Similarly, none of the countries in this study has completely conformed to Esping-Andersen's ideal types; instead they seem to constitute hybrids[4]. England has elements of both the universal social democratic and the selective liberal type in 'unstable combination' (Taylor-Gooby, 1991). The universal welfare system designed by Beveridge was never fully

[4] The UK was given a *liberal* de-commodification score of 23.4; the Netherlands, a *social-democratic* score of 32.4 and Japan – the only Eastern country to be included – a *conservative* score of 27.1.

implemented and elements of selectivity have increasingly been introduced in long-term care. Private for-profit providers are becoming increasingly important in Britain (Baldock and Evers, 1991; European Commission, 1993). Therefore, England can be identified as a *liberal* welfare regime with *social democratic* elements. The Netherlands is often compared with Sweden, and is regarded as a *social democratic* type of welfare regime. However its Bismarckian social security system has characteristics favoured by *conservative* Christian democrats. Voluntary associations are particularly strong in the Netherlands (Alber, 1995). Taiwan is similar to Japan (Jones, 1993), offering a *conservative* regime with a strong role for non-government organisations, as well as privileged welfare for state employees, and segmented, corporative social insurance but with a strong market/private or *liberal* element.

This study also differs from that of Esping-Andersen's original work in a number of important ways. Firstly Esping-Andersen was mainly concerned with social security whereas this research applies his typology to the long-term care of older people. Secondly, one criticism of Esping-Andersen's typology was that he looked at the formal aspects of national systems and neglected the local and the informal, whereas informal welfare networks have played an increasingly important role in many countries (Orloff, 1993) and is certainly dominant in many Eastern countries, such as Taiwan. This is particularly true in support systems for older people. As a result this thesis looks at three welfare systems and tries to understand them at the macro-, meso- and micro- levels - from the top to the bottom, formally and informally. Lastly, the impact of internal/external factors on Esping-Andersen's analysis has revealed a rather Eurocentric bias. This study will, of course, include an Eastern country.

One of the main tasks of comparative research is to discover similarities and differences in the ways in which different countries address similar problems. In examining the implications for welfare systems and social policy, it is noticeable that there is an on-going debate between those who sympathise with the assertion that globalisation has a significant impact throughout the world (Mishra, 1999; Bonoli et al, 2000; Shin, 2000; Yeates, 2001) and those who are pessimistic about its influence (Albert, 1993; Hirst and Thompson, 1996; Kleinman, 2002). What theories about globalisation can contribute to this cross-national study is to show that, on the one hand, external factors (e.g. the demands of global competition, global demographic change, the increase in migrant labour, patterns in family types and household structures and the increase in the numbers of people living in global poverty) should

be taken into consideration. On the other hand, globalisation affects different nations differently - state responses and political choice play a significant role within the globalisation process (Helleiner, 1995; quote in Bonoli et al, 2000). Similarly, the context of a nation's particular history, culture and social choice is also affected differently by the impact of global factors. Hence, globalisation contributes to both convergence and divergence factors in long-term care across the countries. There are a number of similar trends and pressures affecting all countries but the actual provision for older people is very varied between different welfare states and also within each country (Tester, 1996). Glendinning (1998a), for example, has compared recent reforms in the financing, scope and organisation of care services for older people in Australia, Denmark, Finland, Germany, the Netherlands and the UK. She concluded that, on the one hand, similar pressures (demographic trends, economic constraints and political trends) had promoted major reforms and common strategies (shifting responsibility to families, creating integrated budgets, improving co-ordination, promoting market-derived mechanisms and managerialism) in all countries. On the other hand, the actual responses of these countries had nevertheless been diverse, reflecting national institutional and cultural traditions.

Convergence in a number of areas on care for older people can be identified in the countries studied here:

- For both economic and humanitarian reasons, the emphasis in care policies is on deinstitutionalisation, developing home-based care and enabling older people to remain at home as long as possible (e.g. Österle, 2001, p 40).

- The direct role of the state is either being reduced (in England and the Netherlands) or remains minimal (in Taiwan). The promotion of welfare pluralism of service provision is increasing, which in its turn complicates co-ordination.

- A weakening of the borderline between health and social care as well as between institutional and community care is evident in all three countries.

- There is evidence of a shift from provision of services 'in kind' in England and the Netherlands to a cash support system which already exists in Taiwan.

- Flexible services and greater choice have been the policy recommendations in either individual-oriented care systems (such as England and the Netherlands) or family-oriented care systems (Taiwan), even though this seems to be in conflict with the dominating objective of cost-effectiveness. Despite a general trend towards convergence, the levels of actual provision for older people remain quite different between the three countries.

2.3 Demography and social issues

Throughout the world, changes in demography and the labour force in past decades have had a strong impact on family structure, living arrangements, the demand for long-term care and the availability of informal care and support. The pressures on the three different societies and the changes they have had to address in providing welfare will now be discussed.

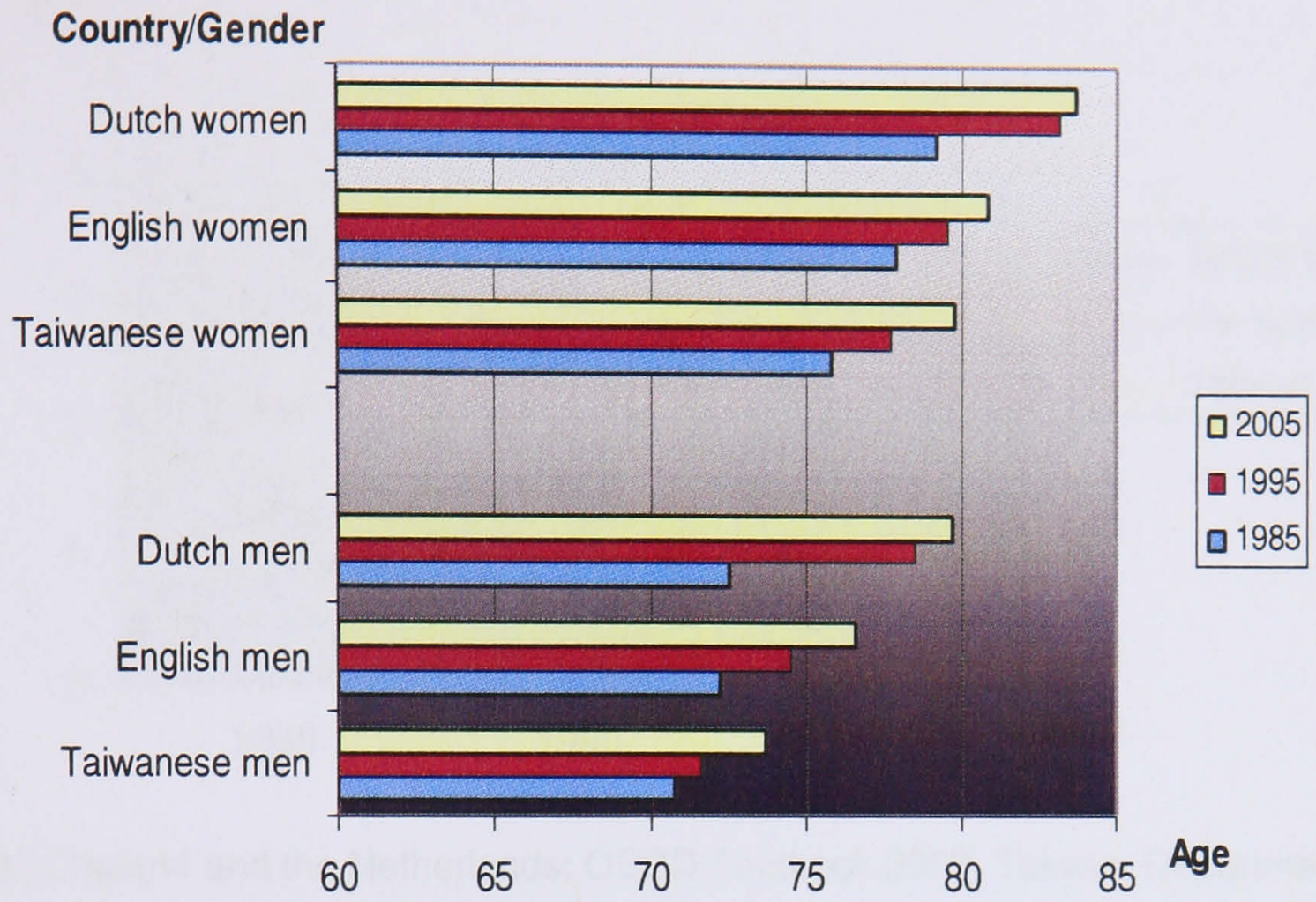
The difficulties in comparing data collected by government departments from different countries are well known. Definitions, such as what is meant by full-time employment, or retirement age can vary from country to country. Data are also collected from different sources in different ways, and are often difficult to compare. This issue needs to be taken into account in cross country studies. The following tables and figures set out data collected in the three countries explored in this thesis. In examining the data, the reader needs to take account of the problems of cross national comparisons; I have indicated specific anomalies where they occur.

2.3.1 Demographics and older people

Demographic factors have an important role to play in the development of social policy. The demand for care has increased as life expectancy has increased (Figure 2.1) in all three countries.

Figure 2.1

Life expectancy of men and women from 1985 -2005

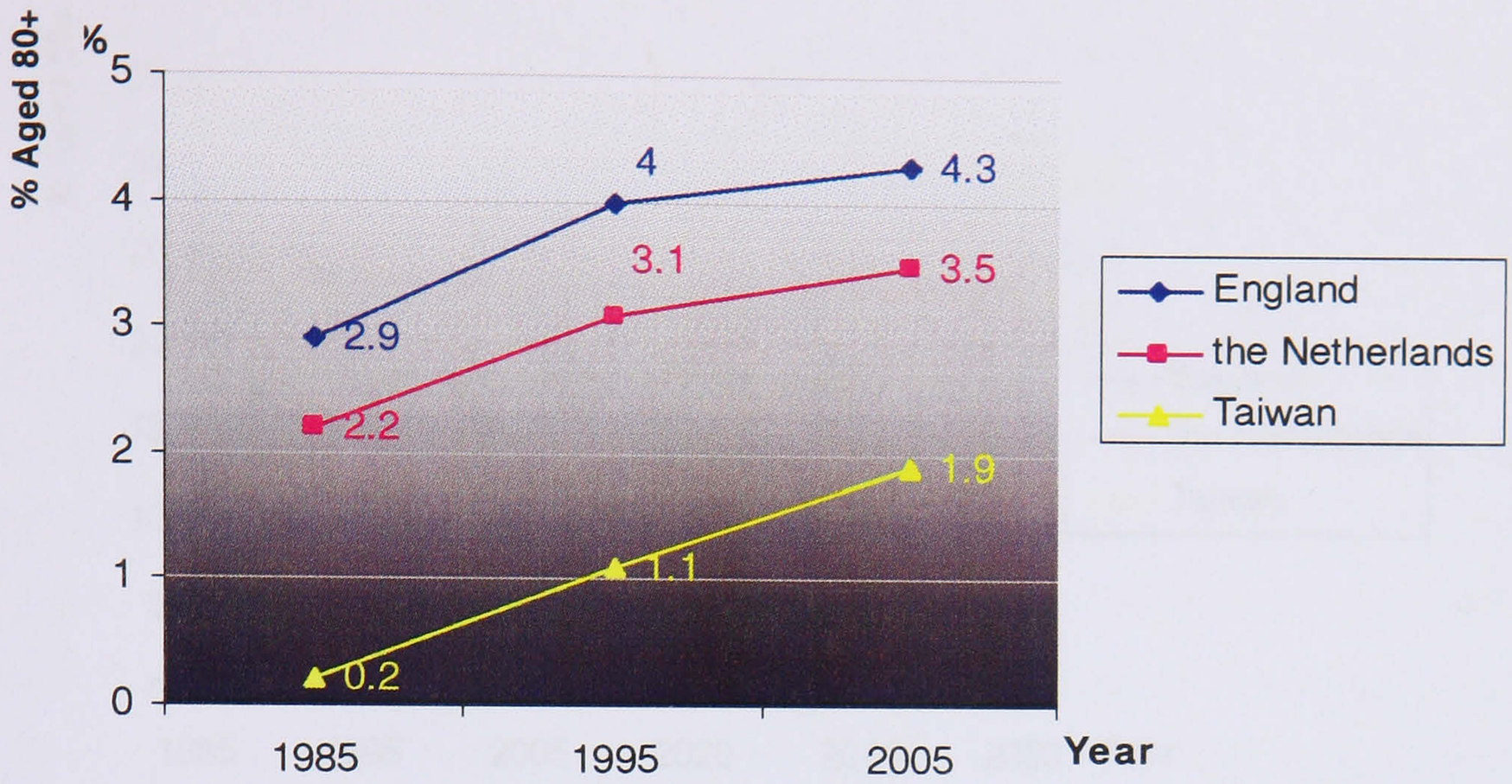


Source: England: Office for national statistics; Netherlands: OECD Factbook 2006 and Eurostat; Taiwan: Department of Statistic, Ministry of Interior.

Life expectancy has increased for both men and women, most remarkably in the Netherlands where average life expectancy has improved more than 6% for both men and women between 1985 and 2005. Unless fertility rates rise, future gains in longevity will continue to increase the old-age dependency ratio. Women tend to live longer in all three countries, so that the elderly population of each country becomes increasingly 'feminised' (though, at the moment there are more males than females aged 65 and over (1.16:1) in Taiwan as a consequence of the high prevalence of males in the group who moved to Taiwan from mainland China in the 1940s).

Figure 2.2

Older people aged 80+ as a percentage of the total population



Source: England and the Netherlands: OECD Factbook 2007, Taiwan: Department of Household Registration Affairs, Ministry of Interior.

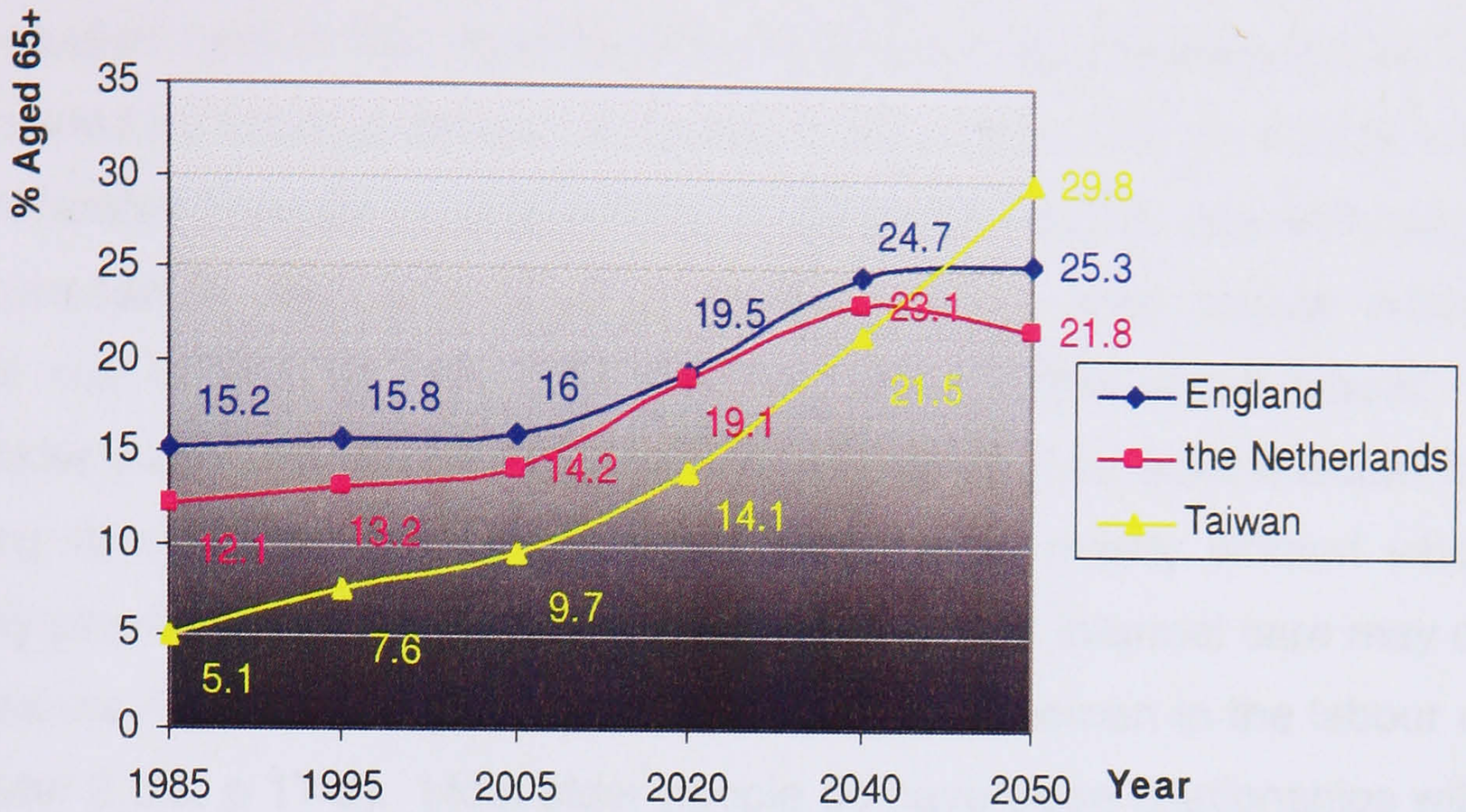
Note: Figures for England cover the whole of the United Kingdom.

Figure 2.2 shows the population aged 80 and over is increasing in the three countries. England has more population aged 80-plus, the Netherlands comes a close second and Taiwan a distant third. The increasing population of those aged 80-plus has the most serious cost consequences for the demand in health and social care (Guardian, 2002).

The number of people aged 65 and over (Figure 2.3) has also grown rapidly in all three countries, especially in Taiwan since 1995. England and the Netherlands will reach a similar percentage by year 2020 when the 1960s baby-boom generation reaches the age of 65. By 2040, all three countries will reach a similar percentage of ageing population around 22.5%. The indications are that over the next 20 years all three countries will experience a growing demand for old age care. After that, England and the Netherlands will face a somewhat slower increase in their elderly population. In contrast, the ageing increase will be most marked in Taiwan – at the moment the 'youngest' of the three countries. By the year 2045, the percentage of the population aged over 65 in Taiwan will more than that of England and the Netherlands.

Figure 2.3

Population aged 65+



Sources: England and the Netherlands: OECD Factbook 2007; Taiwan: Department of Household Registration Affairs, Ministry of Interior.

Note: Figures for England cover the whole of the United Kingdom.

2.3.2 Informal care support

In all three countries, the state relies heavily on informal carers. Eighty per cent of older people in England and Taiwan rely on informal carers (Shieh, 1993; Pickare, 2001) and 16% of the Dutch population are family carers for older people (Visser-Jansen and Knipscheer, 2004). In England, community care and other formalised sources of care have been used to supplement informal care, as evidenced in the community care policy of the mid-90s (Bartlett and Phillips, 2000, p 1777-9). Similarly, an official Dutch report - *Care for Older People in the Future* (Commissie Modernisering Ouderenzorg), 1994 - stated that informal care remained not just an "alternative" but a "supplement" to formal care. This implies that both Dutch and English social policy aim to provide formal care but anticipate that informal care will continue to make a substantial contribution. In Taiwan, however, the policy aim is explicitly to provide employment – as an important part of economic policy - as well as care (detail see Chapter 2.4).

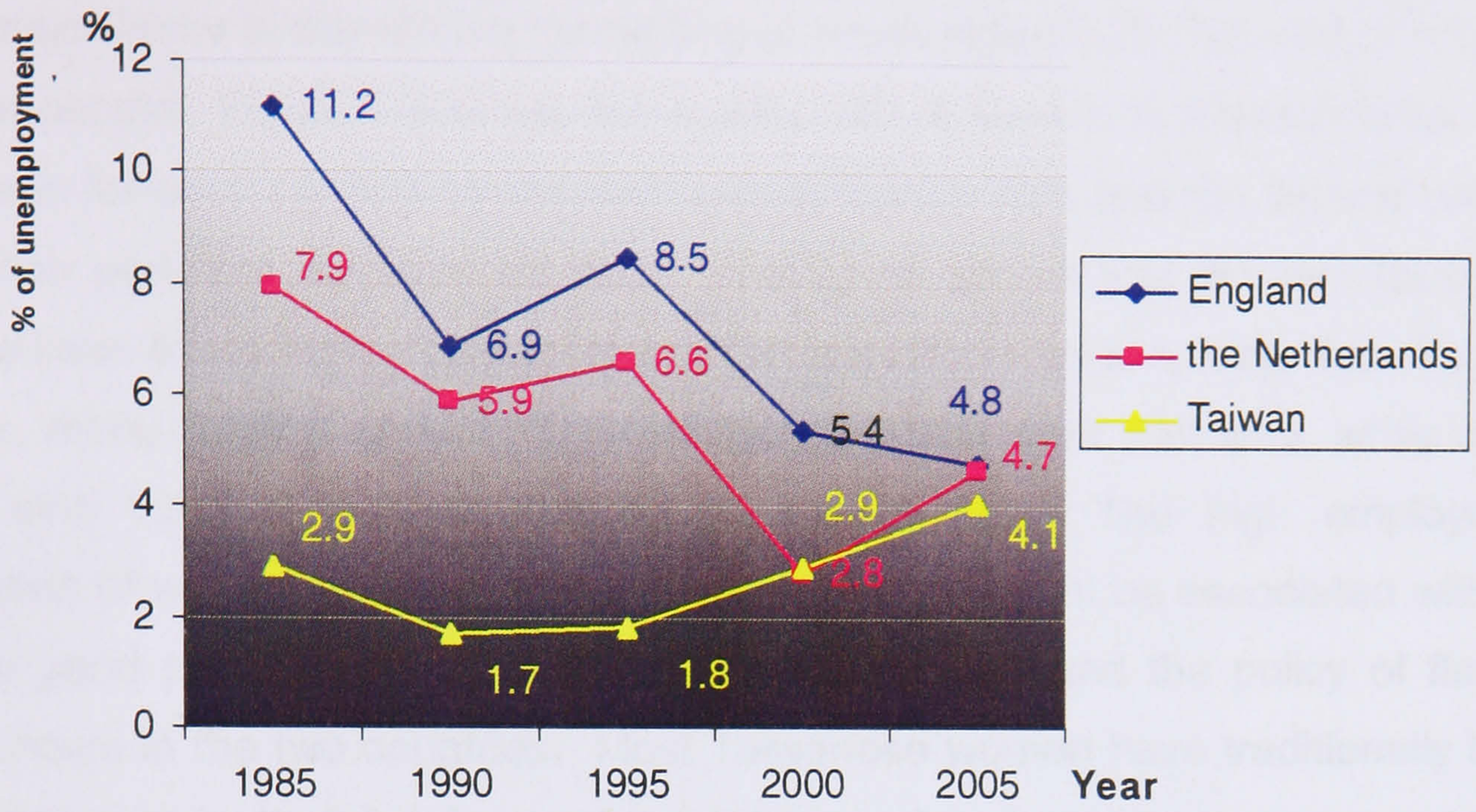
Tester (1996) claimed that in each type of welfare regime, informal carers provided the great majority of care. She also stated that the share of informal care is everywhere estimated at 75-80 per cent of total care. A common feature of all three countries studied here is that most care for disabled older people living at home is indeed provided by informal carers. A decline in the supply of such a resource could have considerable financial consequences. In England, PSSRU research suggested that an increase in the numbers of married/cohabiting older people indicated a substantial rise in 'spouse carers' for disabled older people in the future. Single disabled older people would be the most likely to rely on their adult children for care (Wittenberg et al, 2006). However, since it has been mainly women who have traditionally provided informal care, there is a concern that informal care may decline in the future as a result of the increased participation of women in the labour market (see Chapter 2.3.3, p 17-8). Most older people do have close relationships with their next of kin and often either talk by phone or are visited. Care provided by family members and social networks is thus significant and has traditionally provided the bulk of assistance and care for older people who are in need of help, even in a country such as the Netherlands with relatively high levels of formal care provision. Adult sons and daughters in Taiwan are more likely to rely on their own care-giving efforts than to use formal sector services (Hermalin, 2002).

2.3.3 Labour market participation

England, as a part of United Kingdom, has had the highest unemployment for most of the last two decades followed by the Netherlands. Taiwan's unemployment rate was much lower until the Asian economic crisis in 1997, when it reached a similar unemployment rate as the other two countries (Figure 2.4).

Figure 2.4

Standardised unemployment rates: total

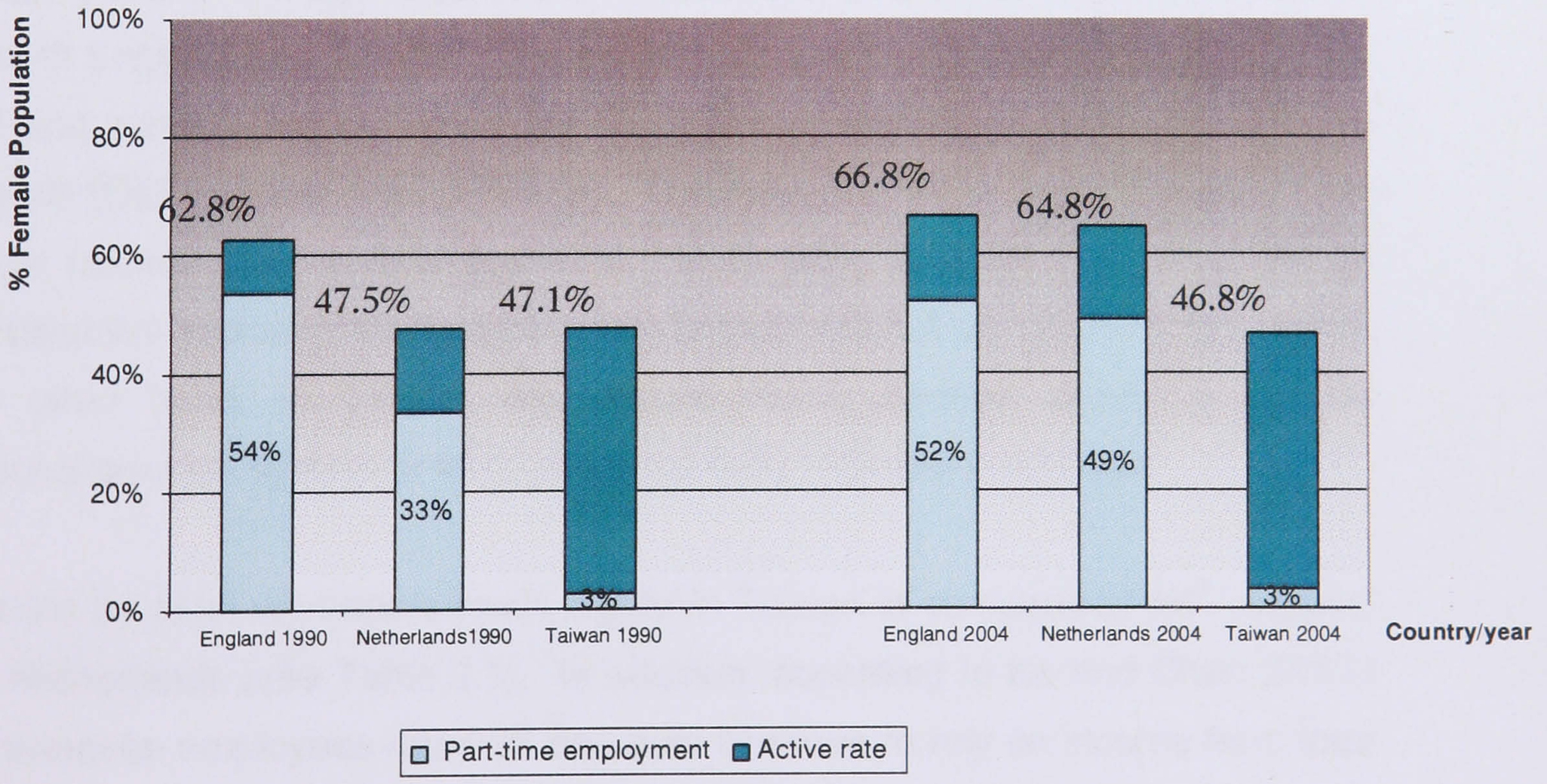


Sources: England and the Netherlands: OECD Factbook 2007; Taiwan: Executive Yuan 2007

Note: England figure from United Kingdom

Figure 2.5

The activity rate of women and their share in part-time employment 1990 - 2004



Sources: England and the Netherlands: OECD Factbook 2007; Taiwan: Executive Yuan 2006.

Note: England figure from United Kingdom.

Increased female participation in the labour market has been one of the most outstanding developments in all three countries and there is little doubt that this has been a major factor in stimulating the setting of a new agenda for the care of children and older people. Figure 2.5 shows the activity rate of women in the workforce. The first column for each country shows their overall activity rate and the second column shows their part-time employment rate. The figure shows that the two European countries have much higher percentages of female labour force activity than Taiwan. However, many English and Dutch women (over 70%) work part-time, while those women who work in Taiwan tend to do so full-time. The high employment participation of women in England and the Netherlands might be associated with the relatively good provision for child and older people care and the policy of flexible working hours in the two countries. Most Taiwanese women have traditionally been expected to care for their family members at home. As a consequence many of them stop working when they have children and nearly all Taiwanese women who still work also provide the main hands-on care for their families at home. This reflects the different norms and culture surrounding family obligations in general and women in particular.

The statutory retirement age is 65 in the Netherlands; and 60 for women and 65 for men in both England and Taiwan. The earliest occupational retirement age is 60 for England and some Dutch schemes but 55 in Taiwan and some occupations in the Netherlands (OECD 2004, OECD 2005a). The main pathways for exiting early from the labour market differ across countries. In England and the Netherlands, it is through disability and other welfare benefits (Engerbersen et al, 1993; Trudie, 1994). On the other hand, in Taiwan this occurs mainly through provisions in the occupational pension system or through formal early retirement schemes.

Participation by older workers is much higher in Taiwan in comparison with England and the Netherlands (see Table 2.1). In addition, according to Ku and Chen (2001) some Taiwanese employees aged 65 and over continue to rely on income from their work, especially in agriculture. This reflects the Taiwanese occupational pension system which is not sufficient to meet the needs of the population. Early retirement without adequate income may cause hardship for many older workers in the form of social exclusion and poverty. In addition it may increase public expenditure (Daniel, 1997). Thus all three countries have begun reducing incentives to early retirement. England and the Netherlands have encouraged older workers to remain in work

longer through age-discrimination legislation[5] and the Taiwanese government has encouraged people to have a 'second career' after their retirement (*Elderly Welfare Act,* 1986; Tsai, 1994). The policies that help older people to remain longer in the work force can also have a more direct impact on improving welfare at an individual level.

Table.2.1

The percentage of older workers in the labour force

	1990	*2000*	*2005*
England	49.2	52.2	56.2
The Netherlands	29.7	39.3	44.6
Taiwan[6]	-- (not available)	59.1	60.4

Sources: England and the Netherlands: OECD (2005). Taiwan: Executive Yuan, 2006

Note: 1. 2001 for England and the Netherlands's data.

2. 2004 for England and the Netherlands's data.

3. English data are focused on aged 55-64.

4. Dutch data are focused on aged 55-64.

5. Taiwanese data are focused on aged 45-64.

2.3.4 Family structure and household composition

Family structures and living arrangements are possible indicators of the availability of potential carers and family support for older people. Living arrangements are affected by several factors including the labour force (as mentioned above), marital status, family size and structure, financial wellbeing and health status. Additionally the availability of informal carers is also affected by cultural attitudes and the availability of social services for older people.

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[5] Age-discrimination legislation was introduced in 2004 in the Netherlands and in 2006 in England.
[6] Taiwanese data are focused on aged 45-64.

Table 2.2

Percentage distribution of living arrangements of the elderly 65 and over in 2000

	Living alone	Living with spouse	Living with adult children (and spouse)	Others
England	35	50	8	7
The Netherlands	33	57.7	7.4	1.9
Taiwan	6.5	13.8	70.1	9.6

Sources: England: GHS 2001; the Netherlands: CBS Stateline, Person in independent household by age and sex 2000; Taiwan: Executive Yuan, 2000.

The large increase in the proportion of older people living alone after the Second World War has been documented in the UK and in many European countries including the Netherlands (Tomassini et al, 2004). In contrast an extremely high rate of multi-generational households (see Table 2.2) can be found in Taiwan. Nevertheless the proportion of older people who live alone has also gradually increased in Taiwan. This issue has brought to prominence concerns about the shortage of suitable housing in England and the Netherlands. It seems likely that this will become increasingly an issue or demand in Taiwan also. Cross-cultural and social expectations are especially relevant in explaining the differences in living arrangements between East and West. The Taiwanese pattern of co-residence follows from a family-oriented tradition. Elderly people used to be, and to an extent, still are looked after by the family. Devotion to parents is an unconditional and absolute duty. In the more individualistic West, however, older people are either expected to continue to lead an active life on their own, or at least not to interfere with the youthful lives of their family. Socio-economic factors such as greater financial independence, possible improvements in health, and also rises in the prevalence of divorce, may be responsible for the increase in independent living for English and Dutch older people. In Taiwan, continued multi-generational living has transformed into a distinct type of household organisation or economy in modern times. The elders often make an important social and economic contribution to their son's/daughter's household - as housekeepers, child carers and other components of the household economy. Taiwanese older people recognise this responsibility and value their roles. This is one of the significant elements of life-fulfilment for Taiwanese older people. The increase in independent living arrangements in Taiwan has led to considerable concern regarding the availability of family support and the

possible effects on the provision of public care services for frail older people when the family is not available.

2.4 Political and cultural differences

Cultural and political factors have some bearing on policies that each society has developed to deal with the long-term care of older people. Part of the explanation for Taiwan being a state welfare 'laggard' can be found in its political development. Unlike the Dutch (*AWBZ 1968*) and the English (i.e. *Poor Law Act 1899*, *National Assistance Act 1948*) where state welfare has developed over a long period of time as part of their systems of representative democracy, Taiwan's political development has only recently moved away from almost one-party rule. This was followed by welfare development in the 1980s. Nevertheless, Taiwan's welfare development has benefited by learning from the experience of other countries, such as Germany, UK, Japan and America (Wu et al, 2001, 2002; Wu, 2003). Unlike England and the Netherlands which have a tradition of strong state social protection, Taiwan has emphasised family and community-based care as well as welfare driven by economics (Walker and Wong 2005). The Taiwanese President has publicly stated that "Economic development is the top priority. Will there be any social welfare if we do a bad job with the economy?" (Taipei Times, 17 September 2000)

2.4.1 Political systems

Government administration is currently divided between the central and municipality levels in all three countries with, in addition, a provincial level, in the Netherlands. In each country, local authorities are dependent on central government for revenues: this provides 80%, 90% and more than 90% of local funding in England, Taiwan and the Netherlands respectively (Budge et al, 1998). Unlike the Dutch[7], the English, and in part, the Taiwanese local authorities have responsibility for providing welfare services to their local older people, but financially and politically they depend on central government.

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[7] Following the *Social Support Act* (WMO), in 2007, the Dutch local authorities have started to provide certain social care services which used to be responsible by central government to older people.

England and the Netherlands are both constitutional monarchies and Taiwan, a constitutional republic. England has a 'first-past-the post' system of parliamentary democracy. This has resulted in a 'two-party' system monopolised by the Labour and Conservative parties since the 1920s. The Dutch and the Taiwanese have a proportional representation (PR) electoral system, and as a result in both countries government is usually undertaken by a coalition. Currently, both England and Taiwan are dominated by centre-left wing politics, whereas Dutch politics have swung to the centre-right since 2002, after seventy years of centre-left coalitions. In addition, the political ideology in Taiwan is historically linked to nationalism. The system in the Netherlands has to be understood in terms of a tradition of 'pillarization'. Bax (1990, 1995) noted that the Dutch pillars (originally protestant and catholic and socialist) were part of a historical process with a strong religious base that began in the 1920s. He identified a pillar as a subsystem in society that linked political power, social organization and individual behaviour in order to promote an ideology of social participation and cohesion. Pillars also served as a set of channels for the allocation of government subsidies. These were seen as equal in status. Over time the pillars lost much of their religious character but many of them still exist and the Dutch welfare state could not function without them. Although their influence is in decline, they continue to contribute to the continuation of social stability in modern Dutch society and to the harmonious co-existence of social classes and religious minorities.

Political election voter turnout rate is consistently high in Taiwan compared with the West - 80% in Taiwan as against 60% in England and 76% in the Netherlands in the 2000s. The recent increase in the ageing population has changed civil participation in the three countries and has had some influence on the policy agenda. An increase in 'grey power' means not only that more than one third of voters are aged over 55 (and the number is increasing), but also older people have a higher voting turnout than the younger generation in all three countries. However, it can be argued that policy relating to older people in the Netherlands and especially England has focused on income security and social risk in old age, such as pensions and long-term care. Thus policies for older people nowadays are primarily debated in terms of costs in the Netherlands and England particularly (Walker and Naegele, 1999). Similarly, Taiwan's policy has also focused on the 'costs of ageing'. In addition, in Taiwan, older people are also seen as consumers who can stimulate the demands for employment. Thus the Council for Economic Planning and Development has published guidelines for central government strategy in developing a care service industry (CEPD, 2003a). Only Taiwan of the three countries has combined *The*

Care-services and Welfare Industry Project with its effort to tackle the rising level of structural unemployment stemming from Taiwan's industrial transition. The *Care Industry Programme 2002-2004* aims to encourage unemployed agricultural workers and mature women to be trained and become formal carers (CEPD, 2003b, 2005).

One principle aim of policies on ageing in the three countries is to keep older people in the community for as long as possible. A major outcome of this approach is recognition of the importance of home support and community care services. However, as mentioned earlier, while all three countries rely heavily on informal carers, they are facing a future in which their numbers are likely to diminish. Joint working between the state and the individual becomes important in the light of this trend.

2.4.2 Rights and responsibilities

The social image of older people and changing ideas about rights and responsibilities have a strong impact on care recipients. In the 1980s, in England a New Right ideology emerged that was both anti-welfare and anti-state. As a result, the idea of 'citizenship' changed from that of 'right holders' to that of 'responsible consumers'. This discourse of English modernisation coexisted with the idea of 'active ageing' which suggested that people had the right to choose care services and make their voices heard. In spite of this, it could be argued that older people in need of care were likely to be excluded and overlooked, simply because they were physically too frail to exercise their rights and views. This was thought to be especially so if they had been left without support to address their own needs (Powell and Edwards, 2002, p 3).

In the Netherlands, the serious question of intergenerational justice has been raised. Instead of relying on institutional frameworks, recent Dutch legislation - *Social Support Act 2007* (*Wet maatschappelijke ondersteuning, Wmo*) and *Health Insurance Act 2006* (*Zorgverzekeringswet*) – has adopted an ideology of solidarity through a philosophical approach to 'social renewal'. This encouraged greater collaborative responsibility between state, individual, neighbourhood, community and family. The Netherlands promoted social integration and the integrated delivery of care services

at the community level, based on an ideology of solidarity between the strong and the weak (Ex et al, 2003).

In contrast, Taiwan took the 'Asian way' based upon the idea of filial piety (Phillips, 2000, p 5). Filial piety is one of the virtues to be Chinese cultivated in Confucian thought : a love and respect for one's parents and ancestors. In general terms, filial piety means to take care of one's parents; not be rebellious; show love, respect and support; display courtesy; ensure male heirs, uphold fraternity among brothers; wisely advise one's parents; conceal their mistakes; display sorrow for their sickness and death; and carry out sacrifices after their death. This took into account limited state provision and the popular strength of Asian family care models in providing for older people. However, the shrinking of family care resources and a growing awareness of citizenship rights has forced the Taiwanese government to establish a statutory responsibility for care. Nonetheless, some Asian scholars and policymakers emphasise that families will and should remain the primary sources of care for elderly members. They recommend that policies directly support the family in its traditional role as care provider for the elderly (Bengtson and Putney, 2000, p 278). Family obligation towards older people is legally stated in the *Family Obligation Act*. As a consequences, over 80 per cent of disabled Taiwanese are cared for by their own families without any formal support (Bartless and Wu, 2000, p 215), and nearly half of older people in Taiwan are financially dependent on their children (DSMI, 2000, p 61). There has been little discussion in Taiwan about the impact of the traditional family model on older people themselves or women, and the orthodox view that older people are better off in the East than West is not necessarily valid. For example, Taiwan has the highest elderly suicide rates in any eastern or western country (Japan has faced a similar situation). As care has primarily been seen as a family concern and a private matter, little help has been available when the families are no longer able to take care of older people, as a result of intergenerational relationship break down (Bartlett and Wu, 2000; Hu, 2005). This may have imposed an impossible burden of self-reliance on some older people and be one explanation for the high suicide rate.

2.5 Economic constraints and the scale of welfare production

The general demographic trends discussed above cast doubt on the ability of publicly funded welfare systems in many industrial countries to continue to be the only

affordable option, especially in the area of pensions, health care and long-term care. The implementation of care and support can never be separated from a nation's economic performance, politics and public policies or an individual's economic well being. To ensure adequate welfare production today has become a question of how to co-ordinate the state, family, private and voluntary sectors.

2.5.1 Macro level

Table 2.3

Real GDP per capita, US $

	1990	*1995*	*2000*	*2005*
England	14,300	16,900	21,800	30,900
Netherlands	13,900	17,200	23,100	30,600
Taiwan	--	10,600	16,100	26,700

Sources: The World Factbook

At the macro economic level, England was the first industrial nation, the Netherlands' industrial revolution was relatively late, and Taiwan only graduated from agriculture to industry in the 1960s. Economically, England and the Netherlands have a similarly strong per capita income and Taiwan lagged behind (see Table2.3). Nonetheless, Taiwan's economy has grown in significance and is now closer to Western economic wealth.

Table 2.4 shows that the Netherlands clearly outperformed the other two countries in its public and social expenditure during the 1980s and 1990s. Nonetheless, Dutch social expenditure had fallen to the level of English by 2000. All three countries have in recent decades experienced significant political and economic pressures on the state in welfare provision and have recently moved towards a combination of public and private provision. A key element for England and especially the Netherlands has been a move towards greater private provision of social benefit since 1990. In contrast, in Taiwan, public social expenditure - education and social insurance in particular- has increased since the 1980s with pressure for liberalisation following Taiwan's accession to the WTO in 2002 (Government Information Office, 2004).

Overall, the total of social expenditure of Taiwan remains much lower, roughly two-thirds of what it is in the other two countries.

Table 2.4

Public and social expenditure as a percentage of GDP

	England			Netherlands			Taiwan		
	1980	*1990*	*2000*	*1980*	*1990*	*2000*	*1980*	*1990*	*2000*
Public expenditure	45.7	42.2	37	55.3	54.8	45.3	14.2	21.4	32.9
Social expenditure	17.9	19.5	21.7	26.9	27.6	21.8	3.8	6.8	13.1

Sources: England and the Netherlands: BNP Paribas and OECD, 2004; Taiwan: Executive Yuan, Statistic Yearbook, 2003.

Note: Public expenditure is government expenditure including transport and defence, whereas social expenditure includes state expenditure on housing, education, health and social security.

2.5.1.1 Social expenditure on health care

Contrary to public expectation, a number of studies have shown ageing is not likely to lead to health care costs spiralling out of control (WHO, 2000; Jacobzone and Oxley, 2002; Wang and Tseng, 2004. Nevertheless, the cost of health care provision is an issue in relation to care of older people. England has the National Health Service (NHS) which is tax funded and free at point of delivery; whereas the Netherlands and Taiwan have health insurance systems.

Table 2.5

Government Health Expenditure as a Percentage of GDP

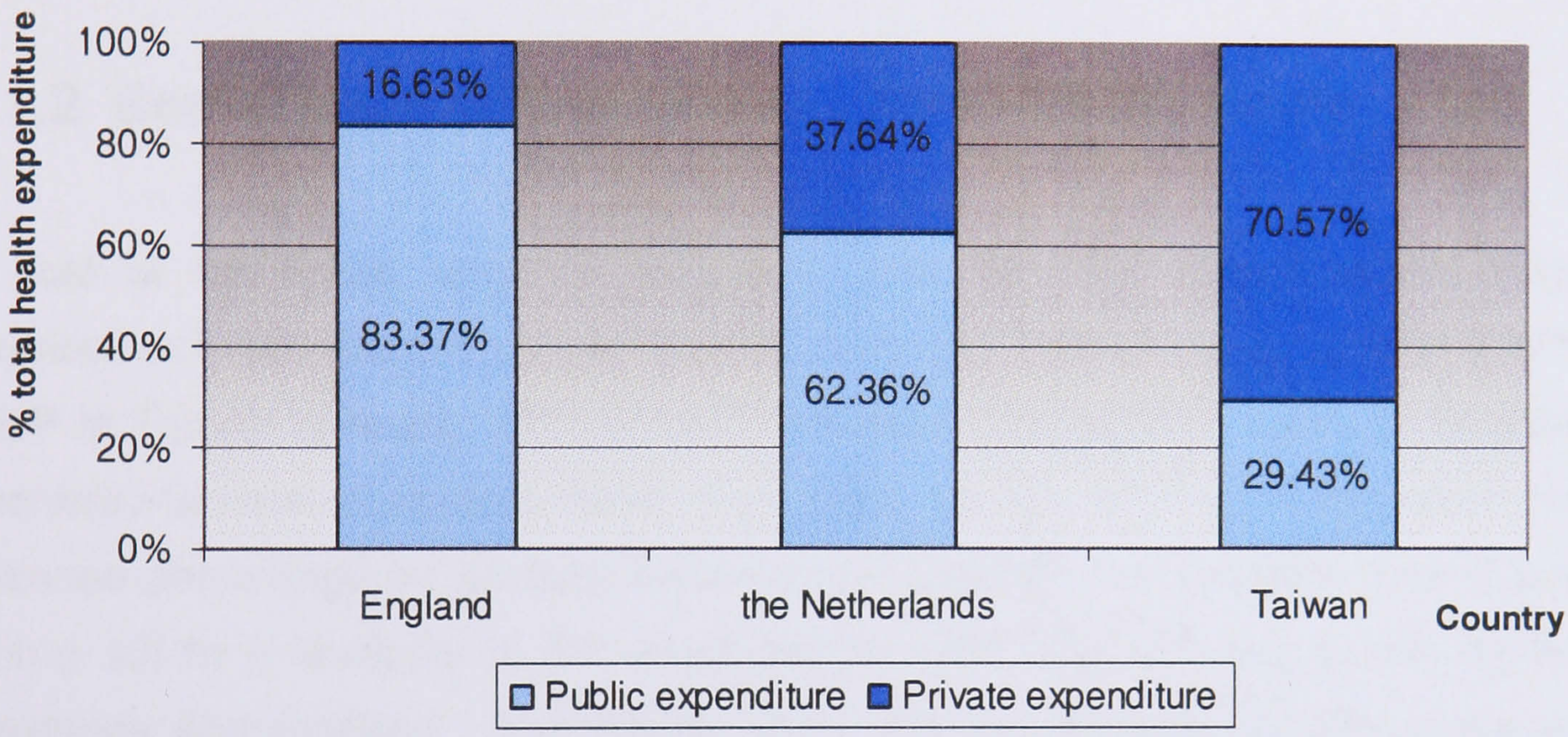
	1990	*2000*	*2005*
England	6.5	7.3	8.3
Netherlands	8.2	8.3	9.8
Taiwan	4.6	5.7	6.2

Sources: England and the Netherlands: OECD Health Data, 2005; Taiwan: Department of Health, 2007.

Table 2.5 present the figures of government health expenditure in the past 15 years. The Dutch devote a higher percentage of GDP to health care expenditure, England comes second and Taiwan, third (for further details of health system see *England*: Bonoli et al, 2000; *Netherlands*: Okma, 2001; *Taiwan*: Chaing, 1997; Ku, 2001; Wang, 2001).

Figure 2.6

Public and private health expenditure in 2003



Sources: England and the Netherlands: OECD Factbook 2006; Taiwan: Department of Health 2006.

Figure 2.6 represents the percentage split between public and private expenditure on health in the three countries. When considering the funding source, all three countries' expenditure on health care is large and growing as a share of both the public and private sectors, either through the NHS in England or insurance systems in the other two countries. The public sector continues to be the main source of health financing in both England and the Netherlands. Health and long-term care in the Netherlands are based on a two-tier health insurance system (combining private insurance for some and social insurance for the whole population). A later scheme, the *General Act on Exceptional Medical Expenses (AWBZ)*, also covers long-term care needs. Similarly, the English government introduced the *National Health Services (NHS) and Community Care Act 1990* as a response to various criticisms of their long-term care system. Although health care is provided free at the point of

need for the whole population including pensioners, social care is means-tested. Both England and the Netherlands have faced the possibility of excessive expenditure in the future and reforms have concentrated on cost retrenchment, decentralisation and deinstitutionalisation (Jonkers and Troisfontaine, 2004). In Taiwan, health care has been primarily funded from the health care insurance contributions made by individuals and their families in employment (see Figure 2.6). One of the health service problems faced in all three countries is bed-blocking. Long-term care provision can be seen as a significant alternative to reducing a country's hospital waiting lists.

2.5.1.2 Social expenditure on the care of older people

The cost of the broad range of long-term care for older people shows huge differences between the two chosen EU countries and Taiwan - varying from 0.27% of GDP in Taiwan to nearly 1.5% in the Netherlands and approx 1.35% in England (Directorate-General of Budget, 1997, Lee, 2002; OECD, 2005b). If we adjust the Taiwanese percentage for its comparatively low proportion of over-65s (see Figure 2.3 on p 15) by a multiplier of 3 it would still be much less than the figures for the Netherlands and England. The figures show that the Netherlands has made an extensive investment in long-term care support, England comes a close second with Taiwan lagging behind. However the cheapness of labour in Taiwan is a factor that should be taken into account and may shrink the gap somewhat. There is also variation in the role of public and private spending, with over 90% of spending in the Netherlands coming from the public sector, compared with 60% in England and just 9% in Taiwan (Lee, 2002; OECD, 2005b). This reflects each country's public financing arrangements where the Netherlands has opted for a social-insurance-type system; and England relies on funding through general taxation and on means tested benefits and services. Taiwanese public expenditure is still relatively low, traditionally being restricted to a limited amount of care provided in institutions. Nonetheless, a social-insurance-type system is currently being discussed (Ku et al, 1997; Ku, 2001).

The share for institution-based care is around 0.11% of GDP in Taiwan to nearly 1.5 % of GDP in the Netherlands and approx 1.3% of GDP in England (Lee 2002, OECD 2005b). The OECD's research (2005b) concluded that there was no evidence that expenditure on long-term care had grown any faster than acute health care

expenditure. Nonetheless, more than 70% of total long-term care expenditure is accounted for by care in care homes in both England and the Netherlands. The cost implications of an ageing population have provided one of the incentives for developing domiciliary care as an alternative to more costly institutional care (Means et al, 2002). There is no statistical data available regarding the expenditure balance between domiciliary and care in the care homes in Taiwan. However the Taiwanese state has paid fully for older people to receive home care services since 2003, based on two scales: a maximum of 20 hours for low-dependency clients and a maximum of 36 hours for high-dependency service users (DSA, 2004). This may give some indication of increasing investment in care support at home in Taiwan.

2.5.1.3 Social expenditure on pensions

Apart from the state's social and health care support, another significant source for an individual's life quality is the availability and the amount of an old age pension. According to Barr (2006) a consequence of more pensioners enjoying a longer retirement has put pension affordability into question. Whiteford and Whitehouse (2006) stated pension systems have three pillars: The first pillar includes redistributive components that are designed to ensure that pensioners achieve some absolute minimum standard of living compared with the population as a whole (such as public pensions). Second-pillar programmes are defined as those with an insurance or savings role: these are designed to maintain a certain standard of living during retirement relative to the individual's earnings when in work (such as occupational pensions). Third-pillar is a private, voluntary savings pillar, available to anyone who cares to supplement the retirement income provided by the first two pillars (such as personal pensions) (Whiteford and Whitehouse, 2006). For reasons of simplicity, both England and the Netherlands have the first pillar of universal state pension. In addition, the Dutch have the second and the third pillars of some private schemes frequently at an occupational level, and a system of voluntary pensions covering a small percentage of the population (Barr, 2006). Similarly, England certainly has increasingly relied on the second pillar's private provision (Whitehouse, 2003). In Taiwan pension provision historically lacked a first pillar till 2007, and has traditionally relied on second-pillar and third-pillar pensions, along with family support to fund the incomes of older people (Chiu, 2004). More and more countries, such as the Netherlands and England, are moving away from an almost exclusive reliance on public pensions toward mixed models of retirement income provision. The policy

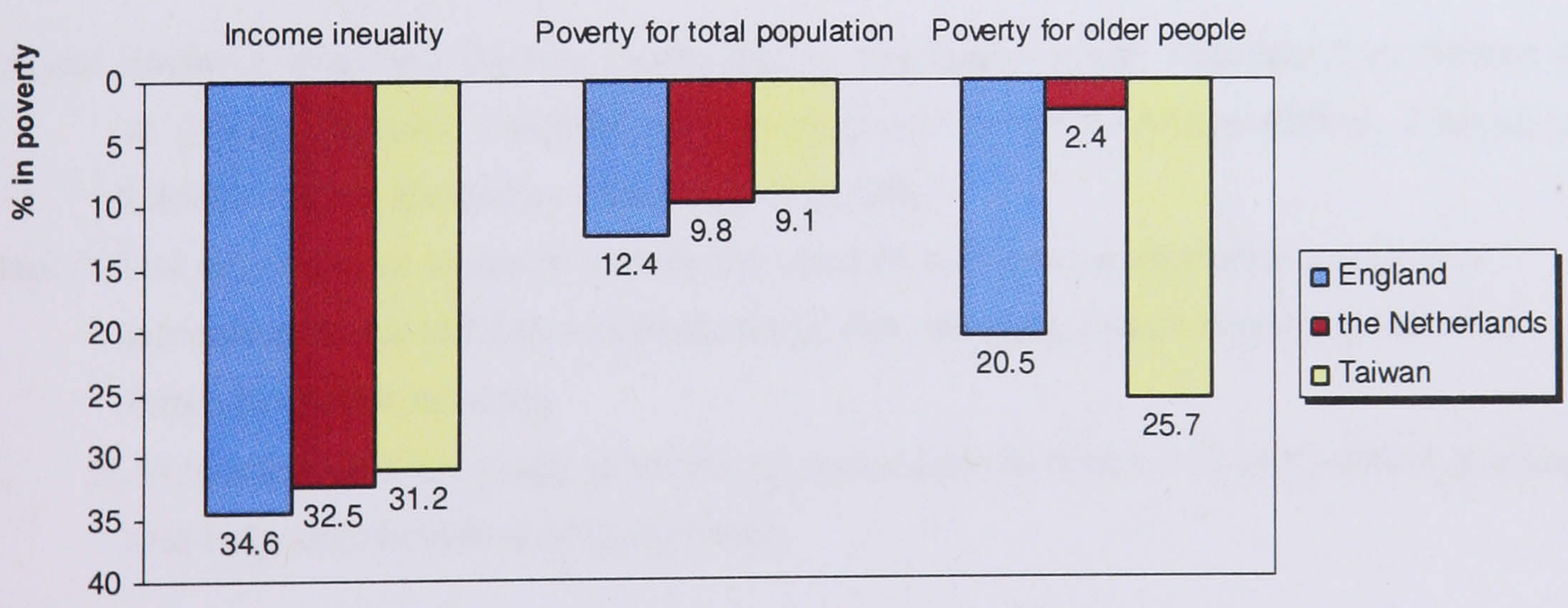
reasons for this trend are risk diversification and a wish to contain the level of compulsory contributions to public systems (Pearson and Martin, 2005).

2.5.2 Micro level

At the micro-economic level, financial security is central to well-being in old age and one of the major resources that older people may command. Of the three countries covered in this study, England has the most unequal income distribution and the highest overall poverty rate (Figure 2.7). There are very few people living in households without an earner in Taiwan and older people also benefit from the wider family income. This is an aspect of private welfare in Taiwan that is difficult to estimate. However, the poverty rate for older people in Taiwan was the highest, England came second and the Netherlands was relatively low. The problem in Taiwan is that although nearly 50 per cent of old people currently receive support from their children, the ratio has dropped drastically in past years, with the decrease in the number of children each older person can depend on (Chiu, 2004; Ku and Chen, 2001).

Figure 2.7

Income inequality, Poverty for total population and older people in 2000



Sources: Income inequality: WIDER world income inequality data base; Poverty: LIS Key Figure, 2006; Statistics Netherlands, Department of Household Registration Affairs, Ministry of Interior, Taiwan.

Overall, the poverty rate for older people is greater than the rate of poverty for the general population in England and Taiwan but this is not the case in the Netherlands (Figure 2.7). European research has shown that there is a higher poverty risk for females aged 75+ relative to males, in England and the Netherlands, due to the high proportion of widows in this age group who are less likely to be entitled to pensions related to their own earnings (Zaidi et al, 2006b). In contrast, older males have a higher poverty risk in Taiwan due to the main income resource deriving from kinship since most sons and daughters are more generous to their mothers (Shieh, 2000).

2.6 An overview of long-term care services

Table 2.6

Share of population 65 and older received care services in 2003

%

Country	Care homes	Home-based care	
		Home care	Live-in care
England	5	4	0
The Netherlands	8.8	12.5-13.0	0
Taiwan	1.3	0.7	5.3

Sources: England: Wanless Review Team (2005), the Netherlands: Adapted from Gibson et al (2003), Taiwan: adopted from Department of Social Affairs (2006), Council of Labour Affairs, Executive Yuan R.O.C (2006).

Notes: 1. The estimates of share of population aged 65 and over in institutions may vary according to the definition of institutions. For example, the Netherlands includes those in shelter housing.

2. Proportion of older persons receiving formal help at home, including district nursing and help with Activities of Daily Living.

Statistically, care homes and home-based care are the two main types of care service provided in all three countries. Table 2.6 provides a general view of the percentages of older people who have received the two most commonly available care services. The Netherlands has the highest ratio of formal institutional care and home-base care for older people as a whole, England comes second and Taiwan comes a distant third. Taiwan is the only country in the three to have introduced live-in care: foreign carers to provide 24-hour home help to older people in their own

home. If we take the service of the live-in care (the preferred option in Taiwan) into account, Taiwan can be considered to have reached a similar level of care support as England.

However, comparing national and international statistical data can be unreliable and overlooks large variations in definitions and categories of different care services for older people in different countries. There are wide differences in national definitions and considerable overlap between different types of facilities making cross-country comparisons problematic (European Commission, 1993; Österle, 2001). The latest EU project describes 8 different categories of permanent residential and semi-residential services and 22 different categories of community services for older people in Europe (European Commission, 1999, p 67). The issues raised here include: what overall care support is available in each country, what care services are provided, what are the chief characteristics of the client group, how have policies been formulated and what are the characteristics of the service system?

Although the ratio of care home admission in the Netherlands is relatively high, both the Netherlands and England have been actively de-institutionalised because of the cost and in England - the poor quality of care (OECD, 1999a). In some parts of the two countries, traditional old age homes have gone through a transformation into care intensive homes or extra care housing (European Commission, 1999). On the other hand, Taiwan is expanding its institutional care alongside community care. It is argued that the extension of institutional care for older people in this country is a response to evidence of insufficient supply to meet demand (DH, 1997; Yang and Soon, 1998).

2.6.1 Types of care service for older people and their informal carers

Table 2.7 shows the types of care services available in the three countries (see Appendix A for details). Given the general policy, in all three countries, to support older people in their own homes, domiciliary care services are obviously one of the most important elements of care and assistance (a point further explored in Chapter 3.2.1).

Table 2.7

Provision of care and assistance for older people

Types of care / Country	Domiciliary care ❶ Personal care ❷ home nursing ❸ Home cleaning and shopping ❹Others	Institutional care ❶ Residential care ❷ Nursing care ❸ Social and recreational services ❹ prevention care	Auxiliary care ❶ Cooked meal ❷ Mobility ❸ Day care ❹ Respite care	Housing for older people: ❶ Sheltered ❷ Pensioner ❸ others	Support for informal care ❶ Care allowance paid to carer ❷ Care allowance paid to older people to cover care costs ❸ Care leave ❹ Employment of carer
England	Home care: ❶❸	Residential home: ❶ Nursing home:❷	Meals-on-wheels: ❶ Transport: ❷ Day centre: ❸ Care attendance and sitting services: ❹	Sheltered housing: ❶ Granny annexes: ❶ Hostel and group living: ❶	Invalid Care Allowance: ❶ Attendance Allowance: ❷
The Netherlands	Home care: ❶ Home nursing: ❷ Home cleaning: ❸	Residential home: ❷❸❹ Nursing home: ❶❸❹ Care hotel: ❶❷❸❹	Meals-on-wheels: ❶ Transport: ❷ Service centre: ❸	Housing connected with care home: ❶ Extra care housing:: ❶ Lifetime housing: ❸	Personal care budget: ❷ Career break for care: ❸ Short-term job absent due to family circumstances: ❸
Taiwan	Home care: ❶❸❹	Residential care: ❶❸❹ Nursing care: ❷❸❹	Meals-on-wheels: ❶ Transport: ❷ Care attendance: ❹	State housing: ❶ Older people apartments: ❷	Foreign care support: ❹

Notes: 1. Extra care housing (Woon-zorg-complexe) in the Netherlands is a block of independent dwellings constructed in a manner similar to sheltered housing, including an agreed care and service arrangement. Sheltered housing complexes function as a replacement for residential homes and nursing homes. The houses meet adaptability standards. The greater part of the sheltered housing complexes have been built in the 'social rented sector' and consist of three-room houses. The emphasis is placed on connecting care and nursing, adapted housing, resources, and welfare services. Examples of the latter include nursing, housekeeping assistance, a linen service, provision of meals and a shopping service. Even education, clubs and associations providing a broad range of social-recreational activities are available. (Arcares, 2002)

2. There were 40 of lifetime housing in 2001 in the Netherlands. They aim at creating conditions in a district or village (with about 10,000 inhabitants) so that elderly

> and disabled inhabitants can maintain their independence by staying in their own homes, instead of moving into an institution. Sufficient adapted houses, an accessible environment and adequate care facilities are the main elements. (Ex et al, 2003)

Home help in all three countries generally includes both domiciliary tasks and personal care. Kraan and colleagues (1991, p 233-237) implied that both England and the Netherlands have moved towards more home-based systems but England has a less generous base-line position with fewer care services available. For example, English home care has concentrated on personal care tasks and has encouraged better off older people to use private cleaning services. In the Netherlands, special staff provide house cleaning in order to reduce the cost of over-qualified staff. Furthermore, home nursing in the Netherlands has been provided by home care agencies to give a coherent service support framework while in Taiwan and England it is provided by nurses from the local health authority but in a more fragmented way (such as Primary Care Trust in England). Newly established domiciliary care in Taiwan has focused on covering as many needs as possible to include a wide range of older people.

Care in care homes, primarily residential and nursing homes, is still an important service in all three countries. Often the two forms of support - housing and care - are integrated in the care homes. However, more nursing input is provided in the nursing homes for older people who need medical attention. As a general development, social and recreational care is integrated into care homes in Taiwan and the Netherlands, whereas in England personal care is the main focus of care provision. Ironically, because it has become accepted policy to provide as much care as possible in people's own homes, residential/nursing homes are facing increasingly high levels of dependency in England and the Netherlands. This has raised some concerns about the ability of care staff to meet the increase in the demand for care. Auxiliary care is provided in all three countries to different degrees. All provision is in the spirit of de-institutionalisation and is supposedly aimed at helping older people lead an active life.

Sheltered housing has also been developed as an alternative to institutional care. In England, shelter housing provides accommodation and warden support but not personal care. The Dutch have taken this development further by converting many care homes into sheltered housing complexes (Ex et al, 2003). These are housing

blocks called 'extra care housing' which have been built in the social rented sector and consist of three-room flats. The emphasis is placed on connecting care and nursing, home adaptation, resources, and welfare services under one roof. Examples of the latter include nursing, housekeeping assistance, a laundry service, provision of meals and a shopping service. Even education, clubs and associations - providing a broad range of social-recreational activities - are available (Arcares, 2002). As shown in Table 2.7, extra care housing which provides wardens, meals and bathing is also available in England. The great difference between extra care housing in England and the Netherlands is that most of English residents have one room not three like the Dutch. Moreover, care needs are met by the local authority with home care support in England but in the Dutch equivalent care needs are met by an on-site carer and professionals round the clock. This means English residents in extra-housing are likely to be moved when they need 24-hour care.

2.6.2 Flexibility and coordination within care systems

2.6.2.1 Service entitlement

It was noted in Chapter one that, in all three countries, there is neither a single definition of long-term care nationally or of those who are entitled to it. This lack of definition makes it easier for the authorities to change the scope of eligibility. At present, long-term care issues are often equated with the elderly population, although the population also includes some disabled people aged under 65 (Österle, 2001). 'Older people' are typically classified as being 65+ (or perhaps 60+) corresponding to the cut-off points national governments have tended to adopt as the threshold of pension eligibility. Moreover, in respect of likely physical dependency, the category of "very elderly" (i.e. 70+ in Taiwan and 75+ in England and Holland) has come increasingly into focus because from this age there is an increased likelihood of a need for expensive health care and intensive social care.

Table 2.8 summarises the major issues that are taken into account in determining eligibility for accessing care support in the three countries. Taiwan is the only country where statutory long-term care is only available to older people. European studies (Grundy, 2006) show that the allocation of statutory home care services is influenced more by household composition than by the characteristics of older people

themselves or the care available. In all three countries – particularly in Taiwan - those who need help and live alone are more likely to receive formal services. It can be argued that one consequence of policies that favour those living alone may be to disadvantage family carers and reduce incentives for older people to live with others. In the case of Taiwan, most of the family carers are daughters (in-law) who provide care without statutory support. This is a particular problem for those who are in the workforce, most of whom are in full-time employment.

Table 2.8

The eligibility criteria for access to long-term care support in the three countries

Criteria	England	The Netherlands	Taiwan
Age	All age groups	All age groups	65+
Health and functional status	ADL/IADL	Physical and psychological functioning	ADL/IADL
Availability of informal care	Considered	Considered	Considered and living alone
Income test	Means tested	Universal	Means tested
Additional eligibility criteria	None	The state of living environment; formal care support network	Living alone

Notes: 1. Activities of Daily Living (ADL) has been used in clinical assessments of older people, such as bathing, dressing, transferring from bed or chair, walking, eating, toilet use and grooming.

2. Instrumental Activities of Daily Living (IADL) has been used to assess functional capabilities of older persons. There are 7 criteria: (1) use of the telephone, (2) use transportation, (3) shopping, (4) meal preparation, (5) housework, (6) medication use and (7) management of money.

2.6.2.2 Needs assessment

England is the only country of the three where assessment is made by the same agency (the local authority) that holds the budget and is therefore subject to resource constraints. The assessment agents in the Netherlands and Taiwan are semi-

independent from budget and resource holders. Assessments therefore are more likely to be objective. Assessments are carried out, before people receive care services, by different professionals in the three countries. The assessors include social workers and nurses in all the countries and occupational therapists in both England and Taiwan. In the Netherlands, in addition, physiotherapists and social gerontologists are included. The Dutch have a wide range of professionals involved in the assessment process, partly due to the broad range of factors to be considered. In England the assessors are mainly social workers and occupational therapists as long-term care is considered to be mainly social (apart from the nursing tasks). In contrast Taiwan involves more medical and nursing personnel in assessment.

2.6.2.3 System integration and innovations

In all three countries, the statutory agency responsible for providing care under the law is part of the health and/or welfare system. England and Taiwan have a number of responsible agencies to operate their care systems. In England, the national Department of Health is responsible for policy-making, followed by implementation through the local authority (i.e. Health and Social Care Department). This is similar to the Taiwanese system, which in addition has four central government departments involved with different issues such as health care, social care, safety, mobility, labour and participation. The nature of the responsible agency and the degree of integration with its other components becomes crucial in respect of present current English and Taiwanese government policy reform. Up to a point, the Dutch central government and service providers are responsible for both social and health welfare delivery (Kickert and Vught, 1995, p 325). The Dutch Ministry of Health, Welfare and Sport is the single responsible agency, under the auspices of existing health insurers. The influence of central public bodies on long-term care is relatively strong, including budget control, eligibility criteria for the services and quality standards (Őosterle, 2001). Nevertheless, while England and Taiwan have faced problems with their fragmented systems (see Chapter 3.3.3.1), the Dutch are going to reform their current responsibility from state only to state, local government and individuals in 2007 (MINVWS, 2004b). This is due to Dutch concerns about future sustainability of finance and the disadvantage of overstretched forms of cooperation in practice (Heineke et al, 2005). The above suggests that partnership and cooperation will

become a significant component in current reforms in all three countries, an issue to be further addressed in the next Chapter.

2.6.3 Standards and quality assurance in services for older people

All three countries have introduced a number of measures designed to ensure the quality of care:

- The training (and supervision) of formal and informal carers as well as relevant professionals,
- The licensing of service providers according to defined criteria,
- The establishment and regulation of quality standards,
- The development of mechanisms to monitor processes and outcomes.

Table 2.9 categorises those care staff and professionals responsible for care provision in the three countries. It suggests that the Netherlands has a higher staff quality and a sound training framework, whereas Taiwan and England are catching up. Recruitment of the care workforce is a shared concern in all three countries. Nonetheless, in the Netherlands, service providers are responsible for the training and education of staff to ensure the quality of care provision. In Taiwan, central government has established regulations and requirements for quality in care workers. The Taiwanese local authorities have provided training to ensure that care workers are qualified to practice. Certain training has to be undertaken by foreign carers, so that they are familiar with caring for Taiwanese older people prior to working in Taiwan. However, the standard of foreign care workers is seen as the responsibility of the providing agency and there is no statutory monitoring or control in this field - as a result, the quality is variable. In England, training has become a big issue as a high proportion of formal carers are unqualified. Of home care and residential care staff, 29 and 15 per cent respectively, had, or were undertaking, National Vocational Qualifications (NVQ) in 2002 (McFarlane and McLean, 2003). The Training Organisation for Personal Social Services England (TOPPSE) and General Social

Care Council (GSCC) have became regulators and guardians for the social care workforce under the C*are Standards Act 2000*.

Table 2.9

Staffing levels and qualifications of carers

Service	Country	Professionals	Semi-professionals	Non-professionals
Home care	England	None	carer with NVQ1,2	Untrained carers (perform personal care)
	Netherlands	Nurse	Trained carer with professional care degree level 2.	Basic trained carers (perform house work)
	Taiwan	None	Trained care with 50 hours taught course and 40 hours placement. Post training required with no stated limit.	None
Residential care	England	None		None
	Netherlands	None	Trained carer with professional care degree level 3.	Volunteers (for social and recreational activities, meal assistance)
	Taiwan	Nurse, social worker	Trained care with 50 hours taught course and 40 hours placement. Post training required with no stated limit.	Volunteers (for social and recreational activities)
Nursing care	England	Nurse		None
	Netherlands	Nurse, physiotherapists, nutritionist, social worker	Trained carer with professional care degree level 3 and 4.	Volunteers (for social and recreational activities, meal assistance)

	Taiwan	Nurse, social worker, nutritionist	Trained care with 50 hours taught course and 40 hours placement. Post training required with no stated limit.	Volunteers (for social and recreational activities)
Extra care housing	England			
	Netherlands	Nurse		None
Living-in care/Foreign carers	Taiwan	None	Trained carer in their own country for 2 months with the training programme regulated by Taiwanese government.	None

In all three countries, the quality of the care services has traditionally been the responsibility of the service providers, however statutory involvement is on the way and joint responsibility between national and local levels can be found. Quality assurance mechanisms lie with the three pillars in the Netherlands. First, at national level, there is a periodic formal inspection of health-related service providers by a representative of the health care system. Second, all the providers have internal quality control mechanisms (so called benchmarks) that evaluate and improve their care services. Moreover, the Netherlands is the only country where consumer councils (so called client boards) are well organised within care agencies by law. In a way, councils provide power to service users, their families and independent legal advisers by addressing their views and acting as watchdogs over services. Furthermore, structured instruments for inspection and regulation are underway to increase regulation by setting price and quality standards (Coolen and Weekers, 1998; Huijbers and Martin, 1998).

In England, the quality of providers is monitored by local authorities through a system of contracting. Furthermore, at the national level, the Commission for Social Care Inspection (CSCI)[8] was launched in 2004 by the *Health and Social Care Act 2003* to

[8] CSCI used to be known as the National Care Standards Commission (NCSC) based on the *Care Standards Act 2000* work partnership with Commission for Health Improvement (CHI) and Social

incorporate the work formerly done by Social Services Inspectorate (SSI), the Audit Commission Joint Review Team and The National Care Standards Commission (NCSC). CSCI is semi-independent from the Department of Health. The Commission provides quality control of social care in England, including: monitoring the quality of local council services, residential care, nursing care, as well as the - recently included - inspection at home care services across all sectors.

Very recently in Taiwan, central and local government has begun to operate quality management and control. A set of standards for residential care institutions was amended in 1995 and nursing home regulations were established in 1996. Since then, residential homes have been monitored and regulated by the Department of Social Affairs. Nursing homes have been monitored and regulated by the Department of Health at national and local levels since 1995. Although many homes are in the process of becoming registered because of the penalties for non-compliance recently introduced, many uncertified homes are associated with poor quality provision (Bartlett and Wu, 2000, p 218-20). Some problems, however, have occurred in this new system. For example, the inspection has emphasised the structural aspects of care (i.e. staffing ratios, size and residents per rooms), rather than processes and the quality of life (Bartlett and Wu, 2000, p 220). Furthermore, a shortfall in quality monitoring staff at the local level has restricted the amount of quality control, resulting in greater inequality of care performance in general (Huang et al, 2003, p 159).

2.7 Conclusion

This Chapter aimed to provide a context for understanding the long-term care of older people in England, the Netherlands and Taiwan – three countries that roughly represent Esping-Andersen's welfare state regimes.

Although cross national comparison are problematic, as the data and definitions vary from country to country, nevertheless some important facts have emerged. All three countries are facing similar tensions and difficulties. The population is ageing; more women are participating in the labour force; all three countries are moving towards

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Services Inspectorate (SSI). There is a further reorganisation in process which plans to integrate with Health Inspection and the name of CSCI will most likely change in the future.

mixed welfare care provision. Even the Netherlands has found it difficult to sustain increases in state provision because of the economic impact. The three countries deal with similar issues in different ways. Taiwan has devoted considerable resources to health and education but comparatively little to social security and social services. In spite of recent developments Taiwan remains a welfare laggard in terms of public and social spending. It is however, difficult to estimate the size and significance of other welfare sectors apart from the state. It could be said that the Taiwanese have not needed to become dependent on the state because they have had lower unemployment on the one hand and an inter–generational sharing of household incomes. It may be that private and familial welfare go some way towards narrowing the gap between Taiwan and the other two countries studied.

This chapter also demonstrated that cultural, political and economic issues impact on welfare systems. The Dutch and English welfare systems have developed over a long period of time as part of their systems of representative democracy. Taiwan's political development however, has only recently moved away from the almost one-party rule that followed World War Two. Similarly, the Netherlands and England achieved advanced industrial status long before Taiwan. However, Taiwan has rapidly caught up in this area and now boasts a highly successful economy with a high level of employment for both men and women. While state social spending may lag behind that of England and the Netherlands, Taiwan can claim to have achieved a similar degree of income equality. The culture and traditions of England and the Netherlands are not so dissimilar but Taiwanese traditions represent a considerable contrast to the other two.

All of the above factors impact on long-term care provision in the three countries. The Netherlands seems to provide wider support for older people who need care, England comes second and Taiwan comes third. The quality control mechanism in England and the Netherlands is developing, but Taiwan is lagging behind. However, while qualified staff and staff training is an issue in England, both the Netherlands and Taiwan have established more comprehensive staff training system. There is little reason not to believe that England and the Netherlands will experience further welfare retrenchment in the near future, but Taiwan will find it necessary to provide more resources for its elderly population. Taiwanese economic ideology has strongly influenced developments in long term care as it not only aims to provide care comparable to that of England and Netherlands, but also to increase employment in Taiwan. The Netherlands has continued to modernise its long-term care services to

become more comprehensive and to meet people's changing needs whereas English services remain primarily at the level of personal care. In contrast, Taiwan has taken advantage of its new system of long-term care to be creative in service development and to support older people and their families, with the result that the gap referred to above may begin to close somewhat.

CHAPTER THREE

Successful Ageing in Long-Term Care:

A Framework for Analysis

3.1 Introduction

The previous chapter demonstrated how the characteristics of welfare regimes have shaped the long-term care system in each country studied. We have also seen what care support is provided for clients. The objective of this chapter is to identify key themes from existing literature to construct an analytical framework for comparative research into the policy and practice of successful ageing in long-term care. While the effects of an ageing population on society are complex, there is a particular concern about the impact on the demand for health and social care. Saltman et al (2006) argue that the large number of suggestions in the literature for specific interventions to cope with the expected increase in demand for long-term care in ageing societies can be organized under four headings: improved system performance; redesigned service delivery; support for informal caregivers; and the shift in demographic parameters. The preference for this study is to focus on whether different welfare regimes deliver a different *quality* of care and why/how the particular issue of *quality in later life* shows up more in one than the others.

The literature reviewed drew mainly on key texts on long-term care research between 1995-2004, although additional studies published until 2008 may be referred to. It focused primarily on English, Dutch and Taiwanese material but also included studies that covered similar themes in other advanced industrial societies. The review shows that research in the area of long-term care is patchy. The approaches underpinning this study were derived from social policy and psychology studies of need and the gerontology concept of successful ageing. This study is based on the assumption that the key conceptual elements of successful ageing are *care needs,*

social inclusion and power and autonomy. Moreover, key factors – *partnership and resources* – in policy development and service delivery need to be present if successful ageing is to be promoted. This chapter addresses the question of current concerns in each country studied and how the concept of successful ageing can be operationalized for research into long-term care. The first section will explore the basic and specific needs of older people that services have to meet. The second section will address those factors that are essential if services are to meet those needs.

3.2 The needs of older people

As already shown in Chapter two (Table 2.6, p 31), there were at least 9% of people age 65 and over in England, 21% in the Netherlands and 7% in Taiwan receiving some sort of formal long-term care support. Old age, however, most often brings disadvantages and less favourable social and economic circumstances. Many social policy studies of the *quality* of long-term care can be operationalized into the following subordinate concepts: (1) the needs and quality of life of older people; (2) the extent to which it can be said older people in long-term care are socially included; (3) the power and autonomy exercised by older people; (4) the resources devoted to care; and (5) partnership and service integration in long-term care.

3.2.1 Human Needs

A number of studies have been devoted to the identification of human needs. The most widely known theory has been proposed by psychologist Abraham Maslow (1943). He stated that people had a hierarchy of psychological needs, which ranged from:

- Physiological needs (such as air, water, food, rest and exercise),
- Safety needs (such as shelter and security),
- Love and belonging (such as included and participating),

- Self-esteem (such as empowered, confident and convivial)

- Self-actualization. (such as actively seeking knowledge and inspired to reach potential)

According to Maslow, higher needs could not be met until the lower ones had been satisfied.

Another theory of need is to be found in the work of the political economist Ian Gough and the medical ethics researcher, Len Doyal (Doyal and Gough, 1991). It goes beyond the emphasis on psychology and focuses on the context of social assistance provided by the welfare state. Doyal and Gogh argued that what made social needs distinct was their claim to be universal. For Doyal and Gough, needs analysis, therefore, had, firstly, to be objective and not political. As a result, social policy would be able to aid the development of welfare services designed according to need. Secondly, they argued that "health and autonomy are basic needs which [all] humans must satisfy in order to avoid the serious harm of fundamentally impaired participation in their form of life... it is possible in principle to compare levels of basic need-satisfaction in these terms not only within but also between cultures" (Doyal and Gough, 1991, p734). To avoid serious harm, in their view, included satisfying not only the most basic material needs (survival or health needs) but also the need for autonomy and social participation (equivalent to Maslow's love and belonging, self-esteem and self-actualization). Through these individuals were given both a sense of their own identify and abilities and the knowledge and freedom to act as autonomous individuals. They further pointed to eleven broad categories of "intermediate needs" that defined how the need for physical health and personal autonomy could be fulfilled:

- Adequate nutritional food and water (part of Maslow's physiological needs),

- Adequate protective housing (part of Maslow's safety needs),

- A safe environment for working (part of Maslow's safety needs),

- A safe physical environment (part of Maslow's safety needs),

- Appropriate health care (part of Maslow's safety needs),
- Security in childhood (part of Maslow's safety needs),
- Significant primary relationships with others (equivalent to Maslow's love and belonging needs),
- Physical security (part of Maslow's physiological and safety needs),
- Economic security (part of Maslow's love, belonging and safety needs),
- Safe birth control and child-bearing, and
- Appropriate basic and cross-cultural education (part of Maslow's safety needs and self-esteem needs) (Doyal and Gough, 1991).

So far, a problem with the theories of Maslow, Doyal and Gough's is that the concept of "needs" might vary between different cultures, gender groups or different parts of the same society (Pearson, 1999; Coy and Kovacs-Long, 2005). Other authors, rather than arguing that needs are universal, have suggested that it is important also to focus on the different needs of different categories of people (Glendinning and Millar, 1991; Barnes, 1991; Hirst and Baldwin, 1994). In this sense children, young persons, mothers and the retired can be said to have different needs. Furthermore, the specific manifestation of objective needs as defined by individual preferences for food can appear in many different ways.

Although Doyal and Gough, and Maslow, discuss needs in general and objective terms, some of those they identify can be seen to be of fundamental importance for the understanding of care services of and the care needs of older people. Firstly, from Doyal and Gough, who focus on how the society can meet the needs of individuals, we learn that the ideology of a service must have, as an objective, that older people need not only to survive but also have some quality of life. Secondly, when we talk about Maslow's needs, his hierarchic of needs included shelter, food, clothing and cleanliness. Policy has to make sure that these are taken into account in the minimal standards of long-term care provision. One of the factors that makes

people require long-term care is that they lose their ability to be able to meet those basic needs themselves and require help to do so.

With regard to long-term care needs' identification, social policies in the countries studied were similar. However, the thresholds in meeting needs were different. Various English reports have indicated that local authority care management has focused spending on those with the highest level of need and the lowest incomes to meet them (DH, 1997a). Similarly, in Taiwan, family care, home care, day care, residential and nursing care have focused on basic physical and medical needs. However in the Netherlands, the support threshold is based on seven assessment criteria which not only include what the other two countries provide, but also the satisfaction of higher ranked needs and guidance, such as supporting and activating/advising (Schrijvers et al, 2001).

How much care support should be provided is an issue in all three countries but is associated with their historical development and culture. In the case of England, Langan (1998) and the latest Wanless Report (Wanless, 2006) highlighted the way in which historical budget and allocation restrictions have affected the outcome of assessment. This means that there is a great variation in the amount of service support within the country. The Netherlands acknowledged a similar problem and identified differences between needs assessors in their decision making (Degenholtz et al, 1999). Although there is lack of literature on this issue, in Taiwan, it is widely acknowledged that there are great variations in assessment because of a lack of central and local guidelines. Assessors are left to themselves to identify the needs of the service users. The Netherlands is the only country of the three where issues of service inequality are addressed by centralising objective assessment criteria and mechanisms carried out since 1997/8 (Ex et al, 2004) by the Regional Assessment Board (RIO). Van der Vleuten et al (1991) emphasised objectivity as 'a set of strategies designed to reduce measurement error'. This strategy may consist of a detailed checklist, protocol and clear criteria. However, Percy-Smith and Sanderson (1992) raised the general concern that universal basic needs, as currently defined, might lead towards service-led criteria and undermine the necessity for coordination in the planning and delivery of care services. Moreover, as long as needs are seen as objective there will be little room for service users to articulate their own needs. In contrast, the paternalist argument is that individuals are not always the best judges of their own welfare. However, if people's needs are misdiagnosed, this may lead to withdrawal and disengagement (Wetherly, 1996). This argument links with Doyal

and Gough (1991) who stressed the importance in reconciling the 'codified knowledge' of professionals and policy-makers with the 'experiential knowledge' of users. This raises the issue of power and autonomy between older people and other partners which will be addressed later in this chapter.

The efficiency of assessment as an issue has been addressed in England and the Netherlands but not so much in Taiwan. In both England and the Netherlands, there are formal timescales for the process of assessment, with decisions required after a maximum of six weeks (Ministry of Health, 1997; Schrijvers et al, 2001; DH, 2004). A number of English research studies have shown that the face-to-face work of assessors with service users has declined in the past 5 years (Levin and Webb, 1997; Audit Commission, 1999; Weinberg et al, 2003; Samuel, 2005). One interpretation of this findings is that this might explain why emotional and psychological needs are often missed in assessment. Rushing the judgment was also likely to result in the offer of a single, often, basic service (Fuller and Tulle-Winton, 1996; DH, 1997a). The Commission for Social Care Inspection (2004) conducted research into the impact of the English *Delayed Discharge Reimbursement Scheme* (HCHC, 2002) and expressed similar concerns. This study found that a third of older people needing social care were moved with too little consideration directly to a care home from hospital. Efficiency and effectiveness of care arrangements are high on the political agenda in England and the Netherlands, and to some degree in Taiwan. However, the quality of life of older people cannot simplify be quantitative. Indeed, much of the research into the care for older people has focused on physical functioning, while mental and social-health measures have rarely been examined (Stawbridge et al, 1996; Chang, 1997). Thus, there is a substantial literature that challenges the oversimplification of needs identification (e.g. Warren, 1990; Glendinning, 1992; Ungerson, 1997). It can be argued that when we examine the ways in which needs are meet in welfare systems, there is an over emphasis on objective, professional, physical and medical definitions but not enough on the subjective views and experiences of participants and consumers.

With regard to older people's experience of care, much English research has focused on older people's experience of formal care. Twigg (1997) for example, in her work on care provision, addressed the often-overlooked consequences of policy concerning the privacy and dignity of service users in care. It is evident from English studies that what older service users want in their care are professionals and carers who are able to develop and maintain direct personal relationship, who listen and

respect service users as individuals (Harding and Beresford, 1996; Godfrey, 2000; Little, 2002; Scottish Executive, 2006).

So far, the discussion of the concept of successful ageing has focused on needs identification and the care satisfaction of service users. However, care satisfaction amongst older people is affected greatly by state provision, family and community support, living environment and many other factors. The availability and affordability of care, the nature of the family and the environment affect all areas of life. There might be an even bigger increase in the demand for formal and informal care provision than would be caused simply by the socio-demographic developments discussed in Chapter two. Both Phillips (2000) and Boyle (2003) suggest that when addressing the issues of care, the breadth of factors such as the capacity and abilities of the carers should also be recognised. I would further argue that satisfying the needs of front-line professionals and carers could in turn increase their ability and capacity to provide care.

Jörg et al (2006) carried out a survey, in the Netherlands, of 214 assessors across RIO organisations in 1999-2001 and concluded that only clearly motivated assessors were willing to support their service users' wishes. A study by Wang (2002) - who examined the inter-relationship between home carers and older people in Taiwan - found that home carers who adopted a 'do-gooder role' (i.e. trying to be kind by acquiescing to their clients' every need) found it difficult to retain a professional distance. An increasing amount of research has been focused on informal/family carers. For instance, much literature - across a range of countries - has focused on:

- informal carers' lives and the cost of care associated with the disadvantage they faced in terms of employment and financial well-being (e.g. Glendinning, 1992, Baldwin, 1995; Carers National Association, 1999; Knijn, 2004)

- gender issues: the stress and risks faced by female carers (Baldwin and Twigg, 1991; Knijn and Kremer, 1997; Lewis, 2002; Lister, 2003)

- care issues (Parker 1993; Parker and Lawron, 1994; Knijn, 2001; Parker and Clarke, 2002; Lin and Harwood, 2003)

- welfare support for informal carers (e.g. Knijn, 2001; Pickard, 2001, 2004; Ungerson, 1997, 2000, 2004).

In spite of this increasing recognition and research focus on informal carers, the *wellbeing* of formal carers and professionals has been largely ignored. It can therefore be argued the volume of care workers and professionals might shrink unless better conditions can be created to stimulate them to continue providing care/services.

3.2.2 Needs specific to the older people - What constitutes successful ageing in long-term care

The earliest definition of "successful ageing" was proposed by the gerontologist Havighurst (1961) who defined it as "adding life to the years" and "getting satisfaction from life". His approach remained significant through subsequent decades, and peaked again with Rowe and Kahn's 1987 article in *Science*. Later Rowe and Kahn (1997a) present a three-component model defining successful ageing by objective and subjective outcome criteria as follows:

- Absence and low risk of disease;
- High psychological and physical function,
- Engagement with life.

Objective outcome criteria have included: length of life, biological health, mental health, cognitive efficacy and social competence and productivity (for an overview see for instance Baltes and Baltes, 1990; Heckhausen and Schulz, 1995, Rowe and Kahn, 1997b). Moreover, a number of scholars have suggested that subjective qualities such as happiness, self-realization and autonomy should also be measured as these are essential factors that need to be taken into account to provide a person with a better quality of life (Doyal and Gough, 1991; Higgs et al, 2003).

Rowe and Kahn's (1987, 1997a, 1997b) studies have been particularly useful for understanding distinctions between primary and secondary ageing in later life, leading to numerous intervention studies designed to identify, prevent and reverse functional losses associated with usual ageing. It is generally agreed that the

process of ageing is a complex process of adaptation to physical, social and psychological changes that accompany increasing age. Evidence was also provided concerning the factors that constitute successful ageing and their differences between the East and West. Studies by Von Faber et al (2001) and Strawbridge *et al* (2002) found that many older people view successful ageing as a process of adaptation even when they are chronically dependent in western societies. Whereas, in Taiwan for example, studies by Hsu and Chang (2004) and Hsu (2006) found that most older people value health and independence and also place considerable importance on economic security and family support. However, most successful ageing literatures do not identify gender issues. Similarly, this study was not able to identify any gender issues, as the total number of service users was relatively small (28 out of 143 in total), and all the participants were female.

Apart from a few researchers such as Guse and Masesar (1999), who studied the expectation of successful ageing among 32 older residents in Canadian care homes, interaction with family and friends, personal qualities and living environment have been identified as affecting the success of elderly residents in long-term care. Overall, most empirical successful ageing studies have drawn attention to successful ageing in general, and have drawn on the views of older people who are reasonably independent. However, research into the term 'successful ageing' associated with long-term care is, by and large, still fairly rudimentary. The reason for this is perhaps, the lack of the voice of older people who are disempowered (Thursz 1995). This in turn raises a fundamental question about what successful ageing and empowerment mean for older people in long-term care and how far successful ageing is promoted to those people who need long-term care services. Therefore, this is an area ripe for further research.

In this study, the analysis of successful ageing in long-term care follows Rowe's and Kahn's (1987) successful ageing criteria of objective and subjective physical, mental and social-wellbeing of older people. The sphere it focuses on is long-term care. In contrast to other studies – Strawbridge et al (2002) (older people's expectation of successful ageing) or Guse and Masesar (1999) (service user's expectations) – this study will focus on service users' expectations of life quality in long-term care and the system response to such expectations. Rowe and Kahn (1997a, 1997b) stressed that strong social ties were even more important in preventing illness than genetic background. This implies that the needs to be addressed for successful ageing in long-term care are social inclusion/participation and power and autonomy. These

would prevent and reverse the usual functional losses associated with ageing (Baltes and Baltes, 1990; Rowe and Kahn, 1997b). In order to age successfully, individuals, their families and the society which they live, service resources and the quality of the care force are crucial to ensure that older people are socially included and have a degree of autonomy in controlling the quality of care they receive.

3.2.2.1 Social inclusion

The concept of social inclusion - according to Rowe and Kahn (1997a, 1997b) and WHO (2002c) - is one of the important elements in successful ageing. They defined the concept as incorporating physical, mental and social wellbeing; and stretched it further to include the level of participation. If social exclusion is a problem for older people, social inclusion can be seen as the response to the problem. This section is therefore concerned with the concept of social inclusion and its relationship to poverty, social exclusion and social participation.

The concept of social exclusion is not new, rather it is a wider dynamic and interactive development of the concept of poverty (see Gordon and Townsend, 2000; Townsend and Gordon, 2002). In 1899 Rowntree defined an absolute measurement of poverty (cited from Rowntree 1991) in terms of being able to achieve minimum standards based on a person's biological needs for food, water, clothing and shelter (corresponding to Doyal and Gough's (1991) minimum standard of *basic* human needs). Recent research on poverty has seen a growth in concern about domains of disadvantage and theories of 'deprivation' (Townsend, 1979; Mack and Lansley, 1985, Nolan and Whelan, 1996). The concept of social exclusion was adopted in particular in Room's work (1995, 1998, 2000). Room (2000) argued that social exclusion was not coterminous with individual's resources but was about the inability to access societal resources. He highlighted the need for researchers and policy makers to concentrate on multi-dimensional and longitudinal disadvantage rather than the traditional focus on financial disadvantage alone.

Nevertheless, studies in social exclusion are, by and large still at a fairly rudimentary stage. The reasons for this lie partly in the overwhelming focus on the economic consequences of various policy options. Studies have therefore tended to focus on the unemployed, lone parents and the disabled together with failing schools, crime,

poor neighbourhoods and public health (for example Phillipson and Scharf, 2004). It may be because those issues are highly costly for society. Studies of social exclusion have been less concerned with older people in care and more with the identification of older people in poverty. The aim has been to recommend actions to address poor finance and health (Walker and Walker, 1997; Deeg et al, 1998; Think, 2006; ODPM, 2006).

In Chapter two, figure 2.7 (p 30) has shown that only one in 50 of Dutch, one in four of English and one in 5 of Taiwanese older people are in poverty. Joehoel-Gijsbers (2004) explained that older people who are in a vulnerable situation can be protected by well-established social rights. The Dutch case has confirmed the argument that the poor or disadvantaged can be socially included by receiving good social care support and adequate benefits. Some English and Dutch research has concluded that women, single people with lower incomes and those in poor health are likely to be socially excluded (Joehoel-Gijsbers, 2004; Barnes et al, 2006; Think, 2006). In contrast, Taiwanese research found older males had a higher poverty risk because kinship resources are more likely to be devoted to mothers (Shieh, 2001).

From the above reasons, it is not surprising that there is no reliable, comparable statistical data available regarding the financial circumstance of older people in long-term care. We, nevertheless, may assume that this group of people will tend to be financially further disadvantaged than older people generally because of the cost of care (though not perhaps in the Netherlands). In England, certain issues relating to residential/nursing care have been brought to the attention of the public. For instance, the inadequate allowance – £2.5 to £3 a day - for older people in care homes (Guardian, January 20 2002); the 'top ups'[9] payment for care homes (Bebbington, 1998); and the selling of older people's homes to pay for the cost of their care (Guardian, July 5 2002). All of these issues can lead to poverty for older people in long-term care. A number of scholars have focused on the concern about home ownership (e.g Hamnett, 1995; Glendinning et al, 2004). They have argued that the means-test that requires older people to contribute most of their income and/or capital to the cost of long-term care impairs dignity and social inclusion. In contrast, the Dutch have funded measures that provide benefits to all eligible individuals, regardless of income (Glendinning et al, 2004). Similarly, in Taiwan, a

[9] 'Top ups' payments is a term used to refer to contributions towards care home fees paid by the third party. The most recent study was in 1995, Bebbington (1998) who indicated about 14 percent of supported residents had 'top-up', and the number is likely continue to increase.

flat-rate and non-contributory allowance scheme was established in 2004. It covered 71.4% of those aged 65 and above who were not receiving contributory old-age benefits (Council for Labour Affairs, 2004). Such a scheme avoids the bias of employment-based contributory pensioners in favour of men. It was introduced following evidence that there was an insufficient safety net available if the family's economic support was not adequate or the family relationship had broken down. This also implies a growing uncertainty over inter-generational transfers of income. As a result the introduction of a national pension system has become a matter of urgency (Ku and Chen 2001, Hsieh, 1997).

In addition to poor finances as a factor, some older people can find themselves socially excluded by their health and also their inability to participate. Three-quarters of older people in England and Taiwan consider their own health to be either very or fairly good (Age Concern, 1998; Ministry of the Interior, 1997). Nevertheless, older people in Taiwan as well as in the two European countries were likely to experience chronic disease - heart disease, cancer, fractured and joint problems (such as fractured hips), circulatory problems (like stroke, diabetes) and respiratory disease (Swun, 1999; Wilson, 2000; Huijbers and Knook, 2001). Many older people experience Alzheimer's Disease, depression and other mental health difficulties, and these result in their exclusion because they are unable to participate so well. Various research reports have pointed out that elderly people use mental health care services less often than other groups (Yeh, 1998; Darby, 1999; Euijk and Kelder, 1999). Moreover, research has found that isolation and loneliness are the key triggers of depression in old age, and this is a major cause of morbidity and poor quality of life and affects more older people than dementia (Heikkinen, 1995; Keogh, 1996). A number of research reports have shown that little support is given to older people who have lost their loved ones or significant resources – such as their homes. Such loss has not led to more therapeutic treatment for older people (Phillips and Rempusheski, 1985; Shieh, 1993; Chiagn, 1998).

3.2.2.2 Power and autonomy

In the context of long-term care, autonomy is crucial in determining quality of life and ensuring that older people are in control of their care (Österle, 2001; Boyle, 2003). Autonomy was emphasised in Doyal and Gough's human needs theory as well as

Maslow's needs model. It was also identified in the theory of successful ageing. The conventional view of autonomy comes from liberal bioethical thought associated with prioritising self-capability, independence, non-interference, self-determination, self-reliance and choice. This is rather difficult to apply to older people in need of long-term care, many of whom experience physical/mental frailty, despair, social isolation and most of all the loss of functional ability, self identity and support (Agich, 2003). Specifically, autonomy in the care system links with the concept of rights and choice, which is closely related to that of needs. Basic human needs themselves are universal and relatively straightforward to describe. However, the needs element in the relationship between the individual and society is complex and varied (Doyal and Gough, 1991; Langan, 1998). Factors that need to be taken in to account are the assessment process, resource rationing, professional power (Walker, 1993) and associated carers (Boyle, 2003). All of these determine how needs are identified and how far older people are or are not able to control their destiny.

It can be argued that autonomy is not only about the ability to make choices, but also about social interaction to make choices work (Silver, 1994; Bowring, 2000). Social inclusion (as reviewed in Chapter 3.2) and engagement involve strengthening the individual's system of support and participation in social activities that can result in an increased sense of social and personal fulfilment (Mullins and McNicholas, 1986). Empowerment is critical in enabling people to participate openly and directly in making the decisions that govern their lives (Etzioni, 1993). Cowger (1994 cited in Thursz, 1995, p xiii) defined service-user empowerment as being characterized into two dynamics: personal empowerment and social empowerment. Cowger defines personal empowerment as being similar to self-determination whereby clients give direction to the helping process, learn new ways to manage their situations and take charge and control of their personal life. It is similar to the social work/care notion of empowerment whereby service users are given information and advice by professionals with non-judgmental conditions and an understanding of older people's experience (Beresford, 2003). In a very valuable contribution to the discussion on empowering older people who are disempowered, Cowger's social empowerment applied and emphasized the need to 'create' social resources and opportunities for individuals as well as for groups of older persons (Thursz, 1995). The formal aspect is particularly relevant to state and multi-agency support. The latter is related with, for example, "collective empowerment" which is grouping people with similar interests or goals for common action (Thursz, 1995). Older people in care want to have choice and control over their daily lives, and need services that support such control

(Qureshi and Henwood, 2000). It is also important to build up a support network for older people to be able to express their views on various levels (Percy-Smith, 2000). The greatest factor in achieving the empowerment of people who are disempowered for both actions - personal and social empowerment - is to construct modes of action in a way that maximizes the involvement of service users, whilst maintaining their autonomy and participation in decision-making.

It is noteworthy that to 'involve' older people is not necessarily the same as 'working in partnership', which implies some balance of power in the relationship between the partners - the partnership between service users and formal carers and professionals in particular. Involving older people at a very basic level might mean to meet them and to inform them about what had been discussed and decided (Tanner and Harris, 2008). This is not necessarily about empowerment or autonomy. Working in partnership might involve a continuum of collaboration and involvement, from a very minimal level of giving information to the service user to a maximum level where service users are giving consent and are in control of decisions and resources (Tanner and Harris, 2008). We recognize that there is a power imbalance between the service users and the relevant carers, professionals and sectors. Concern that older people rather than others should have control over their own lives and a focus on battling for resources and opportunity for that vulnerable population should be the absolute requirement of professional and care practice with older people to offset the threat of power imbalance. Therefore, this study aims to find the ways and opportunities for meaningful participation in various aspects of supporting the autonomy of vulnerable older people.

3.3 Policy and service requirements for promoting successful ageing

Studies (Hyyppä et al, 2006; Philp, 2006; Victor et al, 2005) have shown that social inclusion not only promotes health and emotional well-being, but also increases social interaction, leading to reduced pressure on social and health care services as well as families. Social participation has been seen as one of the significant elements enhancing quality of life as people age (WHO, 2002c). The extent to which older people are socially included, indeed, is an area of concern. Although this is a major issue in EU countries (European Commission, 1994), England has fallen

behind. An English report *A Sure Start to Later Life* (ODPM, 2006) has recommended multi-dimensional actions to promote social inclusion:

- At the individual level - promote advocacy and service delivery to socially excluded people; analyse and pilot possible improvements in cultural, sport, leisure participation; and develop strategies to enable people to continue to live at home.

- At local level - Local authority, the Department for Transport and the Department of Health to improve public transport.

- From wider society- the Department of Health will address social exclusion in terms of isolation amongst older people as a part of wider approach to promoting well-being.

Preventing social isolation seems to be a major theme in English social policy. For instance, the National Health Service *Frameworks for Mental Health and for Older People* has encouraged local initiatives to address loneliness and isolation (DH, 1999, 2001b). Health promotion services and activities intended to ease social isolation and loneliness among older people have been considered to be important in providing support to develop, improve and maintain social contacts and mental wellbeing (Walters et al, 1999). However, the Wanless *Social Care Review* Report (Wanless, 2006) found little evidence of social engagement. Most long-term care focused on personal care and safety and preventing social isolation. I would like to argue that there is a distinction between social *isolation* and social *inclusion*. Isolation is being on your own, lonely, no friends, no visitors and no one to speak to; whereas inclusion is not only about not being on your own anymore, its about taking an active part in live events and activities. Although one could argue that not all of the older people want to take an active part, nevertheless, there is evidence that the more active people are, the better their health, both physical and mental, and the less their depression. Therefore, this study focuses on active involvement as being a positive factor. It assumes an active concept of participation rather than mere passive engagement. Moreover, the concept of participation, whether active or passive, is considered rather than one of disengagement.

In the Netherlands, since the early 1990s, attention has been given to the notions of solidarity and social participation which underpin the development of social cohesion and civil society. This recognises citizens' responsibility for voluntary work as a core element in their active involvement in improving the quality of life in society (MINVWS, 1999). Social participation in the Netherlands is relatively high and there are also positive trends in informal care. Research has shown that informal carers are given support primarily base on their own rights (Timmermans, 2003). In addition, the Netherlands has introduced legislation intended to promote social participation. Key parts of framework include:

- The *Service for the Disabled Act* (WVG). This is building 498,000 houses especially designed or adapted for older people and further developments have emphasised new housing (104,000), care-support centres (35,000), improving quality of institutional homes with small units for dependent older people (MINVWS, 2006, p30, 66,82).

- The *Social Welfare Act* and certain sections of the *Exceptional Medical Expenses Act* (AWBZ). These have increased home care and other services organisations in cooperation with housing to ensure no one is neglected and becomes lonely (MINVWS, 2006).

- From 2007, the relevant provisions will be brought together within the *Social Support Act*. (WMO). The local authority has a responsibility to provide: sport facilities, adult education, public transportation and social work to meet the needs of older citizens (MINVWS, 2003).

Various research studies and policy documents have shown that instead of regarding aged people as being on the margins of society, the Dutch have tried to normalise their lives by promoting social inclusion for all ages. For example, the project reports of *A City of All Ages* (Penninx, 2002) and *Generation in Action* (Merchen, 2002) have provided guidelines for inter-generational participation. Relevant local services and authorities look to increasing participation between child, young people and older people through intergenerational working project in community development.

Taiwan has placed an emphasis on promoting social activities and life-long learning for retired people through the *Mobile Circuit Service for Senior Citizens' Leisure and*

Recreation Plan 2003. Social activities have been emphasised in *National Care Services Standards* to prevent the further deterioration of older people in long-term care. Furthermore voluntary participation has been encouraged as the way to healthy ageing (Social Affairs, 2006). Research (Liu et al, 2000) conducted in 1994 with a small sample of 18 licensed and 204 unlicensed (issues around unlicensed care homes see p16) residential and nursing homes showed that most had provided social activities to older people and more than one in four had systems for encouraging family participation. Another study (Lo et al, 2002) conducted in 1999 with 285 residents in 4 nursing homes, however, found 62% of the residents were bed-bound and nearly half of the participants lacked social interaction with others. The study gives no information about the distinction between registered and unregistered care homes or the differences between residential and nursing care. The latter result may reflect the physical and mental disability of the participants. Nonetheless, quite different results from two studies show the need for further research.

For both reasons of policy and the scarcity of empirical research, it is increasingly impossible to ignore the issue of social inclusion of older people in long-term care. It is easy to argue that older people cannot participate because they are frail and disabled. Older people can be *enabled* with appropriate support. However, social inclusion is more than simply the opposite of exclusion (Walker and Wigfield, 2003). A minimum approach to social inclusion will be insufficient. Care services which focus on participation between older people, their families and wider society as well as care support for them to do so, are required if older people are genuinely to be included and enabled. This would mean older people feeling valued and that they are participating adequately. Such an approach might be judged by the extent to which older people participate in the management decisions of their care services. One of the aims of this study is to take the issue further by asking service users whether they are socially included and by asking their carers, professionals, local administrators and civil servants whether something has been done about it.

In order to achieve the goal of power and autonomy for older people in care, much policy development starts from the premise that individuals have some responsibility to help themselves as best as they can. However, this requires the physical and mental capacity to do so (Doyal and Gough, 1991). The other line of responsibility lies with those close to older people such as families, friends, neighbours, and other community members who have personalised knowledge about them and are able to

tailor help to what is required. This is affected by the availability of national and local resources. In the Netherlands, there are regulations that safeguard service users' rights, namely the *1995 Medical Treatment Act* (WGBO), which deals with the rights and obligations of patients and care providers; the *1996 Care Institutions Quality Act* (WMCZ), which deals with participation structures in the policy of an institution; and the 1995 Client *Right of Complaint Act* (WKCZ) which deals with the possibility of appeal through official complaints committees. In England, the *1990 National Health Service (NHS) and Community Care Act* emphasises the importance of empowerment in professional practice. The Department of Health has established an official procedure for dealing with complaints relating to health and social care under the *2000 Freedom of Information Act.* In contrast, Taiwan is the only country yet to have comprehensive legislation to secure service users' rights, but market forces and family involvement are strong. This raises the question of how far the three care systems have widened network support and/or better participation in decision making by older people.

English service arrangements are characterised by a quasi-market approach. Local authorities are the major consumers/purchasers of care services, not the individual. However, service providers select service users as well as vice versa when they assess the degree of fit between the prospective service users' needs and the services they provide.

3.3.1 Policy response for the promotion of successful ageing

We cannot actually help older people to develop satisfactory autonomy or participation, unless certain elements within the delivery of services facilitate it. In order to do that, a number of key factors in policy development and service delivery need to be present if successful ageing is to be promoted. These factors are resources and partnership.

3.3.2 Resources

The goal of successful ageing in long-term care can only be achieved with adequate resources – in kind and in cash provision for both formal and informal care.

3.3.2.1 Funding issues

Regarding cash provision, much research has focused on public expenditure (see Chapter one). Whether long-term care is regarded as a social risk or a welfare issue, how far and to what extent public intervention occurs is of great concern financially in all countries. According to the European Policy Committee (2001) and the Taiwanese Directorate- General of Budget (1997), the public cost of long-term care at the start of the 21st century was 1.7%, 2.5% and 0.27% of GDP in the United Kingdom[10] the Netherlands and Taiwan respectively. Most Taiwanese older people rely on self-funding with considerable family support; an estimated 30% of older people are self-funded in England (Netten et al, 2001) and almost none in the Netherlands. In both England and the Netherlands long-term care is means-tested. In the Netherlands, nearly all long-term care is covered by a specific national care fund, based on the *General Act on Exceptional Medical Expenses* 1968 (AWBZ) (Ramakers and Miltenburg, 1993). This suggests that the Dutch state spends the most and covers most of the long term care for older people, state spending in England comes a close second with Taiwan (partly due to Taiwan's low percentage of elderly people in the population and partly to the fact that most expenditure tends to be private).

A Dutch parliamentary announcement in 2004 stated that "... we are spending a great deal more than the amount of money available for care. The Cabinet cannot ignore this, and announced measures to tackle the issue..." (MINVWS, 2004b). This announcement put significant emphasis on 'solidarity' and 'social cohesion' with the introduction of the *Social Support Act 2006* (WMO) - in which much of the central government's welfare responsibility will be transferred to local authorities and communities from 2007. In the case of England - in spite of the amount spent on care - under-funding in care services seems to be a problem. Evidence for price pressure has been found by Knapp et al (2001) in research on the domiciliary care market. This study found that 20% of care providers in England had been forced to reduce costs in response to local authority purchasing practices. One in eight stated they had been under funded and 11 per cent were considering organisational closure. In English care homes, 'top up' payments refer to contributions towards care home fees paid by a third party. The most recent study carried out was in 1995

[10] Although the recent Wanless Report (King's Fund, 2006) has produced estimate figure of long-term care cost in England, for the purpose of this study, the author decided to use comparable data from one source.

(Bebbington, 1998). This indicated that about 14 percent of residents faced 'top-up' fees, and the number was likely continue to increase.

In contrast, in Taiwan, the state has been increasing its funding into long-term care, focusing on home care support for people who needed care as well as providing an universal Old Age Allowance for all people above the age of 65. The above evidence shows that in terms of financing long-term care for older people, England and especially the Netherlands have moved from universalism toward selectivity, whereas Taiwan has moved from selectivity towards universalism.

3.3.2.2 The pattern of care market and care services

While most care markets are now part of a welfare mix there are different patterns of mix within countries. This can be explained as a consequence of various factors such as different welfare regimes (see Chapter two), different family ethics (see Chapter two) and long-term care policies or the nature of the social and health care divide (see Chapter 3.3.5). In England, many of the services for older people have been provided by the private for-profit sector. However, there has been a rather uneven development of both cares homes and domiciliary services. Mur-Veeman et al (2003) found in 2001, that nearly all residential care (85%) and nursing care (92%) in comparison with more than half of day care and home care (56%) were provided by the private sector and the rest by local authorities. In contrast, neither of the other two countries have state care provision. In Taiwan and especially the Netherlands, not-for-profit organisations have dominated the care market with a slow development of the for-profit sector.

The English care market can better be described as a 'quasi-market'. This is the result of a strong neo-liberal or New Right influence (Hutton, 2003) which is critical of what is seen as the inefficiency and operational inflexibility of public organisations and bureaucracy (Clarke and Newman, 1997). Bureaucracy and local authorities are seen as inferior mechanisms for delivering markets in public services in contrast to contract-based competitive provision (Milne, 1997). England is one of the few countries, apart from New Zealand, that has taken the radical step toward quasi-markets in care provision (Flynn, 2000). English welfare mix and privatisation policies, such as *NHS and Community Care Act 1990*, required 85% of the social

security funding for local authorities to be spent on the purchase of non-local authority services. *Caring for People* (Secretary of State Department, 1989) further stipulated privatisation in domiciliary care. In spite of the lively debate about such an approach (such as Barlett and Le Grand, 1993; Wistow et al, 1996; Boyne, 1998), the rapid growth in the independent sector in England means that the key goal of the legislation in establishing a mixed economy has been largely achieved. However, some commentators have noted certain disadvantages in this approach. Firstly, Laing and Buisson (2000) estimated that 70% of independent sector income comes from local authority clients. Another survey of 155 domiciliary care organisations found that over one third of respondents acknowledged the risk of high level uncertainty and financial instability (Matosevic et al, 2001). The consequence of relying on short-term finance was difficulties for long-term business planning and service development (Hardy et al, 1999), a low level of pay and staff training and short-term collaborative relationships. These will be addressed in Chapter 3.3.5.

There has been a lively debate regarding the quality of care in the profit and not-for-profit sectors. A number of English studies have concluded that for-profit providers were often motivated purely by profit maximisation (Leat, 1993; Langarm, 1994; Knapp et al, 2001). However, in the case of the Netherlands, Coolen and Weekers (1998) highlighted the problem that not-for-profit sector dominance has resulted in a lack of competition and a failure to stimulate quality improvement. The most severe problem in Taiwan was not so much about the balance of care market sectors but the existence of un-licensed care homes. These are very common in Taiwan and there have been concerns both about abuse and safety.

3.3.2.3 Manpower sufficiency in care services

Social work training is crucial in maintaining a skilful and professional care workforce. In England, post-initial qualifying training in social work professional was substantially recognised during the early 1990s and the framework has recently been reviewed and further changes will be made from 2007 (GSCC, 2005). Prior to this two generic awards were in place - the Post-Qualifying (PQSW) and Advanced (AASW) Award. A number of studies claim that in spite of the increase in the number of PQ registrations and awards, they have not met the Department of Health's target (Eborall, 2003) and the completion rate has been 75% or lower (Stanford-Beale and

Macauley, 2001). Major factors influencing training take up and completion rates include: lack of a learning culture and support within the workplace (Postle et al, 2002), and pressure from work and study (Shaw, 2001). Additionally, one of the factors in England is presumably the delegation of care to unqualified care workers (see Chapter 2.6.3).

3.3.3 Partnership

As mentioned earlier in this chapter, policy for long-term care needs firstly to take into account the higher needs of older people - autonomy and participation. It also needs to be underpinned by sufficient resources in order to achieve the aim. One of the big problems we have in all three societies is that fragmentation of service delivery can be addressed by better partnership and better quality control. One way to strengthen the care support of older people is to improve partnership within the care system. In the early part of this chapter, we demonstrated that successful ageing in care entailed meeting the care needs of older people and their carers, adequate resources, social inclusion and empowerment. A holistic approach is necessary to address all these issues. The aim of such an approach is to harness the energy, skills and resources of the key players who develop, implement or use long-term care services. This is especially important to fulfil the multiple care needs of the chronically ill (Audit Commission, 2002a, 2002b; Leichsenrig, 2004). Fragmented care is a matter of concern in the three care systems studied here (Balloch and Taylor, 2001; Lee, 2002). Therefore, it might be agreed that "partnership" between service users and all the care actors should be recognized as a vital component of successful 'seamless services' (Peck et al, 2002, p 33) for older people needing LTC.

3.3.3.1. The concept of partnership

Partnership is not an entirely new phenomenon (for English examples see: Balloch and Taylor, 2001, p 2; Leathard, 2003; for Dutch examples see Mur-Veeman et al, 2003; for Taiwanese examples see Kuan, 2000; Lai, 2002). Nevertheless, some commentators have noted that there is no single definition or model of this particular concept (Willson and Charlton, 1997; Balloch and Taylor, 2001; Glendinning, 2002). It is often associated with many other labels, such as collaboration, co-ordination, co-

operation, joint working, interagency working and networking (for examples Huxham, 1996; Powell and Exworthy, 2002). All of these terms are concerned with "relationships" between relevant authorities, organisations and participants in the care system. People involved in partnerships have been defined at different levels:

(1) Macro-level: the financing and policy context of the care system within a national or state ministry or on a country level;

(2) Meso-level: the organisational context of the local level; and

(3) Micro-level: individual service users (Glendinning, 2003).

Collaborative activities can be divided into two levels:

(1) Strategic level: at which strategic decision-making concerning resource allocation and investment is coordinated; and

(2) Operational level: at which service delivery is coordinated across people and functions.

Ideally, there should be both a horizontal and a vertical link between the two levels of decision-making, resulting in actions to improve the quality of care (Challis, 1998; Leichsenrig, 2004). In reality, this ideal is difficult to put into practice. Cross-national research on integration by Kümpers et al (2002) and Leichsenring (2004) suggest that different macro institutional frameworks, and, particularly, different funding sources can have a different impact on the possibility of integrated care development. The Dutch Bismarckian insurance based system comprises a public-private dimension which includes short-term and long-term care provision with elements of the public, self-regulatory and the market competition model (Hardy et al, 1999). The English situation is more formal and complex. Based on the tax-funded Beveridge system, this includes national health care and social services which are predominantly publicly funded but delivered by a mix of statutory, voluntary and private agencies. In Taiwan, two national departments and two sets of agencies for social and health care, combined with an individual and family funded system, result in difficulties in the organisation and administration of care services (Lee, 2002). There are, however, cultural and historical factors involved. For instance, Dutch values of solidarity, equality and needs-led services, promote a more negotiated and

self-governing system with a client-centred approach (Ex et al, 2004). The English network can be conceived of as operating within a relatively more hierarchical model of governance (Kümpers et al, 2002). In Taiwan on the other hand, the predominant NGO welfare tradition is more focused on flexibility, co-ordination and networking between different types of providers (Kuan, 2000).

3.3.3.2 Objection to partnership

Policy initiatives from all three LTC systems researched here have reflected the intention to move from working in isolation to networking; and from competition to co-operation. In England, partnership working is a key component of the government's modernisation agenda, particularly in the health field. The *New NHS* white paper (Great Britain Parliament ,1997) requires a 'duty of partnership' (Balloch and Taylor, 2002, p5) between the NHS, local authorities and local service providers. Also the *National Service Framework for Older People* (DH, 2001b) and *Our Health, Our Care and Our Say* white paper (DH, 2006b) in England are intended to create quality benchmarks across a wide range of health, social care and other services for older persons including the extent of their integration (for details of earlier initiatives from 1997 to 2000 see Glendinning et al, 2001; Leathard, 2003). Equally, in the Netherlands, the *Medical Treatment Agreement Act* (WGBO) (1995), the *Care Institution Quality Act* (CBO) (1996) and the *Individual Health Professions Act* (Wet BIG) (1997) regulate participation between clients, health/social care organisations/professionals and various national ministries to share responsibilities for the outcomes of care/treatment. In Taiwan, the *National Health Promotion Plan* and the *Rehabilitative Care and Long-term Care Plan* were implemented in 1991 (DH, 1997; Juan, 1999). These were reinforced in 1998 by *Long-Term Care of Older People – a three year plan*, to integrate and merge social, health and retirement military care into a holistic long-term care network (LTC Association, 2003, p2).

Much research shows that the benefits of promoting partnership-working in care systems could be a sharing of risks and profit between relevant participants, the surrender of some element of power and resources. These would, however, require full integration and cost effectiveness in terms of finance, services and human resources (Gray, 1989). Moreover, four sets of questions have been raised about the potential extent of collaboration between players (Gray, 1989; Delnoij, 2001).

Firstly, there is an imbalance of power and resources available to different partners. Although the English government has been actively developing inter-agency and multi-agency partnership (Glendinning et al, 2001, p 411), there is an unequal power between Department of Health and local government; and between local authority public services and voluntary and private organisations. As a result, in each case, the latter has the least power and incurs a larger burden of costs (Rose, 1997; Means et al, 2002). Considerable interagency variations in the take-up of LTC responsibilities in Taiwan seem to result to some extent in difficulties in policy making and the organization and administration of aged care services (Lee, 2002).

Secondly, reluctance to fund shared and joint-service delivery - caused by different lines of accountability and lack of role clarity between each partner, such as the financial split between care (*Exceptional Medical Expenses Act, AWBZ. 1967*) and cure (*Sickness Fund Act, ZFW. 1964*) in the Netherlands and the divisions between health and social care as well as between public, private and voluntary sectors in England and Taiwan - has hindered integrated care development and delivery in the countries studied. Many older and chronically ill people need co-operation between cure and care, and between social and health provision. In this context, the *Raad voor de Volksgezondheir en Zorg* (2001) stated: that when trying to arrange for a smooth transition between care and cure, one ran into a wall of tight regulations. To promote integration in Dutch care, the financial split will be abolished by 2005 and a shift made away from a centrally directed, supply oriented system. In England on the other hand, the financial split between health (centrally funded) and social care (80% national taxes and 20% local taxes) has been in existence since 1948. Whereas the NHS operates an internal market, local authorities have developed an external market and a mixed economy of provision under the *NHS and Community Act 1990* To develop a partnership between health care trusts, local authorities and other providers, the government introduced a range of 'flexibilities' in the *Health Act 1999* (Section 31) to allow health agencies (i.e. NHS Primary Care Groups and Primary Care Trust) and local authorities to pool their separate budgets by planning and purchasing integrated care jointly. Running concurrent to *The New NHS* (Great Britain Parliament, 1997) and *Partnership in Action* (DH, 2001c) were two more White Papers: *Modern local government: in touch with the people* (DETR, 1998) and *Modernizing social services: promoting independence, improving protection, raising standards* (DH, 1998). The latter includes a whole chapter on partnership working to help people get the services they need through integrated health and social care.

Thirdly, culture clashes can often be expected between people who come from different levels and organisations and who need to find ways of working together. Social and health care staff may have different perspectives on tackling joint issues, as seen in the English experience. In England, the 'Berlin Wall' (Hudson, 1999) between health and social care professionals has been well documented (DH, 1998; Clark and Seymour, 1999; Balloch and Taylor, 2002; Leathard, 2003) In order to overcome this, the Single Assessment Process (DH, 2000) has been introduced to ensure that professionals from different disciplines work together to give full consideration to the whole range of older people's needs. Fourthly, structural factors that cover different geographical areas and ICT systems, can make it difficult for parties or individuals to link with their opposite numbers (Williamson, 2001, p120; Clarke and Glendinning, 2002; p38; Cameron and Lart, 2003, p15). Any of those barriers can contribute to distrust (Powell and Exworthy, 2002; Banks, 2002; Cameron and Lart, 2003).

3.3.3.3. The relevance of partnership

While the principle of partnership is now quite widely accepted nationally and internationally to reinforce the traditional value of service provision and help to keep 'quality in care' a unifying concept, there is too little acknowledgement of how the best examples can demonstrate a lasting impact on the life quality of older people who need care on a broad and multidimensional basis (Kümpers et al, 2002; Balloch and Taylor, 2002). The value added by partners and the associated impact attributed to them need to be better measured (Powell and Exworthy, 2002). A degree of consensus between academics and policy makers exists on the key measurement criteria of successful partnership. Outcomes such as accessibility, acceptability, accountability, effectiveness, efficiency, equity, implementation and responsiveness appear to be common across studies (Audit Commission, 1998; Hudson, 1999; Ling, 2000; Glendinning, 2002). However there has been little cross-national and cross-level assessment. More evidence is required on the evaluation of different models and structures of partnerships, about the outcomes for different partners and stakeholders, including those directly involved (i.e. service users, carers, professionals and service providers) and those with a wider interest in the success of initiatives (i.e. civil servants at national level and local administrators). While there

have been a number of practice-based studies, research tends to focus on a specific project (i.e. Peck et al, 2002) or a particular level of the care system or form of collaboration (i.e. Calarke and Rummery, 2002; Geddes, 1997). This further raises the question of who will be the best person or authority to judge. Outcome studies either from van Raak et al (1999) - measuring join-working in multidisciplinary teams - or Evans and Killoran (2000) - examining partnerships working in tackling health inequalities - were based on qualitative research which involved interviewing key participants (i.e. stakeholders and professionals). I would argue, firstly, that we need to examine whether partnerships in practice fulfil policy intentions. Secondly, we need to ensure that contributions from all organisations ranges across specialisms and can be integrated to achieve a more coordinated service for users and better joint-working structures for care contributors. Holistic research is needed to gather an overview of partnership working in the whole care system.

3.4 Conclusion – An attempted analytical framework of long-term care of older people

Historically, long-term care for older people has been about meeting their basic needs. Through this chapter, it has become evident that if older people's higher needs are not met, their arousal will be lower, they will be more likely to be excluded and they will be likely to require more care. Therefore, I would like to argue that successful ageing is an important criterion of the long-term care of older people. Those who are vulnerable require support to achieve a good quality of, and satisfaction in, later life.

Carrying out a literature search on the concept of *successful ageing in long-term care* has been a complex task. This chapter has identified the concepts providing the framework for the empirical aspect of this study. In spite of much research into these concepts, the result is patchy rather than a holistic view of the care systems studied. Nevertheless, five specific themes emerged from the literature: three do to with meeting older people's needs (care needs, power and autonomy and social inclusion) and two to do with the difficulties in meeting those needs (resources and partnership).

From previous chapters, we now know that our three countries are facing an increase in the ageing population. We also know from extensive literature that there are a

number of issues particularly relevant to older people and to the policy development. For example all three countries have similar needs assessment criteria but different service eligibility thresholds based on economic conditions, public resources and social values. Different patterns in the care market exist. The English market has experienced radical privatisation and short-term contracting. The Dutch have acknowledged that further state welfare has become unaffordable and are shifting towards de-centralisation to strengthen social solidarity. In contrast, the Taiwanese state has increased state support to tackle historically under-funded state welfare. All three countries have faced difficulties in maintaining the required amount and quality of staff.

The importance of *active* social inclusion for older people has been recognised by the Dutch which is evident from their policy and legislation. The Taiwanese believe social inclusion promotes good health. In contrast the English have emphasised *passive* social inclusion by focusing upon the more basic issue of isolation. Nonetheless, there is little empirical research into social inclusion in long-term care across the three countries. Despite various policies which have come into force to promote the empowerment of older people, English policies have yet to achieve their aims. In the Netherlands however service users' rights have been safeguarded. And for those in Taiwan are rely closely on their families. While we found partnership and service integration are core issues in the long-term care of older people across the three countries, we do not have enough empirical research to justify the practice.

Autonomy and social inclusion are key elements in successful ageing in long-term care systems. They should be promoted as policy objectives rather than simply satisfying the basic care needs of the older population, In order to do this, adequate resources and a unified/integrated service are required. So three of the key questions this study will address will be (1) how far each care system meets basic care needs, (2) how far they have sufficient resources to provide a good quality of life and (3) how far the fragmentation of services make this possible.

Part Three

Empirical research:

A comparative perspective

CHAPTER FOUR

Empirical Research: Methodology

4.1 Introduction

As we have already seen, many industrial societies are facing an expansion of the elderly as a percentage of the population. Previous chapters have indicated how important are the recognition of needs, social inclusion, care support and participation by relevant care actors in the care of older people. The arguments presented in Chapter two and three led us to conclude that we needed empirical work to further identify how different welfare regimes supported older people; to discover whether the elderly encountered similar problems in different countries; how different countries supported older people; and what different countries could learn from each other about improving their care. The main aims of this research, therefore, are:

- To understand and evaluate current systems of care.

- To discover how long term care for older people is provided in different countries; and how needs are assessed and met.

- To obtain a better understanding of the implications of long-term care for different welfare systems.

- To identify which factors influence the quality of long-term care for individual service users.

- To assess the impact of policy upon the provision of long-term care services in different countries.

- To examine what the different welfare systems can learn one another in order to more closely meet the needs of their population.

In order to achieve these research goals, it was clear that a comparative, cross-national study would be the most appropriate approach, rather than examining a single country in isolation.

4.2 Qualitative cross-national comparison

Cross-national study takes many forms. Much cross-national or cross-country social policy research is in fact a comparison of core social policy programmes such as social security, housing, health, education; covers 'the welfare state' as a whole (for example Johnson, 1987; Gould, 1993; Esping-Andersen, 1999; Ebbinghaus and Manow, 2001; Kennett, 2001); or deals with the development of particular social policy programmes over time, such as unemployment protection (Clasen and Freeman, 1994), pensions (Bonoli, 2000) or health policy (Freeman, 2000). Parallel to this strand of literature with a focus on policy development, there are studies investigating the impact of social policy on particular groups (for example Hugman, 1994; Walker and Maltby, 1997; Bradshaw and Finch, 2002) and studies which are focused on particular problems, such as poverty (Townsend and Gordon, 2002).

There are many books which describe, discuss or analyse social policy instruments, outcomes and policy developments in a large number of countries, with individual chapters devoted to particular countries (for example Goodman et al, 1998; Walker and Naegele, 1999; Finer, 2001). However, there is often little attempt to introduce central concepts or insufficient discussion about how these have been operationalized. For instance Finer's work did not have a central concept of welfare typology. She described what was happening but she did not have a theoretical framework on which to peg the discussion. Walker and Naegele had a wonderful theory and it was extremely interesting, but they did not discuss how their theory was operationalized in the practice. As a result it was difficult to draw comparative conclusions. Alternatively, the comparative method can be used to study a small number of countries qualitatively where researchers can look at a well-defined issue in two or more national contexts with an intimate knowledge of all the countries under study (Wilensky et al, 1987; Hantrais, 1995). Furthermore, a cross-cultural approach, according to Levinson and Malone (1980), gives scholars in this field a real international perspective and opportunities for mutual understanding.

In order to understand the care of older people in the context of different welfare systems, selecting similar systems could help us to find out who performs best within a relatively controlled setting. Looking at very different countries, nonetheless, is a challenge in itself. There are many difficulties in terms of controlling for different factors but such a study is rewarding in its own right. I therefore chose to compare the care experiences of older people in one country with conservative welfare system (Taiwan), another with more liberal system (England), and one with a more social democratic system (the Netherlands) (Chapter two has given the detail of why those three countries have chosen). The idea of including three welfare systems in this study derives from Esping-Andersen's original welfare typology (Esping-Andersen 1990). Although I have confirmed his typology was relevant, the 3 countries chosen in this study are hybrids (see Chapter two). It is important to include a country such as Taiwan which shares a Confucian culture with many other states in Asia. This study is an attempt to break down the civilisation "wall" between East and West through a cross-cultural approach. Such research is rare, and it is hoped that it might further encourage a more international approach which moves away from comparisons that focus only on European or English speaking countries in social policy research. It is also hoped that the findings from this study will help us to gain a greater understanding of the impact of different policies and practices in this field and in some small way contribute to improvements in long-term care.

In conducting cross-national research, many researchers have adopted a quantitative approach (such as Castles, 1985; Esping-Andersen, 1990; Kennett, 2001; Walker and Wong, 2005). While this has many advantages there are also limitations. For example, national and even international databases are not always strictly comparable (Lindner and Comolet, 2007). Therefore, in this study a qualitative methodology seemed to be the most sensible approach. A few qualitative comparative analyses (see example of Hannelore, 1993; Glendinning, 1998; Ungerson, 1996; 2004) have been carried out but they are restricted to the micro level rather than the welfare system as a whole. For this research in order to achieve a degree of policy learning, it is important to understand the different perceptions and objectives of the different policy actors in the field of long-term care for older people and show how they performed. This study, therefore, focuses not just upon one part of the *care process* but the whole of the *care system* at macro, meso and micro levels. The terminology of macro-, meso- and micro- derives from social cohesion literature and has been applied to this research into three different welfare systems in seeking to explore the interaction between bottom-up and top-down activities in

different societies (see Woolcock 1988, Narayan 1999, Lockwood 1999 and Phillips 2006). This study will use these levels in order to identify the characteristics of each care system and the adequacy of the services necessary to promote the key components of successful ageing (Chapter three) in terms of social inclusion, power and autonomy, meeting care-needs, resourcing and partnership of long-term care amongst older people. This should shed light on "system as a whole", rather than concentrating on "individual" experience.

4.3 Area selection and approach

It was important to ensure that participants selected at the micro level in each country were not from too dissimilar a geographical area, in order to provide relatively comparable research material. Constellations of service users and carers were therefore selected from midland county suburban localities on the edge of medium-sized cities. Sub-urban locations were chosen because cities have their own problems and rural areas are not typical of the industrial countries studied. A further reason for avoiding urban or rural areas was because the former would be likely to attract greater formal and/or informal resources and the latter fewer. The experiences of the elderly in these areas would probably be too extreme and atypical to represent each country.

To avoid a possible conflict of interest between my roles as a social worker, researcher and community member, the areas where I have lived or worked were excluded from the selection. Information from service users and carers from those localities, however, made a great contribution to the pilot studies in each country (see in next section), and helped to improve the comparability of the research instruments. The choice of localities was itself a very difficult exercise that occupied a great deal of time and effort. Research governance procedures meant that it took 5 months to obtain acceptance by an English county in the Midlands.

4.4 Pilot studies

Having designed the interview schedules, I then piloted these in each of the countries studied. In the pilot study, 21 interviews were carried out in the three countries in

2003. The purpose of this was to see how useful the interview questions were and whether these covered the right areas of concern. The interviews covered the same questions, translated into each of the three languages used in the study. My first language is Mandarin Chinese – the language used for the Taiwanese part of the study. I wrote the first schedules in English and tested them out with participants in the pilot study whose first language was English. I myself translated the schedules into Taiwanese before piloting them in that country. A colleague whose first language is Dutch translated the schedules from English into Dutch before the pilot. They were then translated professionally from Dutch into English so that I could check the consistency of the language. As far as possible I therefore was able to ensure that the language used was comparable in each country. Interviews in both the pilot and the full study were conducted by myself in the language of the country; in the Dutch interviews I had some additional assistance from a colleague. In studies of this nature there are numerous issues concerning differences in meaning and language – these are discussed later in this chapter (Section 4.10). Following the pilot in each country, I made some changes to ensure that later interviews would provide the material that was comparable between the three countries.

4.5 Participant selection

The research design was to adopt an organic approach, focussing in depth on a relatively small sample of older people and the relevant actors involved in their care. In order to minimise the variation in the core service user sample, the research design was to select female service users who had been looked after for more than 3 months. The three month timescale corresponds with UK practitioner guidelines for carrying out service reviews of social care. This suggests that at least three months experience of care is necessary for older people to make a judgement about the care they have received. Prospective participants were identified and access was through social workers and service providers in all three countries. Older people had to give their consent before I could get their names and addresses.

In England social services identified older people who met the research criteria; assessors discussed the study with potential participants and passed details of those who had given consent to me. In Taiwan access was through different routes: service providers identified older people receiving home care, residential care and nursing

care who met the research criteria; local authority civil servants identified those receiving foreign live in care. In the Netherlands access was initially through service providers. However they were unable to nominate a sufficient number of older people who received home care support and a personal care budget (PGB). Additional older people had to be accessed directly by handing out an explanatory leaflet.

Differences in the structure of the care systems in each country meant that older people could not be accessed in an identical fashion. Taiwan, with its liberal conservative welfare regime, has a greater emphasis on private provision, and so not all elderly service users are known to the statutory services. Providers therefore had to be involved in the selection. In contrast the vast majority of elderly service users are known to the statutory services in the social democratic conservative Netherlands; however in this country there is a greater emphasis on protecting the privacy of service users with the result that a direct approach had to be made to the general public in the community, by handing out a leaflet inviting anyone who knew of someone who met the criteria to contact me.

To maximise the coverage of each care system, a different range of care situations was selected. The original intention was to interview 9 service users in each country (3 people living in their own home, 3 in residential care and 3 in nursing care), their main carers (either informal or formal), one of their assessors (for definition see Chapter 5.6, p 108-9) and one of their service providers at the municipality level. In addition interviews were planned for two individuals at the county level with some responsibility for older people (such as policy and planning officer or deputy director of social services); and two individual interviews at the national level in each country, one of whom would be a civil servant and the other a senior official in a national voluntary organisation concerned with older people. The total number of respondents planned was 29 in each country – 87 in total. However, the process of carrying out a pilot study in the three countries (see below) provided the opportunity to rethink this design. It was evident that the *same* numbers of participants in each country would not elicit comparable data on the three care systems. The size and structure of each care system, also, had to be considered. It was therefore decided to adjust the number of the respondents with reference to the scale of the support network for the service users studied, a point further explored in Chapter five.

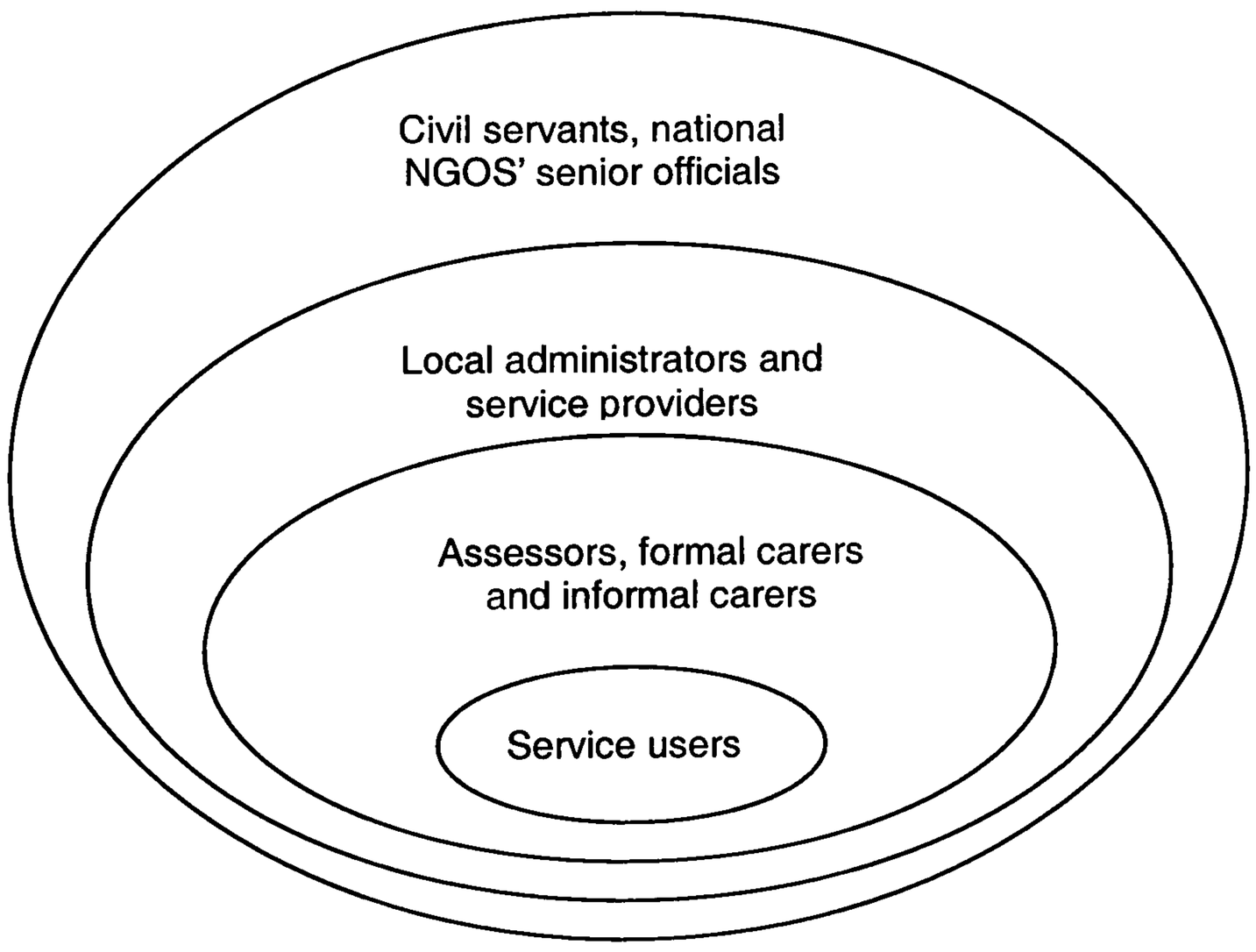
Twenty eight older people (9 in England, 10 in the Netherlands and 9 in Taiwan) were deliberately selected to reflect a comparable range of care services across the three

countries. Roughly one half were receiving community care, about a quarter were receiving nursing care and around a quarter, residential care. There was one extra service user in the Netherlands in order to include a resident in a *care hotel*, a service not provided in England and Taiwan. This type of care provision was provided by the private-profit sector and reflects the increasing influence of these providers in the Dutch care industry. The difference between a care hotel and the more widespread residential and nursing home care is that all of the residents are willing to contribute the major part of care cost with a supplement from the state, so they could receive higher quality of care services to meet their 'individual' needs and wishes. This also meant most of them were middle or higher class.

The reader needs to be aware that the core sample is relatively small, and entirely composed of women aged sixty and over. It cannot therefore produce generalisable findings that demonstrate how the three societies studied promote, or fail to promote, successful ageing; however what it can do is to show how far the circumstances of the older people who formed the focus of the research were conducive to their wellbeing, and this is the central tenet of the study.

Figure 4.1

Participants framework



As long-term care is ultimately about the experience of service users, a client-centred approach was favoured for this research. An "organic approach" was used which "centred" on the views and experiences of service users then "radiated" out to those who were supporting them. This approach (as showed in Figure 4.1) proceeded from the bottom to the top of the care system hierarchy. Most importantly, each set of actors was related or connected with one another. The notion behind such a design was to confirm or contradict views from different levels in each care system. It was also practically useful in the process of conducting empirical research as participants were able to relate their experiences to those of other groups of interviewees.

As already mentioned, the principle of this organic empirical approach was that other participants would have either a direct or indirect caring relationship with the service users selected. Such an approach made it difficult to plan the total number of participants, partly because there were different care structures in the three countries, and partly because each older person had different needs and required a different level of support. Because in the majority of cases initial access was through a third paty, we do not know how many older people met the research criteria but refused their consent to participate. However, once access had been obtained, a potential sample of 39 clusters of older people and their carers were identified, resulting in 176 possible participants. To meet the criteria a complete cluster had to include a minimum of a service user, a formal or an informal carer, an assessor and a service provider. Eleven clusters could not be completed and had to be abandoned: two elderly service users in England were too frail to be interviewed; in Taiwan, three service users were too frail to participate, one assessor and one formal carer could not be contacted; in the Netherlands one service user who had given consent did not meet the research criteria, and four assessors could not be contacted. Those service users who were too frail to participate were either suffering from dementia or unable to communicate with the researcher for other reasons. As a result, 28 clusters with a total of 142 participants (46 in England, 45 in the Netherlands and 51 in Taiwan) were included in this research (see Table 4.1). A detailed description of the people who were interviewed is to be found in Chapter five.

Table 4.1

Numbers of participants in this research

Interviewees	Number of interviews			
	England	The Netherlands	Taiwan	Total
Service users	9	10	9	28
Informal carers	6	1	3	10
Formal carers	5	9	9	23
Assessors	11	8	11	30
Service providers	10	7	8	25
Local administrators	4	4	6	14
National level	3	4	6	13
Total	46	43	52	143

4.6 Means of gathering data

This study was conducted using the same research design and methodology in each country. In researching "systems", the views from relevant actors at different levels seemed appropriate. Face to face interviews were an important way of achieving the aims of this research. Individual semi-structured interviews were carried out on three levels in each country: national (macro), county (meso) and local (micro). Semi-structured interviews – rather than open or structured interviews – were chosen because on the one hand similar questions facilitated comparison but on the other hand they could be adapted to recognise differences in each system which could not be anticipated.

Furthermore, cross-national comparisons benefit when a full appreciation of culture such as language, values, attitudes, care systems and institutions can be recognised (van de Vijver and Leung, 1997). For this reason single-person cross-national studies which attempt to cover the full impact of policy can be difficult to undertake. I can claim to have cultural knowledge and experience from having lived in all three countries. My familiarity with three languages was also an advantage - fluency in Mandarin (and Hogkang[11]) as my first language, a good working knowledge of

[11] Although Mandarin is the official language in Taiwan, Hogkang is a local dialect and is widely used by many older people in many part of Taiwan.

English as my second and a reasonable grasp of Dutch. Familiarity with local dialect and slang[12] were also important in conducting research at the local level.

Each interview schedule covered issues concerning successful ageing drawn from the literature review (See Chapter three). When framing the questions for the interview schedules, it was important to take into account the context, situation, experience and expertise of each group of actors. As a result seven interview schedules were used in the fieldwork (for copies of the seven interview schedules see in Appendix Two):

- The interviews with service users focused on how much they were involved with decisions about their care; what impact services had had on their lives; how they thought care services were meeting their needs; and what service users thought should be included in the provision of long-term care.

- To evaluate the contribution of informal and formal carers to the care system and to examine the process of long-term care from their perspective, two separate interview schedules were designed. The interviews were focused on how care affected a carer's individual welfare in the family and in society; what might be the impact on them in the future; what they considered to be important to them as carers; how much they had been involved with the assessment of the older people whom they cared for; what did they think was important for the long-term care of older people.

- Interviews with assessors explored how they put policy into practice; how the criteria of service admission and the decision of an assessment system influenced the care support that older people received; how they worked in partnership with others; what they thought was the greatest challenge faced by those who provided older people with long-term care; and what they thought could be done to ensure these challenges were met.

- The aim of interviews with service providers was to examine the process of care provision and management quality; to find out their current staffing and financial situation; to find out their principal concerns; and the quality of their relationship with service users, professionals and other agencies.

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[12] In my interviews in the Netherlands, I had a Dutch assistant.

- The interviews at the county level aimed to see how the local authority implemented national policy; how the local authority ensured that long-term care met local needs and how it met national targets; what the local authority thought were the important issues that needed to be addressed to improve long-term care for older people; and what the local authority thought were the important issues that needed to be addressed by national government.

- The interviews with participants at the national level examined how long-term care policy was formed and implemented; how policy set standards of care; and what was the national influence on local practice.

Some questions were phrased differently for some interviewee groups, but the focus was always the same. For instance, in order to get participants at the national level to offer their expectations of current long-term care, they were asked,

> "How well is current policy working?" " What are its strengths and weaknesses?" " What needs to be done at the national level to promote long-term care for older people?".

Respondents at county level were asked,

> "How are things working at the moment?" "What would the local authority like to do in terms of long-term care for older people?" "Is it possible?" "If not, why not?".

Similarly, service users were asked

> "Do you think you have received enough support?" "What support would you like or what could be changed?" "What would you like to do if you had with more help?"

Furthermore, service providers, assessors, formal and informal carers were asked

> "How well is the current long-term care system working?" "What are its strengths and weakness?" "What more should be done to help older people and you as a [service provider, professional and so on]?"

In addition to the interviews, extensive data were collected from case files in all three countries. This was held by assessors and service providers in England and Taiwan, and service users in the Netherlands. However, not every service user's case file was accessible for research. There was one missing file in England, more than half of the Dutch service users (7/10) denied access, and there were no files for those Taiwanese who employed living-in carers. As a result, recorded data (case files) was not comparable. Hence, interviews with all participants became the most significant means for gathering data in this study.

In addition, wherever relevant in this study, photographs have been used to provide an additional perspective on the experience of care. A number of authorities have stated that cultural products, such as visual materials, in some way mirror the social factors and that this is one of the best approaches for the illustration and elaboration of research findings (Albrecht, 1954; Alexander, 2008). Current research using visual methods is an interdisciplinary initiative, with contributions from anthropologists (Bank, 2001; Pink, 2007), geographers (Rose, 2006) and art historians (Mitchell, 1992), as well as from sociologists (Chaplin, 1994; Emmison and Smith, 2000). Nevertheless, visual methods are still relatively uncommon in cross-national social policy and practice research.

Cross-cultural studies, such as those of Dingwall, Tanaka and Minamikata (1991, cited in Chaplin, 1994: 195) who used visual images to compare parenthood in the UK and Japan, have argued that a comparison of images can be an effective general indicator of cultural differences, because images show a wealth of detail about the social situation they depict. In this thesis, for example on page 163, I have chosen photographs of ageing service users participating in cultural and leisure activities in the residential care homes in England, the Netherlands and Taiwan. These immediately draw attention to the different approaches and supports that older people have received in the countries studied.

Visual images are information-rich: on the one hand, they contribute to an understanding of everyday life by giving a more immediate and detailed account of people than is possible by a simple verbal description (Chaplin, 2002); on the other hand, they are also ambiguous in that different people will interpret them in different ways (Alexander, 2008). It is important to note that to make visual images meaningful, the existence of the photograph is no guarantee of a corresponding pre-

photographic existence, but it should be constructed with specific contexts and specific forces (Tagg, 1988). This study utilises photographs as the researcher's visual recording method during the field research, which, when carefully classified as a visual inventory, can record and "reflect" "the views of the participants" across the countries studied.

This study acknowledges that the strength of the visual images is to draw readers' attention to what is "real"; however it is clear that the achievement of absolute reality is a challenge (Chaplin, 2002), especially in this research where a few photos can only catch a moment of the time and place. Moreover, needing to gain consent from the participants means that they are aware that a photo is being taken, which can make perfectly natural behaviour difficult to achieve. Nonetheless, the photos have been carefully chosen to introduce visual images to strengthen the voice of the people interviewed, especially for those older people who are likely to be disempowered in society.

4.7 The phases of research

Qualitative cross-national research demands a large amount of time. This is particularly true for the lone part-time researcher. Table 4.3 shows the overall time frame for this project.

An application to carry out the fieldwork in one Midlands local authority of England was made in October 2003. This arrangement took 4 months of negotiation before being turned down by the Director of the Social Services on the grounds that their assessors were experiencing a high caseload. A second local authority was approached at the end of February 2004. This successful application took two and half months to gain approval.

The empirical work for this project was carried out within comparable time frame between May 2004 and January 2005. The English empirical work was primarily conducted within three months on a part-time basis as I was working as an assessor/ social worker in another county. It was not possible however to gain consent for the interviews with the English participants at macro-level until the rest of the cross-national empirical work was completed. Nonetheless, all the empirical work was

completed in a similar period for each country (roughly two months).

In order to speed up the research process, the tape transcriptions were carried out by three transcribers in each country. The data coding and analysis of around 142 interviews took me more than one year to complete. Finally, more than one year was needed to attempt a concise and precise writing up of the complicated issues surrounding long-term care systems.

4.8 Choice of methodology for coding and analysis

Verbatim interview transcripts in both the original language and English were transcribed up to minimise the possible loss of nuance and culturally determined meaning (Ungerson, 1996). All correspondents answered in such an individual way as to make comparison a challenging task. This suggested that it would be sensible to apply Becker's 'sequential' methodology in the systematic coding and analysis of the interviews, and some thematic characteristics emerged (Becker and Bryman, 2004, pp 300-303). In addition, a very small amount of data from the 34 abandoned interviews was used for illustrative purposes.

The process of analysis was not much different from the approach of other social sciences. Miles and Huberman (1994) have shown that table structures are powerful tools for data analysis. The advantage of using a template or code manual may be more focused and time efficient than other organising styles such as editing and immersion/crystallization, however, the down side is that when used alone, there is a potential for information to go missing (Crabtree and Miller, 1992: 164). Therefore, this research adopted multiple organising styles in the overall analysis to reduce this risk. At the first stage of the sampling/collecting process, all the raw data was written in Microsoft Word. Giving each sample of text a sequence number helped to find the references in the original data more efficiently. Using Microsoft Excel helped to display relevant quotes selected systematically at the second stage:

Table 4.2

Example of Microsoft Excel setting

#	Country	Participant	Question	Q #	Responses Quotes	Quotes # on transcripts	Themes	Following Columns are personal details: age, gender, service, ect

Note: # means sequence numbers

In addition, displaying data in the maps and matrices (Dey, 1993) by using MindMan software at the third stage was another powerful means of discovering the relationships between categories, thus providing a visible way to explore possible links and/or associations between code-sorted segments of data. The software (www.visual-mind.com) was used alongside Excel to reinforce/confirm the logical link of participants' views within and across the countries studied.

4.9 Ethical and legal considerations

Ethical issues must be considered in social research, especially when dealing with vulnerable adults. The key ethical principles to be followed in any research involving human participants are well documented (see for example Medical Research Council, 1991; Kayser-Jones and Koening, 1994; Sankar and Gubrium, 1994, p14; Becker and Bryman, 2004). A principal ethical obligation on the part of researchers is to take particular care when researching human subjects, particularly vulnerable groups such as children and older people. It is an area surrounded with confidentiality, to prevent harm to individuals or communities. It covers data protection and the prevention of conflicts of interest. However, I would argue that the assumption that standard ethical criteria can apply to all types of people is rather narrow. Firstly, not all people aged 65 and over would be classified as vulnerable adults. Secondly, much research related to ethical issues on ageing has focused on service users with dementia (e.g. Flynn, 1986; Atkinson, 1989; Bond, 1999). More research is needed on ethical issues concerning a broader range of vulnerable older people, such as those with multiple health difficulties and those who are carers, and this in which will be discussed in detail in the following subsections.

The approach to gain the cooperation of relevant authorities in each country varied because of structural differences. In England, the research began with an approach to a county with responsibility for the care of older people. It then became possible to seek consent from participants at the local and national levels (*from centre to bottom and top approach*). In the Netherlands, with its pillarised social structure and data protection regulations, many consultations took place between the researcher and various groups. As a result some of the service users were recommended by service providers in the local area, and some from public places (*bottom to top*). In Taiwan - which has a strong hierarchical social structure - the strategy of gaining acceptance at ministerial level worked was sufficient. Everything else then fell into place (*top to bottom*).

Before undertaking any interviews and commencing the data collection phase of the research process, formal ethical approval was sought. Ethical approval (see Appendix Three) was gained from two committees: the Loughborough University *Ethical Advisory Committee* and the English county's *Research Ethics Committee* which followed a ministerial Code of Practice (Department of Health, 2001). The research proposal (see Appendix Four) provided to each committee described the research and its aims in some detail. It described procedures that would be used to protect the rights of participants in different groups. It identified any potential risks to participants and explained the nature of these risks and showed that the research was justified in terms of potential benefits of the study to society. In addition, in the process of accessing information in the field, each locality involved had its own local research procedures. In each of these areas I completed the necessary forms and local approval for the project was given.

4.9.1 Confidentiality

A copy of a consent form (see Appendix Five) was given to all participants before the interview began. Photos were taken with the permission of those who were in them (see Appendix Six). In addition written information about the research was provided (see Appendix Seven). The principle of informed consent has become seminal in the codes and guidelines of the British Sociological Association (2002). All the participants were verbally well informed about the aims of the research and their right

to withdraw their participation at anytime. I also made sure that the participants had the ability to understand what the research was about, what their role in the research was and that they were able voluntarily to give their consent. On the day before each scheduled interview, I contacted each person again to check that they still wished to have a meeting. This gave all of the potential participants the opportunity to decline to be part of the study without me being physically present and time to decide whether they were comfortable sharing their experiences with someone they hardly knew. Making contact with all of the potential participants several times before an interview takes place is consistent with viewing informed consent as a process (Reid et al, 2001; Usher and Arthur, 1998). The process of consent ensures that people - vulnerable ones in particular - have plenty of opportunity to be reminded of and understand what they are consenting to. This was important for the service users in the present research who might still have been experiencing some health and life difficulties in the process of needing care.

Participant confidentiality was maintained by the allocation of pseudonyms to each service user. Other care actors are identified by their relationship with service users or their post, such as:

- Ms Becker's son.

- Civil servants in Department of Health.

All tapes, field notes, transcripts and any findings submitted for publication were scrutinised to ensure that any references strictly followed the above approach. Participants were reassured that the tape transcriptions would be done by professional transcribers who signed a confidentiality statement (see Appendix Eight), and that all details related to the study would be kept confidential. They were also assured that all tapes, field notes and transcripts would be kept locked in a filing cabinet. Access to this information was limited to myself. In addition, none of the personal information would be discussed with others. At each interview it was made explicit that the working transcripts and tapes would be kept until completion of the dissemination of findings and then destroyed. All people interviewed were offered a copy of their transcript. Only one senior official at the national level in the Netherlands asked for a copy and it was provided.

4.9.2 Potential harm to participants

As mentioned above, all efforts were made to maintain the anonymity of participants, other people, organisations and authorities. The service user participants have been asked whether they would like to be known by their real name or to be anonymous. A few of them did choose to appear using their real name in this research. However, the balance between the choice and ethics has never been easy, especially in research involving visual images of vulnerable people. Respondents can give permission for these images to be shown, but the researcher must not use identifying photographs if this will bring harm to the participant or relevant others (BSA Visual Sociology, 2006). All the participants gave consent both to be interviewed and for photographs to be taken and used in the study. People and places in which the field research took place have been kept anonymous to protect the participants' and others' privacy and vulnerability.

Hancock et al. (2003) have urged researchers to consider some of the sensory changes that occurred when communicating with older people during the course of the interview. I addressed these by ensuring that people could understand and hear what I was saying by allowing more time and repeating or re-phrasing questions where necessary. If they wore a hearing aid I checked to see if this was working and if glasses were worn that these were clean. Nearly all of the older people studied had physical, sensory and/or minor cognitive impairments and some were acutely unwell. Those few who had minor cognitive difficulties were, nevertheless, able to give their informed consent. All of the service users agreed it was better to conduct the interviews in their home. Older people with moderate or severe cognitive difficulties were not included because it would be harder to gather a comparable sample by including them and their needs might be very different from those people without severe cognitive difficulties.

One of the overall difficulties of involving older people who receive long-term care is that older people are very likely to have experienced the impact of the loss of health, families and/or independence as part of life. In the case of formal/informal carers and assessors who provide front-line care, I was cognisant that they too were in a vulnerable position. In many instances, they had displayed some stress as part of the demanding responsibility of their role. It was important to allow time for participants to express their feelings and to ensure that individuals participating

realised they were free to decline to take part or to answer specific questions, without any negative outcome (Cheston et al, 2000).

4.9.3 Conflicts of interest

Sohng (1994) has argued that many traditional empirical research methods are inherently biased in favour of the dominant society and fail to take into account the unique perspectives of the minority groups they studied. It is also noticeable that the voice of the service user is often absent (Bastian, 1994, p5) unless it confirmed ideas already held by those in power (Cheston et al, 2000). Readers need to be aware that the partnerships between the participants in this research could not be equal. For instance, involving professionals and service providers to gain access to the service users and informal carers who were to participate in the research might have resulted in service users having given their consent because they were afraid that their care might be adversely affected if they refused. Moreover, the professionals and formal carers might have given their consent because of the authority of, and/or pressure from, their employer. However, this did not necessarily mean that the 'researcher' was the 'senior' partner. Throughout the research, I have been careful to address the power imbalance between participants and myself by promoting an understanding of how older people and their relevant care actors constructed their social worlds within a care system. To ensure the views of each group studied would not be overtaken by the views of another, efforts were made to ensure that all the participants were viewed as equal. Particularly, there were also ethical issues about sensitive topics (i.e. evaluating care), which might involve some personal or professional experience with other people interviewed. To overcome this possible conflict of interest between my correspondents, I have been particularly careful to address the issues of confidentiality and prevent potential harm to participants as earlier discussed. In addition, as earlier mentioned, the empirical work was located in a geographical area that had no connection with my professional and personal experience, to minimise a future potential conflict of interest in the research.

Although inevitably there is some degree of data content bias in this study, as indicated above, it is noteworthy that interpretation and representation are inevitable in a narrative account. However, the researcher (myself) should be as explicit and reflective as possible, when constructing and interpreting narratives. Within the field

of health and social care, both practitioner and user knowledge have traditionally been marginalized (Beresford, 2005). However, user participation in research has being valued in health and social care throughout the western world only relatively recently (Hulatt and Lowes, 2005). Such approaches have no implied hierarchy of evidence but, rather, differing types of knowledge are seen as suiting differing purposes. A number of commentators (Lewis, 2001; Bradbury and Reason, 2003; Marsh *et al*, 2005) have provided an overview of the type of knowledge that should inform social care and practice:

- Organisational knowledge with governance and policies.
- Practitioner knowledge: personal, practice and context-specific.
- User knowledge with first-hand living experience and reflection on care.
- Research knowledge – the most 'plausible' source but requiring a 'broad church' interpretation.
- Policy community with social and political drivers determining the issues of significance.

What is significant is that there is a growing acceptance (in most, but by no means all, quarters) of a wider definition of knowledge.

4.10 Problems and difficulties

There is little doubt that every research project has its limitations. It certainly applies to this project which has been on a large and complex scale covering three very different care systems. All three countries were facing major reforms regarding the long-term care of older people. This implied that the issue was a serious one. The policy changes created some tensions in practice, which were particularly strong in the Netherlands, and to a certain extent in England. This was one of the reasons that fieldwork arrangements were difficult. Eventually, this research was carried out through consultations with potential participants at different levels of each system. The organisation and operation of the long-term care systems were so different

between the countries that appropriate adjustments had to be made to fieldwork arrangements in each country.

Differences in the manner in which the sample could be accessed may also have resulted in some bias. The direct access to the sample from the Netherlands may have meant that those selected were more likely to be autonomous: these older people volunteered without any possibility of pressure from other actors. Differences in eligibility criteria for care may have been the reason why the English sample were likely to be more frail than the older people from the other countries and this has implications for the overall findings.

There is little doubt that informal carers played a significant role in the care of their older relatives. However, the selection of the informal and formal carers in this study was based on the extent of the care they provided (see Chapter Six for further details). As a minimum, either formal or/and informal carers for the service users in the study were interviewed. Whilst access to most the formal carers was possible, it was not possible to access some of the informal carers because, firstly, as mentioned above, I had to gain access to the service users through assessors or service providers who also gave consent on behalf of the formal carers. Secondly, some Dutch and English older people studied refused to provide the contact information of their informal carers because they saw themselves as being independent when receiving formal support and therefore as not being dependent on their families. Thirdly, some Taiwanese older people, saw the research involvement as a burden for their family/informal carer, especially since many of them are full-time employees. As a result the sample of informal carers may exhibit some bias.

The principle behind the organic approach to the selection of interviewees resulted in some operational difficulties. Firstly, even though there was close cooperation with the possible participants, some of the service users or their relevant carers refused to participate. This was only discovered at a late stage. In this case, all the interviews around particular service users had to be abandoned. Secondly, in England and Taiwan, most of the service users had a regular main formal carer. However this was not so often the case in the Netherlands. Although the original principle of interviewee selection was still maintained, it worked out a little differently in the Netherlands. When there was no *one* main carer, one was selected at random.

As a result of trying to take Eastern and Western cultural and political contexts into consideration it was found that there was some variation in the responses. For example, firstly, the idea of a consent form worked well in England but not in the Netherlands and Taiwan, due to differences of understanding. In the Netherlands, nearly all of the older people and their in/formal carers interviewed saw their verbal agreement to participate in this research as equivalent to the signing of a consent form. In Taiwan, nearly all of the participants at county and municipal levels were not welcoming but frightened by the offer of consent form. They saw the consent "form" as an official constraint on their voluntary contribution toward the research, and did not like to think of it as part of a governmental investigation. Secondly, there were a few questions which some participants found it difficult to respond to. This difficulty was reduced by giving explanations and examples to the interviewees when required. Thirdly, the condition of older people (hearing, vision and cognition) had some impact on the interviews, but this was minimised by my own experiences with older people as a social worker. With the exception of the interviews with older people, each interview lasted for an hour on average. It might be thought that English and Dutch service users would be more likely to clam up because a foreigner was interviewing them. However, interview length suggests that Taiwanese older people (approx 20minutes) were, in general, less forthcoming and more private than older people in England (50minutes) and the Netherlands (40minutes).

"Time" and "funding" were important factors in this research. This was a self-funded single person study with the support of family and friends in each country included. Nevertheless, it has taken 6 years to complete the whole research including carrying out cross-national empirical work between 2004 and 2005. Given that reforms were underway in each of the care systems, there was a danger that the findings might be less relevant to future practice and policies. To reduce the disadvantage, I have presented my draft findings to several international conferences in 2006 and 2007 where I was able to discuss them with several researchers from the countries studied to ensure they remained relevant.

Language can present a major obstruction to effective international comparison, since it is not simply a medium for translation, but part of a wider system reflecting institutions, thought processes, values and ideology. This can mean that the approach to a topic and interpretations of it will differ according to the language of expression. For instance, the meaning of terms such as 'social services',

'assessment' *et al*, can vary a great deal. One Dutch researcher confided in me that his fellow researchers would often translate a word literally without being familiar with the system in which it was used. Hence, the terminologies used in and by each country/participant group became important and had to be dealt with carefully. Indeed, a comparable study throws up substantial questions about terminology. In the following study, I have used a number of terms which cover a whole range of occupations in different countries. For instance, the term *assessors* refers to all those people who assess older people's needs for formal care. This would mean local authority social workers, nurses and occupational therapies, and district nurses working for the NHS in England; social workers, physiotherapists, nurses in a regional assessment office (RIO), and nurses and social workers from service providers in the Netherlands; local authority contracted nurses, and nurses, social workers, physiotherapists, nutritionists from service providers in Taiwan.

4.11 Conclusion

This chapter has presented an overview of the methodology and approach adopted in this research. I have argued that qualitative cross-national comparison of a whole system provides a good basis for international learning. However, cross-national comparison is very demanding in terms of language skills, cultural understanding, money and time. How to get information about the relative effects of different levels of actor on actual welfare outcomes was crucial for this research. Some of the difficulties faced were addressed by trying to understand the contexts in which comparisons were being made. Difficulties were also avoided by careful and detailed planning. An organic approach was used to gain a better understanding of how each country provided long-term care for older people. The ethical components associated with this project have been explained and the validity of the research methods adopted discussed. Multiple organising methods in the overall analysis were used to obtain consistent and systematic results.

All participants were interviewed by one researcher (the author of this thesis), visiting each of three very different countries. I also analysed all the empirical data from three countries thus ensuring a greater consistency in comparison. Later Chapters of this thesis will critically analyse how each care system supports the wellbeing of older people in long-term care. Before moving on to the analysis, Chapter 5 will provide an

overview of the characteristics of the interviewees. It will provide further details of the similarities and differences they shared.

CHAPTER FIVE

Participants Characteristics

5.1 Introduction

Chapter one has provided a general introduction to what this research is about. Chapter two examined the welfare and long-term care systems of the three countries studied, while the literature review of Chapter three has provided a structure and focus for this research. In the previous Chapter four, the methodology adopted in selecting the geographical areas, participants, the interview questions and themes for the fieldwork was described. From Chapter six onwards the results of this fieldwork will be explored and discussed. However, before readers can understand and make sense of the research findings, it is necessary to provider some more information about each group of participants.

There were 28 groups of participants, clustering around nine services users from England, 10 from the Netherlands and nine from Taiwan. In addition to the service users, 23 formal carers were interviewed (for all service users except for four English participants, Ms Bames, Ms Becker, Ms Owen and Ms Munro, for whom only informal carers could be accessed; two of the Dutch service users (Ms der Horst and Ms Veltman) had the same formal carer). Eleven informal carers who provide hands-on care were interviewed (six in England, one in the Netherlands and four in Taiwan); the assessor who identified the service user's care needs was interviewed for each service user; three of the English service users (Ms Becker, Ms Holmes and Ms Sempik) had more than one assessor. All service providers were interviewed (ten in England, seven in the Netherlands and eight in Taiwan): some of these providers offered services to more than one participant and Ms Munro received more than one care services. In addition interviews were held with four English, four Dutch and six Taiwanese local administrators who construct local policies and ensure local and national policies are implemented; and finally, three English, four Dutch and six Taiwanese civil servants responsible for national policy making or senior officials from NGOs who monitor government policies and practices (3, 4, 6 in England, the Netherlands and Taiwan respectively). Further details are given in Chapter Four

(pp76-80).

It is important to point out that the characteristics of individual groups in the countries studied varied. Hence, each "interview set" in this research will be examined to reveal these characteristics. Further information is given about the profiles of each service users in Appendix Nine.

5.2 Service users

Table 5.1

Older people participants in England, the Netherlands and Taiwan

	CARE SERVICES		SERVICE USERS (All are pseudonyms)
England	Care in older people's own home	Extra care housing	Ms Munro.
		Home care	Ms Becker, Ms Holmes, Ms Bames and Ms Owen.
	Residential home care		Ms Powell and Ms Sempik.
	Nursing home care		Ms Ward and Ms Gould.
The Netherlands	Care in older people's own home	Extra care housing	Ms Schoonwater.
		Home care	Ms Flipsen and Ms Boersbroek
		Personal Care Budget (PGB)	Ms Duijts and Ms Ruiter
	Residential home care	Not-for-profit Residential care	Ms der Horst, Ms Veltman
		Care hotel	Ms Jorna
	Nursing home care		Ms Reinaerdts and Ms Reginek
Taiwan	Care in older people's own home	Live-in care	Ms Tsai, Ms Chung and Ms Lin
		Home care	Ms Fu and Ms Bai
	Residential home care		Ms Wang and Ms Pang
	Nursing home care		Ms Li and Ms Yen

Table 5.1 lists the 28 service users who participated in this research across the countries. With such a small sample of service users it was important to *minimise the variables* involved to make comparative analysis possible. It was therefore decided that service users selected had to be female, aged over 60; from the majority ethnic group and in receipt of formal care support. In both England and the

Netherlands the respondents' ages spread from sixty-five to the nineties; whereas in Taiwan the ages were sixty onwards. This reflected a characteristic of each country's service delivery. Women were chosen rather than men, because their propensity to live longer than men meant that they were more likely to be in need of long-term care.

As will become clear, the type of care the participants received corresponded to the characteristics of each country's welfare system. Of the older participants who received community care (5 in each country) (apart from one English and one Dutch person who lived in extra care housing (see Chapter 2.6.1) three of the English and two of the Dutch lived alone, but all of the Taiwanese respondents lived in a cross-generation household. Of those who lived in their own home, all the English, half of the Dutch (2/4), and some Taiwanese (2/5) received home care support. Taiwan was the only country that had live-in carers (3/5) and provided 24-hours care. Nearly all of the live-in carers were from South-Asia.

In the Netherlands, a few older respondents (2/5) were receiving a Personal Care Budget (Persoonsgebonden Budget, PGB) similar to the English 'Direct Payment'- a financial contribution from the state to clients who can then buy care tailored to their own needs. The amount of funding was based on a needs-assessment by the Regional Assessment Board (RIO). Unfortunately, there were no English older people in this sample in receipt of Direct Payments during the course of this research.

The residential homes for older people in England were smaller than those in the other two countries. They were smaller in size, had smaller rooms and less residents - under 40 residents in comparison with about 70 residents in Taiwan and around 100 residents in the Netherlands. As the photographs below show, group living of around two to four people sharing the same room is common in Taiwan. Most of the English residents lived in a single room, sometimes en-suite. The Dutch on the other hand, had their own bedroom, bathroom, toilet, living room as well as a kitchen unit.

Photo 5.1.
Ms Sempik's[13] room in an English residential home.

Photo 5.2 Ms Veltman in her living room in the Dutch residential home

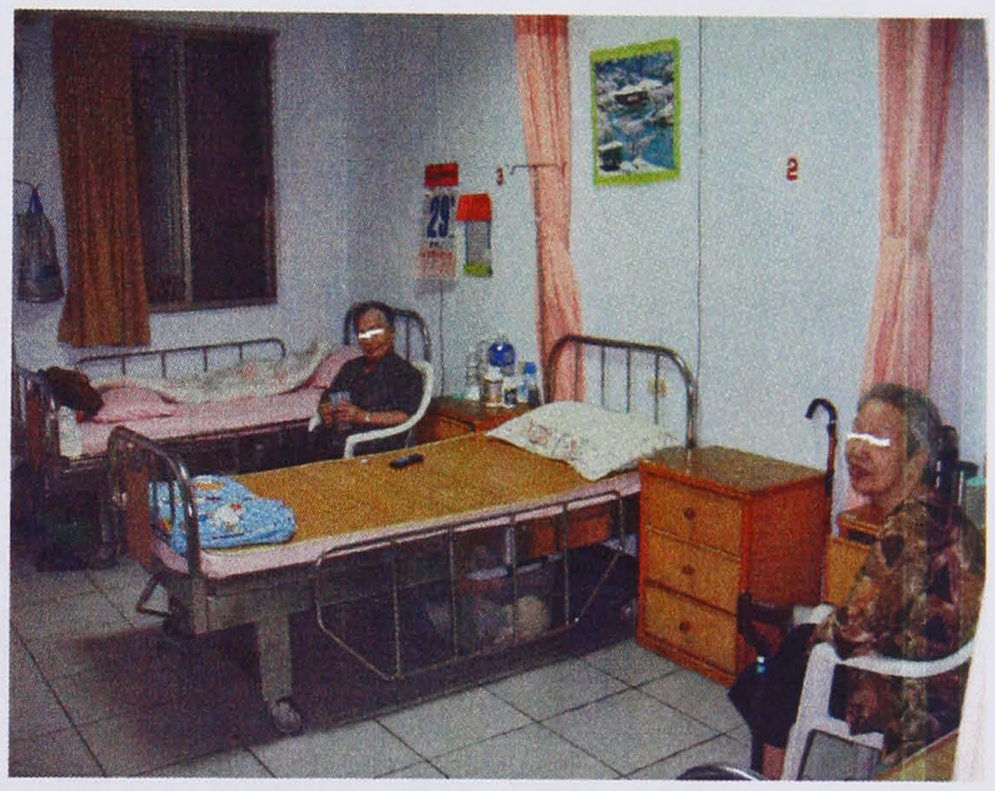

Photo 5.3 Ms Pang with her room mate in their en suite room in the residential home in Taiwan.

Some of the participants were living in nursing homes, i.e. Ms Ward and Ms Gould in England, Ms Reinaerdts and Ms Reginek in the Netherlands; as well as Ms Li and Ms Yen in Taiwan. The principle differences between residential and nursing care home were that the latter contained more health care support than the former. The English nursing homes were also comparatively small, whereas those in the Netherlands and Taiwan had more than 100 residents. Nearly all of the nursing care residents shared a room with others in the Netherlands (Photo 5.4) and Taiwan (Photo 5.5), whereas in England (Photo 5.6), many single rooms and a few double rooms were available.

[13] Please note, all names used in this thesis are pseudonyms.

Various social and health professionals and formal carers were based in Dutch and Taiwanese nursing homes. In contrast, nursing care for older people is primarily provided by qualified nurses and carers in England.

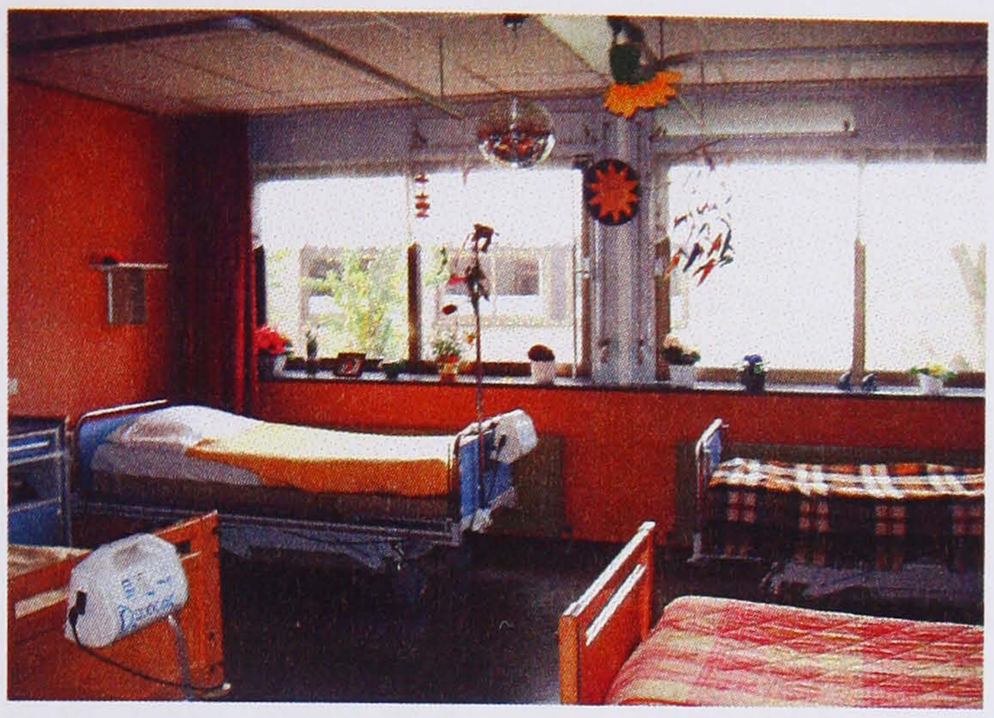

Photo 5.4 Ms Reinaerdts' room in the Dutch nursing care home.

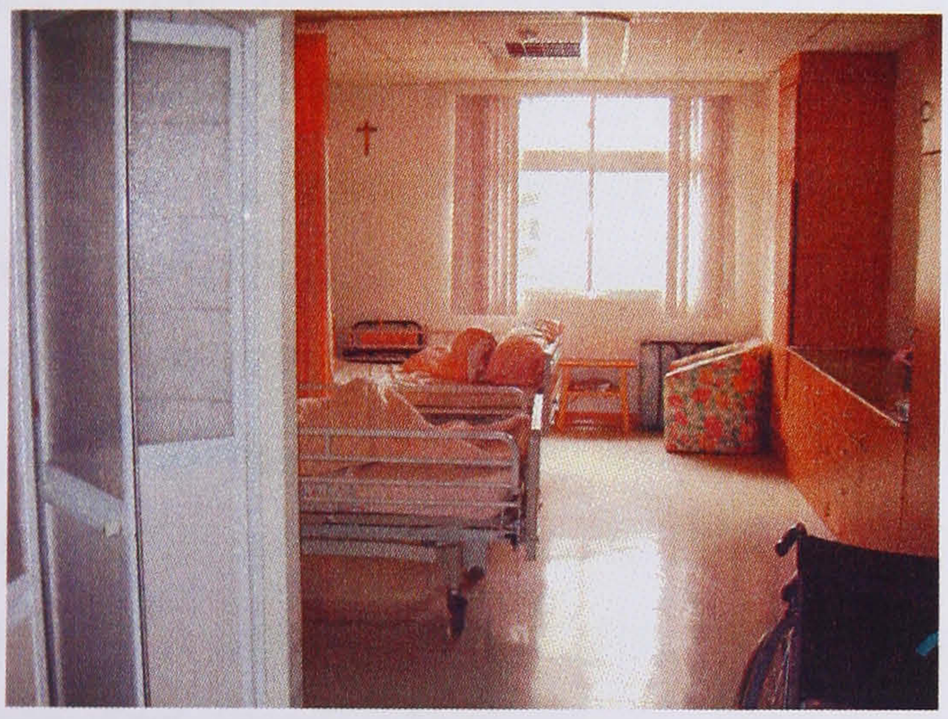

Photo 5.5 Ms Li's room in Taiwanese nursing care home.

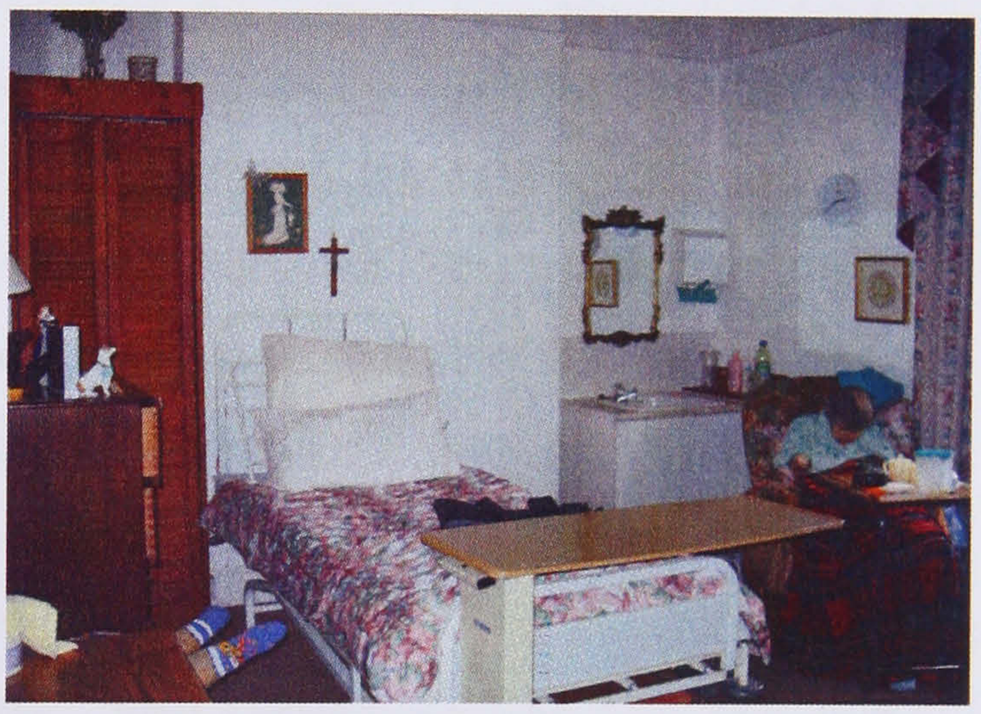

Photo 5.6 Ms Ward's room in English nursing care home.

The health conditions of the older people interviewed in the three countries were comparable. All of the older people in this research had multiple chronic health problems. Most of the older participants (25/28) in the three countries had poor mobility. With similar mobility conditions, the Dutch seemed more independent with their walking aids than participants from the other two countries. Unlike England and Taiwan where walking sticks and walking frames were widely used to support older people's mobility, in the Netherlands, the rollator[14] is well used by people who can walk a short distance. People can use the rollator to walk or to sit when they are tired and to carry their

[14] Four wheel walker with solid tyres and locking brakes. Features include backrest, seat and basket.

shopping, and this helps them to retain their independence. Three Dutch interviewees were wheelchair users and two of them were receiving nursing care. Nonetheless all of them were able to use their hands/legs or electronic controls to move about their homes. In contrast, English (4/9) and Taiwanese (2/9) older respondents who used the wheelchair required assistance to move it.

5.3 Civil servants and NGO senior officials

At the national level, long-term care policy for older people was constructed by a range of government departments and influenced by a number of pressure groups. The various interested parties groups and departments included central government, older people's pressure groups; the independent inspectorate in England and an umbrella organisation for service providers in the Netherlands. In the Netherlands, non-government organisations played a stronger part in shaping long-term care policy than in Taiwan and England. Both England and the Netherlands had a lead department in central government which was responsible for the care of the older people – the *Department of Health* in England and the *Ministry of Public Health, Welfare and Sport* (VWS) in the Netherlands. The difference between the two countries was that the Department of Health in England was more dominant in the regulation and planning of the care system. In the Netherlands, central government co-operated with service providers and pressure groups in its policy making. In contrast, four major central government departments in Taiwan - the *Department of Health, Department of Social Affairs, Council of Labour Affairs* and *Council for Economic Planning and Development* - shared responsibility for the care of older people. All of the Taiwanese national departments had their own authority within the bureaucracy. It is important to note however that during the time the fieldwork for this research was being carried out, Taiwan was in the process of moving to the English and Dutch system of one department with a Minister of State to manage and integrate any issue relating to the long term care of older people.

Table 5.2

The participants who present at the national level

	AGENCY	SECTOR	ROLE	TOTAL
England	Department of Health	Government	National policy maker	3
	Council of Social Care Inspection (CSCI)	Quasi-independent	Monitor the quality of care and the performance of Local Authority Social Service	
	Age Concern	Voluntary organisation	Represent the interests of the older people	
The Netherlands	Minister of Public Health, Welfare and Sport (VWS)	Government	National regulator	4
	Acrares	Political lobby for service provider	Look after the interests of the connected Institutional care organisations and act as a representative for the sector	
	CSO	Voluntary organisation	Represent the interests of the older people	
	NIZW	Umbrella organisation for service providers	Carry out the research to assist service provider to develop their care service. In addition to comment on the current policy	
Taiwan	Department of Health	Government	National regulator for nursing and health care	6
	Department of Social Affairs	Government	National regulator for social benefit and residential care	
	Council of Labour Affairs	Government	National regulator and mechanic of foreign carer	
	Council for Economic Planning and Development	Government	National long-term care regulator and mediator of all national departments relating to care of older people	
	Association of Welfare of Older People	Voluntary organisation	Represent the interests of the older people	
	Disability Welfare Alliance	Voluntary organisation	Represent the interests of the older people	
Total	**13**			

Note: 1. CSCI is quasi-independent organisation; it has a contract with national government to carry out care inspection in England.

2. Acrares is the rural trade association for nursing and care. The association represents 334 nursing care homes and 1366 Residential care homes. They provide care to about 200,000 clients and most of them are older people. www.acrares.nl

In order to have a better understanding of each country's characteristics at the national level, the selection of the interviewees was based on each country's national structure. Table 5.2 lists all the participants interviewed at the national level and their role within the long-term care system. In England, this included one civil servant from the *Department of Health*, one senior official from the semi-independent inspectorate organisation – the *Commission of Social Care Inspection* (CSCI) and one senior official from a voluntary organisation - *Age Concern*. It was not possible to interview a senior official from the other major voluntary organisation in England (*Help the Aged*). In the Netherlands, one civil servant from central government was interviewed, one senior official from the political lobby of service providers, one representative of an umbrella organisation for service providers and a senior official of a voluntary organisation. From Taiwan there were four civil servants representing the different departments in central government and two senior officials of voluntary organisations. In total, there were thirteen interviewees at the national level (3 in England, 4 in the Netherlands and 6 in Taiwan).

5.4 Local administrators

Local authorities have significant roles and responsibilities for the care of older people in England. However, the private and voluntary sectors are heavily involved in the delivery of services. To some extent this applies to Taiwan but less so to the Netherlands. Taiwan has primarily market-oriented provision with a smaller publicly-funded sector than England. In the Netherlands, the main responsibility for the care of older people is at the national level; however, decentralisation was well under way during the period in which fieldwork was being carried out. Dutch local authorities will therefore start to take of some regulatory role in the very near future. For these reasons relevant actors within and outside the local authority in the Netherlands were interviewed.

The interviews were held with administrators at the local level who had responsibilities for the care of older people (see Table 5.3). In Taiwan, nearly all of the administrators had worked in the local office of the *Social Affairs Bureau* and one in the local branch of the *Department of Health*. The Social Affairs Bureau had the major responsibility for the social care of Taiwanese older people, whereas the local offices of the Department of Health were responsible for the nursing/health care. In the Social Affairs Bureau, there was a head of department at the local level responsible for social care; 3 service developers responsible for developing and regulating the care services to help people to live in their own homes or in residential/nursing care homes and a *Foreign Labour Officer* responsible for employment issues of foreign carers who provided live-in care to the older people (see Chapter 5.7 below). In the local offices of Department of Health the long-term care co-ordinator was in charge of the nursing care of older people.

Table 5.3
Local administrators with responsibilities for older people

	ORGANISATION	PARTICIPANT	ROLE	TOTAL
England	Local Authority Department of Social Service	Service Director	Responsible for local government administration in the care of older people	4
		Home Care contracting officer	Making contracts with service providers to provide care in their own home to the older people through the local authority	
		Residential and Nursing Care Contracting Officer	Making contracts with service providers to provide care to older people in residential/nursing home through the local authority	
	Primary Care Trust	Long-term Care Co-ordinator	Carry out the assessment of and provide funding for nursing care in the nursing home or continuing health care in either nursing care home or at people's own homes	

The Netherlands	Local authority	Policy Officer	Local policy making and development related to older people's wellbeing and mobility (basic care needs were met by central government)	4
	Independent Building Corporations	Project Manager	Building and adapting housing for older people to live in their own home or extra care housing	
	Local Authority Contracted- Welfare Organisation	Senior Official	Provide welfare advice to older people and families and organise voluntary services	
	NGO- Older People Association	Senior Official	Local older people representing their group in the local authority	
Taiwan	Local Authority-Social Affairs Bureau	The Head of the Department	Responsible for social benefits for and care of older people	6
		Home Care Service Developer	Carry out home care service development, contract out the assessment and service provision	
		Day Service Developer	Carry out day services development and contract out service provision	
		Residential Care Service Developer	Carry out residential care inspection and funding, support to NGO and NPO care homes through central government	
		Foreign Labour Adviser	Monitor the wellbeing and legal issues of foreign carers	
	Local Authority-Department of Health	Long-term Care Co-ordinator	Manage nursing care at people's own home, monitor the quality of nursing care staff in both residential and nursing homes, inspect nursing homes, respite care development	
Total	**14**			

Similarly, in England, apart from one participant who worked for a *Primary Care Trust* (PCT - a local health board responsible to the NHS), nearly all of the local administrators interviewed worked for the *Department of Social Services* (now the Department of Health and Social Care) in a local authority. There was one Service Director, responsible for policy, service implementation and public funding of care for older people and two care service contractors who drew up contracts with the service providers for social services to arrange for care services for older people. The PCT was responsible for providing funding for those needing nursing care in nursing homes or their own homes.

In the Netherlands, at the time of the research, a municipality/county had responsibility for the social wellbeing of older people. This included improving their living environment in the household and the community; providing adequate housing, safe road environments and accessible community resources. From 2006 local authorities have been expected to meet the social care needs of older people but the detail is still in negotiation with central government. The Dutch cooperative system is also to be found at both national and at local level, where the local authority is closely involved with other NGO actors - such as independent building cooperatives, older people's pressure groups and welfare organisations - in local planning. Not all the material from an interview with two representatives of provincial government could be used, due to their rather limited involvement with the care of older people. Nevertheless some relevant information from the interviews was included to add to our understanding of the way the Dutch system operated. In total, 14 interviews were carried out at the local level in the three countries- 4 in England, 6 in Taiwan and 4 in the Netherlands (see Table 5.3).

5.5 Service providers

All service providers who were providing care to the service users in this research were interviewed. A few older participants received care from the same provider. As Table 5.4 shows a total of twenty-five managers from service providers in the three countries were interviewed (10 in England, 7 in the Netherlands and 8 Taiwan respectively).

Table 5.4

Interviewees- management officials from service provider

	SERVICE PROVIDER OF THE OLDER PEOPLE	TYPE OF CARE SERVICES	SECTORS	TOTAL
England	Ms Becker	Home care	Private	10
	Ms Munro	Home care	Private	
	Ms Owen	Home care	Private	
	Ms Bames and Ms Holmes	Home care	Local authority	
	Ms Gould	Nursing care	Private	
	Ms Ward	Nursing care	Private	
	Ms Powell	Residential care	Private	
	Ms Sempik	Residential care	Private	
	Ms Munro	Respite residential care	Local authority	
	Ms Munro	Extra care housing	Local authority	
The Netherlands	Ms Schoonwater	Extra care housing	Non profit	7
	Ms Reinaerdts	Nursing care home	Non profit	
	Ms Duijts	Home care	Private	
	Ms Flipsen and Ms Boersbroek	Home care	Non profit	
	Ms Reginek	Nursing care home	Catholic non profit	
	Ms der Horst and Ms Veltman	Residential care	Non profit	
	Ms Jorna	Residential care hotel	Private	
Taiwan	Ms Lin	Foreign care agent	Private	8
	Ms Chung	Foreign care agent	Private	
	Ms Fu and Ms Bai	Home care	Non profit Hospital foundation	
	Ms Li	Nursing care	Non profit Hospital foundation	
	Ms Pang	Residential care	Private	
	Ms Tsai	Foreign care agent	Private	
	Ms Wang	Residential care	Non profit Religious foundation	
	Ms Yen	Nursing care	Hospital foundation	
Total	**25**			

Although each of our countries was an example of welfare pluralism the balance between sectors was different. The private for-profit care sector in England was growing and was slowly replacing care provision in the statutory sector. The non-

profit sector had been dominant in the Dutch care system, but in recent years, a small number of private for-profit care providers had come into existence in the Netherlands. In Taiwan, a mix of private for-profit and non-profit care organisations could be found in the family-oriented welfare system. As Table 5.4 shows, the interviewees came from different sectors, reflecting the mixed economy of welfare in each country.

The service provision in each country was different in terms of service type and market framework. However, even with the same type of service, there were different patterns of support in each country, a point further explored in Chapter six, seven and eight. In general, home care, residential care and nursing care were available in all three countries. On the other hand, there were unique services which had been developed in each country to meet its own socio-economic circumstances – e.g. respite care in England; private institutional and home care in the Netherlands; extra care housing in both England and the Netherlands; foreign care agencies for live-in carers in Taiwan. For some services, the names might be the same in different countries, but the nature of the service might vary considerably. For instance, the extra care housing provided in England was very different from that in the Netherlands. In England the service provided accommodation and light care (meals and showers) for older people, whereas in the Netherlands the service included accommodation, meals, personal care, laundry, medication and night care.

5.6 Assessors

'Assessors' for the purposes of this study were persons who had carried out assessments of the needs of the older people before and during care provision. Assessors involved with the service user participants were interviewed (see Table 5.5) in order to collect more in-depth information on various care issues. There were eleven assessors interviewed in England, eight in the Netherlands and eleven in Taiwan, a total of thirty.

For each country, a similar range of assessors was involved in the care system. They were mainly - social workers, occupational therapists, physio-therapists, nurses and doctors. The proportion of assessors between social and health care was different in the three countries. In England assessment was carried out mainly by

social care professionals (7/11). In contrast, assessment was carried out by health professionals (8/11) in Taiwan, and in the Netherlands there was a balance between social (5/8) and health care (3/8) professionals. In addition, at the operational level, there were more similarities between the Netherlands and Taiwan than between them and England. In Taiwan and the Netherlands, assessors included those who made care need assessments for public-funding purposes and those who were employed under service providers to constantly assess older people's daily care. In England, all of the assessors were making assessments in terms of resource availability. Most of them were professionals and carried out assessments to decide for whom and how the care service could be delivered. In the Netherlands and Taiwan, some assessors carried out assessments as well as providing direct care. Whether this division had some effect on the quality of care will be explored.

Table 5.5

Assessors: interviewees who carried out assessments of service users in this research

Country / Role	Britain		The Netherlands		Taiwan	
	Before service users received care	After the service users received care	Before service users received care	After the service users received care	Before service users received care	After the service users received care
Social worker	6	0	3	2	0	3
Nurse	3	0	1	0	1	4
Occupational therapist	1	0	0	0	0	0
Physiotherapist	0	0	0	1	0	2
Others	1 Service organiser	0	1 Welfare advisor	0	0	1
Total	11	0	5	3	1	10
	11		8		11	
	30					

Note: 1. Including one Social worker assistant.

2. A GAP nurse and a Nurse assessor working with social services and a District Nurse working for health
3. The service organiser worked for social services to arrange home care services
4. Working for local government to provide benefit information and assess minimal equipment and adaptation

5.7 Formal carers

Table 5.6

Background information on formal carers

	FORMAL CARER OF	THE ROLE OF FORMAL CARER	GENDER	TOTAL
England	Ms Gould	Care assistant in Nursing Home	F	5
	Ms Holmes & Ms Bames	Social Services Home Carer	F	
	Ms Powell	Care assistant in Residential Home	F	
	Ms Sempik	Care assistant in Residential Home	F	
	Ms Ward	Nurse in Nursing Care Home	M	
The Netherlands	Ms Boersbroek	Home Carer	F	9
	Ms der Horst & Mrs Veltman	Nurse in Residential Home	F	
	Ms Duijts	Nurse Home Carer-PGB	F	
	Ms Flipsen	Home Carer	F	
	Ms Flipsen	Domestic carer in Home Care	F	
	Ms Jorna	Nurse in Care Hotel	F	
	Ms Reginek	Nurse in Nursing Home	F	
	Ms Reinaerdts	Nurse in Nursing Home	M	
	Ms Veltman & Ms der Horst	Volunteer in Residential Home	F	
Taiwan	Ms Bai	Home Carer	F	9
	Ms Chung	Foreign Carer	F	
	Ms Fu	Home Carer	F	
	Ms Li	Care assistant in Nursing Home	F	
	Ms Lin	Foreign Carer	F	
	Ms Pang	Care assistant in Residential Home	F	
	Ms Tsai	Foreign Carer	F	
	Ms Wang	Care assistant in Residential Home	F	
	Ms Yen	Care assistant in Nursing Home	F	
Total	**23**			

There were a total of twenty-three formal carers (5 in England, 9 in the Netherlands and 9 in Taiwan) who looked after the older people in this research (Table 5.6). Formal carers were predominantly female in all three countries, demonstrating again that caring is seen as a female profession. Nonetheless, the differences in the care

system in each country were reflected in some of the background characteristics of formal carers.

There were more professionals (5/9) and carers (3/9) trained to provide a wider range of hands-on care in the Netherlands, where historically most of the professionals had provided direct caring tasks in care organisations prior to the *Regional Assessment System* (RIO) which came into to force in 1998. Formal care in the Netherlands included: house cleaning provided mainly by unqualified care staff; personal care provided by a nurse and trained carers, and feeding provided by volunteers. In Taiwan, most of the homecare, residential and nursing care was provided by trained carers, with supervision from the assessors. In England, the majority of hands-on care was provided by trained or untrained carers, but in one case it was provided by a qualified nurse (1/5) in the nursing care home. As a result, there were some professional/nurses in the Netherlands and England in the formal carer interviews.

Significant care actors whom the field work was unable to include fully were the volunteers. These were widely utilized in Dutch care homes and Taiwanese care services, but were less visible in England. Nevertheless, all the participants studied were able to reveal the strength and weakness of the volunteer resources, and this is discussed further in the following chapters, especially Chapter seven.

Moreover, as shown in the Table above foreign (live-in) carers were only involved in the Taiwanese part of the study. However, immigrant care workers exist in many industrial countries. It was explained in Chapter two that coupled with a declining or limited public provision of care in industrial countries, as well as women's increased labour force participation and an ageing population, a 'care deficit' has emerged as women struggle to combine paid labour with their gender-ascribed role of being primary carers (Hochschild, 2003). In addition, opportunities to work are not necessarily found in the locality leading to the rise of "global commodification of caretaking" (Parreñas, 2005) and the creation of "global care chains" (Hochschild, 2003). One of the differences in the care workforce between Taiwan and the other two countries was the importing of formal carers from South Asia come to Taiwan to help older people live at their own home as open government policy within the *Live-in Caregivers Programme*. This is a very different programme from the rising number of non-family informal carers, who are often immigrants either from outside the EU or work informally, and the related problems of "black market employment", "illegal

immigration" in South and East Europe in particular (Nesti et al, 2003; Campostrini et al, 2004; Leeson, 2005). Taiwanese policy was adopted from Singapore, Hong Kong and Canada (Lin, 2003). It is based on a three year maximum work-permit, and a standard salary protected by the state. Carers are bounded with a named employer (most of them are the adult children of older people) and their agency. In addition, they are expected to return their country when their permit expires. This means, they would not be entitled to become long-term residents, nor apply for citizenship in Taiwan.

Migrant care worker have been an increasing concern in industrialise countries. A number of research studies have focused on the effect on migrant care workers' own society. Having so many people migrate to other countries might reduce their own capacity for looking after their own older people. There have been conceptual debates about the ethics of care and the intersection between these and citizenship, rights and justice (Conradson, 2003; Stahaeli and Brown, 2003); and about the poor quality of the care some migrant workers provide. In Taiwan, research and government officials have focused on the impact on domestic employment opportunities (Shai, 2001; Council of Labour Affairs, 2003), and the prevention of domestic abuse of foreign carers (Lui-Whang, 2001; Lin, 2003). In this study, I want to engage with the above studies yet from a different perspective. I want to explore the expectations of some of these workers by the families who employ them, and concentrate on migrants who work as domiciliary care providers looking after older people. When talking about Taiwanese migrant care workers, this study has adopted the term 'foreign carer' (a precise translation of the Taiwanese original) to differ from the English use of 'migrant care worker'.

5.8 Informal carers

One of the criteria for sample selection was that a minimum of either a formal or an informal carer could be interviewed. Many of the older people had both formal and informal carers; for instance Ms Chung had a formal live-in carer, but her granddaughter-in–law also provided hands on care. Ms Sempik was in residential care but her son visited her regularly and managed her financial affairs. Wherever possible both informal and formal carers were interviewed, but many of the former could not be accessed. Only the informal carer was interviewed for four English

service users (Ms Bames, Ms Becker, Ms Owen, and Ms Munro); both the formal and the informal carer was interviewed for two service user in England (Ms Sempik and Ms Ward) and four in Taiwan (Ms Bai, Ms Chung, Ms Fu and Ms Lin). According to the older people interviewed, most of the informal carers were their children or spouses. Most of them lived in the same household as the service users in Taiwan. However, a few Taiwanese and most English and Dutch family carers lived some distance from the service users. They worked during the day and visited their older family members during the weekend to assist with shopping, gardening and taking them out. There is little doubt that the family provided care to the service users as much as they could. The daily care of the service users studied, however, was primarily provided by the formal carers. For this reason, only a few informal carers involved in daily hands-on care were included in this study. There were four in England, one in the Netherlands and three in Taiwan (see Table 5.7). This table gives information about the informal carers interviewed. Please note it was not possible to interview all the informal carers (see page 92 for details).

Table 5.7 Background information on the informal carers

COUNTRY	PARTICIPANT REGARDING	AGE	GENDER	PROFESSION	RELATIONSHIP WITH THE OLDER PARTICIPANT	SAME HOUSEHOLD LIVING	TOTAL
England	Ms Bames	46	G	Unemployed	Daughter	No	6
	Ms Becker	53	M	Prison Officer	Son	Yes	
	Ms Owen	32	M	Unemployed	Daughter-in law	No	
	Ms Munro	58	F	Unemployed	Daughter	No	
	Ms Sempik	61	F	Pensioner	Son	No	
	Ms Ward	72	M	Pensioner	Husband	No	
Netherlands	Ms Schoonwater	74	M	Pensioner	Husband	Yes	1
Taiwan	Ms Bai	60	M	School bus driver	Son	Yes	3
	Ms Chung	28	F	House wife	Granddaughter -in-law	Yes	
	Ms Lin	56	M	GP	Son	No	
Total	10						

Most of the literature on caring suggests that informal carers are predominantly women. However, by chance there was no great gender division amongst informal carers in this study. Female informal carers were mainly daughters. Amongst the males, there was one husband of a service user in the Netherlands and sons in Taiwan and England. Most of the informal carers (2/3) in Taiwan were sons; this reflects the traditional family ethic that the elder son has the lead responsibility for the care of parents, with assistance from his spouse and the rest of the family. Two were

also sons providing informal care for their mothers in England, either because they were the only child or the only child available in the family. Most of the informal carers in the three countries (7/10) were aged over 50. The age of the Dutch informal carer interviewee was over 70. Many informal carer interviewees were aged around 60 in Taiwan and between 32 and 72 in England. Many of the informal care participants in Taiwan were employed but in England and the Netherlands most of them were either retired or unemployed.

5.9 Conclusion

This chapter has further explored the characteristics of each individual interview group to help contextualise findings of this research discussed in the chapters that follow. Each set of interviews in each country reflects the nature of the three welfare systems.

The 28 older people for this study were selected using comparable criteria across the three countries (see Chapter four, p 77-8). They were also deliberately selected to reflect a comparable range of care services across the three countries. Roughly one half were receiving community care, about a quarter receiving nursing care and around a quarter receiving residential care. The health and mobility condition of the older people studied were comparable between the countries. Most of them had multiple health problems with poor mobility.

Long-term care was centralised in the Netherlands, but less so in England and Taiwan. There were more participants at the national level in the Netherlands and Taiwan than in England, because of the pillarised nature of the Dutch system and multi-department involvement in Taiwan. Each country studied provided an example of a mixed economy of welfare in the field of care. The national framework was reflected at the local level. The dominant agency for providing long-term care was the local authority in England; the local authority co-operating with other agencies in the Netherlands; and various local offices of central government departments in Taiwan.

The balance between sectors of care providers, however, was different. One of the care market characteristics shared by the three countries was that none of them was dominated by state provision. There was the private sector in England, the non-profit sector in the Netherlands and a mix of profit and non-profit sectors in Taiwan. How this care market arrangement supported the quality of care amongst older people will be further addressed in Chapter nine.

The assessors who carried out needs assessment or identification of older people requiring support from public-found were primarily employed by the local authority in England, with independent assessors and service providers in the Netherlands and Taiwan. Such arrangements had strengths and weaknesses in practice and will be further explored in Chapter six.

Formal carers were a mix of trained/untrained carers and a few professionals in England; trained carers and professionals in the Netherlands; in Taiwan, there were trained carers, most of whom were supervised by professionals. Only a few informal carers were involved in this research, as most of the informal care was provided by families who lived a distance from the service users. Nonetheless, their views were significant as there is little doubt that informal carers make an important contribution in care systems.

The profile of the participants given in this chapter provides a context for the presentation of the data from the interviews, given in the following five chapters. Following the framework developed in Chapter three, the analysis focuses on older people's every day experience in care; power and autonomy of older people; social inclusion in long-term care; care resources and capacity; and quality control in care; as well as partnership in the care system in the implementation of care.

CHAPTER SIX

Everyday Experience OF Care

6.1 Introduction

As discussed in Chapter three, successful ageing in long-term care is dependent on identifying and meeting the needs of older people appropriately. As people become more disabled, they will require assistance with a whole range of issues. This will include physical care, help with un/dressing, help with food and help with house work; and emotional and psychological support to dealing with bereavement and lost of life style (detail see in Chapter two). Although objective needs measurement was the policy in all three countries, in practice the outcomes are complex. While applying the theory of human needs and successful ageing into the content of long-term care, the basic premise is that if older people researched are to receive excellent care, then they need to experience six senses: a sense of security; a sense of belonging; a sense of continuity; a sense of security; a sense of achievement; and a sense of significance. Furthermore, in order to deliver such care, staff and family members studied also have to experience the senses themselves (Nolan 1997, Davies et al 1999, Nolan et al, 2001). While other studies have explored the possibilities of needs measurement and care provision (see Chapter three), other issues were of more concern here. How did the different care systems meet the care needs of the older people studied? To what extent did the relevant care actors support them? What amount of care tasks and responsibilities were undertaken by them? To what extent did the care actors influence the quality of care for the older people studied? To what extent did the care which the older people received affect their quality of life and to what extent did the caring role affect the lives of their front-line professionals and carers? As indicated in earlier chapters, the small size and the bias of the sample studied mean that the findings illustrate the experiences of the participants but cannot be reliably generalised as typical of the experiences of the relevant actors in the three care systems studied.

6.2 Needs identification

Frailty and poor mobility prevented older people in the three countries from performing their daily living tasks. Assistance with care needs included washing, un/dressing and household tasks. Food preparation and access to the community were also in high demand. Needs identification by older people in the three countries indicated that many social and health needs were basic and universal. In particular, nearly all of the older people emphasised the great importance of social inclusion (this will be addressed in Chapter eight). The intensity of care needs and the frequency with which support might be required could vary depending on individual older people themselves and the resources available. For instance, some people could have their needs met by one person, others needed two people to visit them at times because of poor mobility problems. There was no clear identification of a particular type of care for meeting similar needs across the three countries. For instance, Ms Reinaerdts (Dutch), Ms Pearce (English) and Ms Lin (Taiwanese) had similar needs for assistance with all their personal care, including toileting and 24-hour supervision. Their care needs were met by a nursing home in the Netherlands, a residential home in England and live-in care in Taiwan. However, we have already seen (Chapter 2.6.1 and Chapter 5.5) different service response to the same needs appeared within each country. The question explored in this chapter is how such needs were acknowledged and met in the three different care systems.

6.2.1 Macro perspective of needs: The views of civil servants, NGOs senior officials and local administrators

The participants at macro and meso levels (civil servants and local authority administrators) claimed that, at national level, health care had been a higher priority than social care in the English system. The Director of Social Services in the English county interviewed argued that current health care policy had prioritised the reduction of hospital waiting lists, and that came into conflict with other policies such as client-centred care. Furthermore, there had been a very long tradition of minimum care support in England in which the state did not take responsibility, particularly if it felt that families were able to step in. The poor law principle of less eligibility had still not been entirely eradicated. Most English interviewees at macro and meso levels (5/7) suggested that the care system was subject to the availability of local resources

and provided a 'safety net' of care, implying a selective welfare approach:

> The amount of service they get will depend again on their dependency levels, their frailty and so on… And a lot of it is, who decided at what point in their, you know, history, what they needed, as it were, what was the assessment of need, what was available locally and so on, so people with equivalent levels of need might end up in different services. (Senior official, Commission for Social Care Inspection, England)

Similarly, the Dutch interviewees at macro and meso levels acknowledged that health care had dominated in their system. However, all of the Dutch participants at the national level expressed a clearer ethical obligation by the state to deliver high quality care. The state expected the care system to offer support to disadvantaged 'citizens' to improve their 'social participation', to achieve 'normalisation' and to obtain an 'equal right' to a decent quality of life:

> The vision of Dutch government is that we want elderly people or disabled people to live as normally as they want to in Dutch society. (Civil servant, Ministry of Health, Welfare and Sport, the Netherlands)

> This may also include more things like participation in society… to give people as much quality of life as possible… What are the basic rights of people… in this undesirable situation? (Senior officials in Arcares, the Netherlands)

In both study examples of Taiwanese and English, the supply of care was particularly dependent on the availability of resources. In England, there were disparities at the local authority level which led to different service entitlement thresholds. In Taiwan, the supply of care was dependent on the availability of family resources. It was also the Taiwanese aim to stimulate employment through care provision:

> The government hopes it can provide affordable welfare for those older people who are financially disadvantaged. For those older people who are able to afford it, there will be a service available to help them to buy care services. It is our aim to develop both welfare and the care market. (Civil servant, Council of Economic Planning and Development, Taiwan)

Nearly all of the Taiwanese participants at the macro and meso levels (10/12) argued that the economy-oriented perspective might have a significant impact on the quality of care provision. Moreover, the limitation of what families can provide within an fragmented system of state support, must be a matter of concern.

6.2.2 Needs identification in practice: The views of professionals and service providers

Methods of assessment had a strong influence on the support which individuals were entitled to receive. Each country's assessment mechanism and process in theory reflected the outcome of needs identification and the entitlement to service amongst older people. Needs identification could be defined in two parts – assessment for public funding purposes and assessment by service providers. England was the only country of the three where the assessors and budget holders were under the same authority. It is hardly surprising that English local authorities had such a strong influence on assessing needs in practice. High dependency needs, available family resources as well as funding availability were the keys to the assessment. The availability of resources restricted the assessor's autonomy significantly as most of their recommendations had to be approved by the Resource Allocation Panels (RAPs) within the local authority:

> Your assessments are presented to a funding panel [RAP] who are examining those assessments and deciding whether or not to accept the recommendations. (Assessor social worker of Ms Ward, England)

Many English assessors (8/11) shared the concern that resources-led services assessment had been interpreted as aiming to fit the service users into criteria, available service resources in particular, rather than to make an objective judgement which addressed the needs of individuals.

> To meet the demand of care, [We assess clients] by rationing, by gate keeping, by spreading the jam very thinly, by applying the criteria more rigorously and by other routes, ie funding panels. This is something that forms a regular pattern within this part of social services when we get to a part of the financial year when the resources are getting low, then restrictions are applied, criteria alter. (Assessor social worker of Ms Ward, England)

> It doesn't matter whether that person meets this [needs] criteria, if there's no service available, that person does not meet this criteria [for care services]. (Assessor social worker of Ms Powell, England)

This seemed to result in some difficulties for many English assessors (8/11). As one of the participants argued, it was difficult and rather lacking in objectivity to be an assessor and then gate-keep the very resources you were assessing for.

By contrast assessment of needs in both the Netherlands and Taiwan were more or less independent and separate from the agencies that provided public funding. The assessors from the regional assessment agencies (RIO) in the Netherlands and health care professionals in Taiwan carried out assessments and identified care needs. Based on the assessment, the budget holder (the insurance company in the Netherlands and the local authority in Taiwan) had the obligation to arrange for services to be funded. The advantage of such a structure was that identification of care needs could be more objective.

> The strength is that if there's a need for care, you can get it. (Assessor social worker of Ms Bowman, the Netherlands)

'Objective' needs identification was relatively strong in the Dutch system from this study. Firstly, the organisation of assessment was independent from local and national resource allocation. Secondly, nearly all of the assessors (7/8) said that a second opinion was usually sought when there was a disagreement between the client and the assessor. Thirdly, a uniform assessment tool was used across the country. However, more than half of the Dutch assessors (5/8) were concerned that the standard assessment tool did not reflect every individual's care needs.

The Dutch government, however, was moving in the direction of Taiwanese practice where, in order to speed up the process, assessment had been introduced with little face-face contact. Most of the Dutch assessors (6/8) were opposed to this, as less time spent on an individual client might prevent an adequate assessment outcome. The Taiwanese assessor claimed it was the only way to work in a big geographical area with a limited amount of time. In most cases, they only saw the older people once and the rest of the contact was by telephone or letters. The English assessors

studied maintained strong face-to-face contact with their clients, family and relevant professionals and agencies throughout the assessment process. However, the frequency of personal contact had also declined:

> At the moment, for each service user, we spend 2-3 hours visiting but several days, not hours, sitting in front of the computer to complete the paper work of their assessment. (Assessor social worker of Ms Bames, England)

Most assessments were carried out by social workers and health professionals in Taiwan and the Netherlands; and by assessors, senior carers or nursing professionals in England (see Chapter five). Assessors who worked for the service providers interviewed in Taiwan (10) and the Netherlands (3) worked in a multi-disciplinary organisation and carried out the needs assessment from their own professional field:

> The nurse is the focus for the medical treatment of the clients, the nutritionist is the focus for the nutritional needs of clients and I am the focus for their daily wellbeing and provide them the emotional support. When the older people are first admitted into the care home, I work with them to deal with any financial problems and apply for financial support from the government, private sector or voluntary sector when necessary. (Assessor residential home social worker of Ms Li, Taiwan)

In Taiwan, assessors commented on the strong family influence on needs identification:

> Families have a very strong influence in the assessment. Some families would force us to provide certain care, which is not of much benefit to the client. (Assessor physiotherapist of Ms Wang, Taiwan)

In particular to those older people who were seeking live-in care:

> The family has to specify their household situation, what they want the carer to do and what kind of carer they are looking for. We will then provide the CVs according to their requirement for them to choose. (Foreign carer agency manager of Ms Lin, Taiwan)

In practice, needs identification was often far more complicated. We have seen in all countries that assessments are undertaken following the same principles. The assessors look at older person's physical health, mental health, mobility and ability to self-care. However, the thresholds and the services provided vary from country to country. In addition, three quarters of the assessors interviewed across the countries had to address the difficulty of meeting the expectations not only of older people themselves but also of their families, other professionals and service providers. This shows that the power and autonomy of various actors was influential in determining the needs of and care supports for older people, an issue which is discussed further in Chapter nine.

6.3 Meeting needs: Care provision

Following the needs assessment, the service providers, and formal and informal carers in particular, were central to providing care.

6.3.1 Service providers

This chapter looks at people's day to day experiences under the care provision. Part of day to day experiences was not only about basic care provision – personal care, but also about the experiences of opportunity to retain some forms of independence. Chapter nine looks further at the issue of power and autonomy.

A basic knowledge of needs was evidenced in interviews with English service providers, nearly half of whom (4 out of 10) visualised the principle of long-term care needs as primarily a matter of basic day-to-day living tasks:

> My little pet flowers that were dying. But, she's [home carer] been told she mustn't help in the garden. She's only here for personal care, they say. (Ms Becker, England)

> We're just there to see to the day-to-day living... personal care, shopping, helping with laundry, cleaning. That sort of thing. (Home care manager of Ms Bames and Ms Holmes, England)

In England, the formal carers were focused on trying to get the job done and meeting people's basic needs. It was pretty stressful for the service users, too, because they couldn't expect anything more sophisticated.

Many of the service providers interpreted promoting independence of older people as meaning providing less care:

> [Ms Munro] is very independent, but if you do a lot for her, she'll let you do it. So you do have to be very careful, because if you made her tea every day, she'd never make her tea again. You do have to push the independence really, say to her, come on, get yourself dressed, come on get yourself a cup of tea. (Extra care housing manager of Ms Munro, England)

While English care providers tried not to help with what the older people could do by themselves, Dutch providers focused on client-centred care provision to meet individuals' care needs and promote their independence:

> To meet individuals needs… [clients] need time to talk, to do the washing, not quick, quick, quick, but slowly and waiting and resting, and then again… what we always do was to get to learn about these clients, and to see what's important, and think about how to do it… and I can't tell you what that is, because every one is different. (Home care manager of Ms Duijts, the Netherlands)

The above quote also shows that the Dutch ideology of 'normalisation' was not only about individuals having equal rights, but individuals having the right to their own normal routines. The interpretation of promoting independence of older people from the English and Dutch sample also reflect the differences of care culture and training opportunity of care workforce. These issues all relate to the differences in values reflected by the different welfare regimes in the English and Dutch societies. The latter will be further explored in Chapter nine.

In the open care market of Taiwan, care providers were competitive in providing low cost (3/8) or full range of care (5/8) to attract potential clients:

It's more economic to have a live-in carer to take care of the older people, which cost them 20,000 Taiwanese dollars [400 British pounds] a month in their own home [compared with] admitting them into a care home which will cost them much more. (Foreign care agencies manager of Ms Lin, Taiwan)

We do not provide personal care but health care, treatment, rehabilitation and social care to the clients. We have our own transport for older people to attend our hospital for rehabilitation. (Nursing home manager of Ms Yen, Taiwan)

Nearly all of the service providers (7/8) viewed the care service as primarily for the families:

> We are helping the family to take care of their elderly. (Residential home manager of Ms Wang, Taiwan)

6.3.2 Informal care

There was little doubt that most older people, whatever kind of formal care they received, also received support from their families. The small numbers of informal carers in this research project (6, 1 and 3 in England, the Netherlands and Taiwan respectively) has already been mentioned (see in Chapter four and five). Most of the informal carers across the countries (8/10) started to provide care for their elderly relatives far earlier (more than 5 years in average) than formal services. There was little doubt that formal care support reduced but did not replace the physical work and responsibilities of informal carers. Although Taiwanese informal carers had less physical care involvement with older relatives who received live-in care, they provided a similarly large amount of psychological and emotional support for their elderly as they did in the other two countries. In all three countries, informal carers also organised doctor appointments and visiting relatives. Those who had assistance from live-in carers in Taiwan, nevertheless assisted their elderly relatives with managing financial matters and medication, arranging hospital appointments and supervising the foreign carer regularly. Two Taiwanese and most English and Dutch informal carers who received support from home care services performed similar care tasks to those who received live-in carer support. It was difficult to quantify the

amount of caring which informal carers undertook in all three countries, because even when there were times when informal carers did not need to provide hands-on care, there were other tasks relating to older people's overall well being that had to be performed. In addition, alertness was constantly required of informal carers for needs that were difficult to foresee:

> It is difficult to say how long care takes, because, it's not just her that we look after. We look after her garden and house as well. It all takes time. (Daughter of Ms Munro, England)

> There are 24 hours a day and of those 24 hours, I spend a few hours in bed, and the rest of the day I am looking after her. From the minute I get up till the minute I go to bed. (Husband of Ms Schoonwater, the Netherlands)

> 24 hours a day, 7 days a week. Because I am afraid of her having a fall and need to supervise her all the time. (Granddaughter-in-law of Ms Chung, Taiwan)

The complexity of informal care was often underestimated. For instance, providing care was not a natural task as such, but required learning. However, in the interview with assessors and formal carers, there was only one Taiwanese home carer and one English health professional who admitted they had given training and advice to informal carers on family care provision. This suggests that family carers have been left alone to face the care situation, a task that can be particularly difficult for male carers:

> Cooking! Well I learned how, it wasn't exactly my profession after all. Let's face it, in the old days the wife took care of the food and the husband went out to work, by which I don't mean to say that housework isn't work, of course. (Husband of Ms Schoonwater, the Netherlands)

> It was very difficult to start with but you pick up how to do the care day by day. By trying different ways of doing things with [mum]. (Son of Ms Lin, Taiwan)

Meeting psychological needs could be far more demanding and challenging than physical care work. Nearly all of the English informal carers (4/6) expressed the

great challenge in emotional/psychological support for the people they cared for and for themselves as carers:

> Doing the job, it's okay. It is when she is depressed and that, you know, and you have to cheer her up. I think that is the most horrible thing to do, you know, when they are, oh, like, when she keeps saying, I've got this wrong with me and that wrong with me. I say, well, look, we all have pains and that, and we have to learn to live with it. (Daughter-in-law of Ms Owen, England)

> Surviving I think really is the most difficult task just simply surviving, carrying on with a way of life that is not obvious what anybody wants so you know that in itself is a difficult task. (Son of Ms Becker, England)

There were constant debates about safety and independence during care provision. When disagreements occurred between the older person and their informal carer, it could make relationships difficult:

> Putting up with mum at times because she can be very aggressive, awkward at times. Everything has to be her way and if I do it a different way, she gets quite annoyed. I don't like those flowers like that and that's how she talks to you and I just have to bite my tongue you know and think you silly, old devil. Otherwise it would upset me. (Daughter of Ms Bames, England)

6.3.3 Formal care

The interviews with service users and formal carers across the countries revealed that the care, which the formal carers provided, varied depending on the individual needs of the older people and also the quality of the carers. For people who lived in their own home, a wide range of support with a variety of carers providing specific tasks could be found in Dutch home care services. For example, Ms Flipsen received formal care to assist her with personal matters by a home care assistant and two hours per week house cleaning provided by a domestic carer. There was also a volunteering hot meal delivery service available for Ms Boersbroek daily during the week. In addition, the home carers of Ms Boersbroek and Ms Flipsen said there were also nursing staff within home care support to provide health care for them.

The Dutch personal budget (PGB) made it possible for Ms Duijts to employ a single carer to provide support involving personal, health and domestic care assistance. In contrast, in England, Ms Becker received only personal care. House cleaning services were seen as housewifery rather than care and were unlikely to be available unless the person was very dependent. Formal care in Taiwan provided flexibility and single care support to meet the needs of older people in the community, especially through foreign carers who provided 24-hour care in all respects. Taiwanese home care support was more likely to be provided by the same carers to assist older people, such as Ms Bai and Fu with personal care, domestic tasks, shopping, meal preparation and basic health needs such as daily blood pressure measurement and massage. Live-in carers in Taiwan provided all the care support for older people as well as the families who live in the same household.

For older people who lived in residential/nursing homes, in the Netherlands, there were many nurses providing personal and health care and volunteers providing feeding assistance and social/recreational activities. In contrast, care assistants provided personal care primarily and some degrees of health care in England. In Taiwan, it was the carers in the care home who were primarily responsible for providing personal care to meet the older people's daily needs. As in the Netherlands, volunteers were used in the care home setting to meet the social and recreational needs of older people.

In short, all the formal carers in each of the three countries provided personal care to the older people. Essential personal care needs were seen as universal basic human needs. However, the Dutch had a more comprehensive professional care arrangement within a unified service, the Taiwanese were more likely to be able to provide one single carer to meet an older person's complicated needs, and English care support was primarily focused on personal care tasks.

A number of the older people studied received both formal care from professionals and informal care from relatives; for instance Mrs Bames lived in her own home and received home care from the statutory services while her daughter provided emotional support and performed a number of domiciliary tasks. We have already seen that the care carried out by the informal care in the three countries was influenced by issues such as kinship. For formal carers also, care was not only associated with manual caring tasks. They tended to bring their personal experiences into the job. Old age and caring were closely related to every one's life and influenced many

people deeply. Issues of daily care could reflect on one's life experience universally:

> ...we should provide care with passion and love and care for them just like your parents. Because one day when we need to be cared for, we also want to have care with love and emotional support. (Residential carer of Ms Wang, Taiwan)

> I've got elderly parents, I've still got both my parents who are in their eighties, so I can empathise with the people I go to because they've got the same problems that my mum and dad have got. So I try and, I try and treat them like I treat my mum and dad. (Home carer of Ms Holmes, England)

> Imagine if my mother was in bed here with a broken hip for a week without the correct help, then I should be very angry. I should not agree with the situation. (Nursing carer of Ms Regniek, the Netherlands)

To maintain older people's daily routine and individual expectations, however, was the greatest challenge to formal carers in the three countries. Nearly half of the Dutch (4/9) and Taiwanese (4/9), and one English formal carer had difficulty meeting older people's individual daily routine and care expectations. To satisfy older people's individual preferences and habits was a great challenge to carers.

6.4 Service users' satisfaction with the long-term care they had received

Within the concept of successful ageing - either from a well being or social justice perspective – happiness and satisfaction would be appropriate outcome measurements (Boyle, 2003) for this research, indicating the extent to which an individual's needs were supported by intervention, placement and care provision.

Older people were therefore asked how satisfied they were with their living circumstances; how satisfied they were with their social life; and how satisfied they were with the care they had received.

6.4.1 Living environment and space

All the older people studied were asked how satisfied they were with the place they were living in. As Table 6.1 shows, scoring four for very good, three for good, two for fair and one for poor, produced average scores for England and Taiwan of 2.6, but for the Netherlands they were 3.6 out of the maximum of 4. This indicated that most Dutch older participants were satisfied with their accommodation either in the community or in the institution. Dutch accommodation tended to have more living space and privacy for the individual, and the living environments were purpose built (or appropriately adapted) for people who had disabilities. In contrast, many Taiwanese and some English older participants felt physically restricted because their living environments were far from user friendly.

Table 6.1

Service users' satisfaction with the living environment

	Very good (4)	Good (3)	Fair (2)	Poor (1)	Total
England	2	3	2	2	9
The Netherlands	7	2	1	0	10
Taiwan	1	4	3	1	9
Total	10	9	6	3	28

6.4.2 Satisfaction with formal care services

Table 6.2

Service users' satisfaction with care services

	Very good (4)	Good (3)	Fair (2)	Poor (1)	Total
England	3	2	0	4	9
The Netherlands	6	4	0	0	10
Taiwan	3	3	3	0	9
Total	12	9	3	4	28

Service users were asked about their satisfaction with the care services they had received. The results (see table 6.2 above) produced scores of 3.6 for the Netherlands, 3 for Taiwan and 2.4 for England. The sense of security and continuity has reflected on reliable services, good consultation and the meeting of older people's needs directly by their carers led to satisfaction amongst the Dutch and Taiwanese participants. In addition, older Dutch respondents enjoyed a well-organised and varied choice of social activities in meeting the sense of belonging, achievement and significance. In contrast, services unreliability had been a main concern to English service users. This had had a significant impact on their daily living and led to English older participants' dissatisfaction:

> It is, so long as they come in at the time they are supposed to do. [The home carer] coming in at ten o'clock and after [to help for preparing breakfast] is no fun, when you've had nothing to eat or drink. We specified that time when we agreed to have a carer that they would come in round about half past nine. (Ms Becker, England)

6.5 The well-being of front-line carers and professionals

As it is likely that the work satisfaction of carers or caring professionals affects the quality of care older people receive (Redfern et al, 2002), this section draws attention to the circumstances which affect the caring role of professionals, informal and formal carers.

6.5.1 The assessors

Nearly all of the Dutch assessors/professionals (7/8) worked part-time and only one worked full-time (36 hours/week), just over half of the English (6/11) worked full-time (37.5 hours/week) and all of the Taiwanese (40 hours/week). This would seem to reflect the general employment situation in each country (see Chapter 2.3.3, p 17-8). This study reinforces evidence concerning the demanding nature of care work. Nearly all of English assessors (10/11) stated they worked around 5 hours extra per week and most of Taiwanese (8/11) claimed they often worked an extra 5-10 hours

per week. In England, nearly half of the assessors (5/11) experienced a high workload which restricted the quality of work performance:

> I normally have no control over how the care is provided to the service users,. The drive of this job [assessor] is to get the referrals assessed as quickly as possible, get the service in, close the case and move onto the next one, because that's about reaching targets and turnovers and that sort of thing... (Assessor social worker of Ms Munro, England)

Comments such as these reflected a rather under-funded and under-resourced service in England; it was no wonder that people felt their workloads were unmanageable. In contrast, all of the Dutch respondents thought their workload was manageable, but a few of them (2/8) claimed they limited the quality of the work they performed for individual clients. Just over half the Taiwanese (6/11) felt they could manage their workload; others claimed staff turn-over and unexpected crises with clients (i.e. hospital discharge) were the main reason for not being able to manage.

Considering the complexity and emotional involvement of caring professionals, there were few assessors in the three countries (3/30) who raised the issue of professional stress:

> I do a lot of sport to de-stress, if things get too bad, I have my colleagues to discuss issues and to support me. (Assessor social worker of Ms Reinaerdts, the Netherlands)

> I can never do everything I'm supposed to do. I have to prioritise all the time and some tasks just don't get done. The most important task is to get people to stay at their own home. But because we have all these debates and all this knowledge, people are always waiting for reports from us, like how much money we're spending, how the contracts are, how many hours people have got. We are also dealing with complaints. All of that is often very time consuming. (Service organiser of Ms Owen, England)

Although the numbers of assessors/professionals who raised concerns of work related stress was small, there did seem to be a need for support of their well-being to enable them to be able to deliver good quality work.

All of the assessors/professionals across the countries valued caring for and interacting with people:

> I love my job with a passion. I think I'm very fortunate that I'm trusted and involved in working with people at a time in their life when they're perhaps reached crisis. (Assessor social worker of Ms Powell, England)

> I've got a beautiful profession that comes into touch with people and has contact with people. (Assessor nurse of Ms der Horst, the Netherlands)

> I like the interaction with the clients, because every one has their individual life experience. When you provide services you may not avoid your subjective point of view and make an assumption of what the person may need. However, the clients can tell you how they feel and what they think would be the best time to receive the care. Their voice would help me to improve my professional knowledge and to meet their own needs better. (Assessor residential home social worker of Ms Li, Taiwan)

However, many in England and the Netherlands experienced dissatisfaction with increasing administration. They thought this had impaired their professional ability to work with people in person:

> I wanted to be with people and you know [at] the front line. All the IT work is keeping you in the office, writing reposts and forms that aren't particularly relevant sometimes. (Assessor occupational therapist of Ms Becker, England)

> After January 1st 2005, people will have to provide their own information. It will no longer be our job to gather the information. We will be expected to make all the judgements behind the desk. The policy makers think there's always someone who can help the older people to gather the information. The real interaction between the older people and us has gone. If you want to work with people, maybe it's time to retire. (Assessor social worker of Ms Schoonwater, the Netherlands)

The above mentioned problem is not only in older people's services but is a common problem throughout health and social care services (see for instance, Munro 2005) on

the increase of administrative work in Children Services).

The Taiwanese assessors and professionals shared the same dissatisfaction. In addition, a few of them (3/11) felt pressured by family influence and were sometimes misled on the needs of older persons:

> The family's influence is greater than medical judgement and sometimes can do more harm than good to the clients. (Assessor physiotherapist of Ms Yen, Taiwan)

> The conflict of disagreement between the family and the older people does not happen too often. If it happened, we will tell the manager and she will communicate with the family. Sometimes if the family's expectation is not good for the older people the manager will explain the reason to the family may be relate to reason of the medical or wellbeing. (Nursing carer of Ms Li, Taiwan)

6.5.2 Informal carers

As mentioned in Chapter three, most of the older people in the three countries received formal care and this was on a 24-hour basis. Nearly all of the informal carers had an on-going problem of feeling tired, but had a tendency to provide care for as long as possible:

> I can't have a proper sleep, because I need to supervise my grandmother-in-law constantly to prevent her from having a fall. However, she only sleeps 2-3hours in the night and wanders around the rest of the night in the house. I have two little children who need to be taken care of as well. That's why we employ the foreign carer. (Daughter-in-law of Ms Chung, Taiwan)

> Tired sometimes but yet at the same time I feel good about it because you're not dwelling on yourself,... basically, I don't want to get more strangers coming in and out and let my mum think that she's losing her independence... But as she gets a bit older then I may have to rethink because I don't want mum going in a home. Because I know if she goes in a home she won't last long and I want her on this earth a lot longer... (Daughter of Ms Munro, England)

A similar attitude to care amongst informal carers could be found in the three different cultures. Nearly all the informal carers had mixed-feelings of responsibility, respect and sacrifice for the older people they were caring for. Moreover, all of them saw themselves as a close family member of the older people but also as a carer:

> I am just a family member, a son that does whatever is necessary. (Son of Ms Baker, England)

> I do it because I love my wife. I would have preferred not to do it, as I'm sure you will appreciate. But it works well, as long as we can be together. But it's not a job I'd go looking for. (Husband of Ms Schoonwater, the Netherlands)

> It is kind of repayment and to have gratitude for her for raising me. It is a natural responsibility for a child. It is responsibility. It will have some impact on life. If my mum is healthy, I will not need to worry all the time. For instance I planned to go to America to visit my wife and son, but I have to postpone it because my mum is not well. (Son of Ms Lin, Taiwan)

This became apparent as we looked at the data through the interviews. What the families said illustrated one of the major concerns about care satisfaction which related to informal carers in this chapter. They regarded themselves as having responsibilities for their elderly relatives largely until these reached a point where they could not manage. The points at which they expected the state to intervene was different in each of the countries researched.

When informal carers were asked about what other things they did in their spare time, nearly all of the English informal carers (5/6) said they did not have any spare time, but spent most of the time in the caring role with elderly relatives and their families. As a result, many of the English respondents (4/6) suggested life could be worse without the caring commitment, because they would feel the loss of caring for someone they loved and the loss of the centre of their life as a carer:

> I don't really know. I would see that this would be a great big empty hole that would appear. I'd probably have a bit more time for myself, but I think at the same time I'd have a big hole there, because she's not there. I'm dreading it, I'm really dreading it. (Daughter of Ms Munro, England)

In contrast, many of Taiwanese participants and the Dutch respondent stated they had some spare time and they used it to socialise with friends and families. Nonetheless, the choice and location of the social activities could be restricted by the caring role in all three countries:

> Not much [socialising], The simple thing is because I have to come back and help get mum and dad to bed, I can't stay away from the place. So obviously that creates difficulties. So I haven't got anything else other than I have managed to get a little more time with [my girl friend] but it's at a push. (Son of Ms Becker, England)

> I am also involved in the church,... I hadn't been able to do anything for the church for a long time because of my wife's situation but for the last couple of years I have been able to do various things, by telephone, in writing and on the computer. I read a lot. (Husband of Ms Schoonwater, the Netherlands)

> I also joined some social club, if I need to go out I would ensure the food has been prepared for my mum... I don't go too far from the house, in case she needs me, she can call me and I could come directly back home. (Son of Ms Bai, Taiwan)

Caring had a greater impact on the informal carer's capacity for socialising in England, than the Netherlands and Taiwan. Most of the Taiwanese (2/3) and the Dutch interviewees felt they had a good social relationship with others, whereas all of the English informal carers felt they had been socially isolated:

> We cannot tell you what friends we got, because the older friends, like, now, for example, all the friends we know is they are on holiday, they (...) camping, they doing this, they're going to Skegness, they have something fun, yeah, but we're still here, doing the same job, everyday. (Daughter-in-law of Ms Owen, England)

Examples from the three countries showed that long hours of one-to-one care could be quite isolating for informal carers (see for example Glendinning 1992, Pickard and Glendinning 2002). English informal carers expressed more loneliness perhaps because they had neither the extended family like the Taiwanese nor were they able

to rely on the state in the same way as the families could in the Netherlands.

6.5.3 Formal carers

There is as yet no reliable statistical data on the work conditions of formal carers (van Ewijk et al, 2002). However it was very important to know whether people worked part time or full time as too many part-time care staff means a lack of continuity of care. All of the service providers interviewed in England and nearly all in the Netherlands (6 out of 7) stated their care workers were permanent but many were part-time; whereas in Taiwan, most of the formal carers were permanent and full-time. However in Taiwan formal carers were foreign carers whose contracts were restricted to 3 years maximum by national work migration regulations in order to protect native employment opportunities. Formal carers in Taiwan worked much longer hours and were more likely to work full-time than those in the other two countries. The average weekly working hours of Taiwanese formal carers in this research were 40 for home carers, 72 for residential/nursing care and 24-hours on call for live-in carers.

On average, formal carers worked more than 30 hours full time and 20 hours part-time per week in the UK. In the Netherlands they worked 36 hours a week full time and more than 20 hours part-time. Whereas all the formal carers in Taiwan worked full-time, in England and the Netherlands, the male formal carers worked full time and most female formal carers worked part time. As mentioned in Chapter three, most of the female carers had provided informal care for their own families as well as formal care for others in their occupations. However this study has highlighted another significant employment issue in English society. A woman's benefit entitlement could be restricted by what they earned. Ms Sempik's carer, who was a lone parent, explained that the reason for her choice of low hours and low pay work was to protect her right to receive benefits for her children:

> I do 19 1/2 hour per week... because it's better for my circumstances. You know what I mean. I'm better off in a low paid job- it sounds silly but because I'm a single parent with young children,... Because of your family tax credits and you're better off in a low paid job, which don't make sense but it works. (Residential carer of Ms Sempik, England)

Most of the formal carers in the Netherlands and many in Taiwan seemed to think their workload was manageable. In contrast, many English formal carers and the live-in carers in Taiwan felt their workload was too high. This demonstrates that the issues of care resources is partly concerned with staffing levels in which will be discussed in Chapter eight. For the English, the increasing numbers of high dependence clients and the shortage of staff were the issues:

> If you had all ladies like her, you would be able to give all one to one care, but we haven't, we've got some very high dependency ladies who can't take themselves to the toilet or can't weight-bear, so you have to turn them every two hours, and it all takes a lot of time, and, it's more nursing care, I think, than it is residential care. (Residential care of Ms Powell, England)

For the foreign (live-in) carers in Taiwan, although there was only one who requested some support, it is worth noting that the difficulties live-in carers faced was a lack of back-up support, especially when they were off sick:

> I can't manage all the work my employer asks me to do of course, but I have to. If I have got very sick, I have to ask my employer to take care of A-ma [the client] for me. (Foreign carer of Ms Chung, Taiwan)

6.6 Conclusion

The amount of support from informal carers remains extensive and difficult to estimate in all three countries. This study suggests that official training was not commonly available to family carers in any of the three countries. Informal carers struggled to find out how to provide appropriate care. Adapting to the individual's routine and normality was of great concern to formal carers studied in the Netherlands and Taiwan but not so much in England, and this might be the result of its selective support care system. This study has also shown care goes beyond objective and physical tasks. A personal and emotional element to care is universal and unavoidable. For formal and informal carers, mental support for older people was far more of a challenge than physical work. This was even more so when dealing with someone who was a member of one's own family. Formal carers in the three countries related their own personal experience of care provision. Professionals across the board also found

facing clients' personal and emotional needs unavoidable.

It was also suggested that in order to provide quality care, the well-being of carers and professionals was of significance. Care workers/professionals worked much longer hours and were more likely to work full-time in Taiwan. In England they worked less hours followed by the Netherlands. Informal carers, formal carers and assessors in this study showed less satisfaction with their caring roles in England than in Taiwan followed by the Netherlands. Informal carers interviewed in Taiwan and the Netherlands were more likely than those in England to have spare time and social support for their own well-being. Moreover, the sample of English family carers were more likely to feel loneliness and experience the anxiety of losing older relatives. Most formal care was provided by women in the three countries. The lack of back up support for live-in carers was an issue in Taiwan. There was evidence of unmanageable workloads for professionals in England and Taiwan and to some degree the Netherlands. All three countries showed a tendency for less direct professional contact with service users. This had an impact on the outcome of needs assessment and caused job dissatisfaction. Overall, Dutch older people studied were the most satisfied with their lives in terms of the living environment, the extent of accessibility to social intervention, participation and feelings of loneliness. Taiwan came second and England came a distant third. If this analysis is correct, we may conclude that the Dutch system delivered a better outcome in terms of older people's welfare, and the welfare of their informal carers, formal carers and professionals, the Taiwanese came second and the English third.

6.7 Key points for policy and practice

- Needs assessment is far from satisfactory and insufficiently client-centred in England and Taiwan. Both countries ought to re-examine service user involvement.

- There is little doubt that older people's needs are complex and assessment often involves consultation with a number of parties. Policy makers should consider that the dangers of limiting the assessment time for individuals may result in inadequate assessment and service outcome.

- Similarly, care is not only about tasks but is strongly related to personal perceptions. Time for carers and assessors to spend with individual older people is significant in providing humane care.

- While much research has focused on cost-effectiveness, care expenditure and research should be increasingly directed to ways of reducing work dissatisfaction to prevent staff turnover and to raise productivity. Explicit policies to support care professionals and workers should be developed in all three countries.

- Support for informal carers in how to provide care is lacking from the participants studied in all three countries. Helping informal carers extend their ability to carry out their role may improve their well-being as carers and reduce the demand for formal care services.

CHAPTER SEVEN

Social Inclusion

7.1 Introduction

Social inclusion means human participation and interaction and is a basic need. It is also one of the components of successful ageing. Social inclusion is important for, as mentioned in Chapter three, if older people are socially included, then there is less likelihood of them demanding care services. This supports the argument that long-term care is not just about personal care, daily living tasks and nursing care, but that social inclusion is important too. An English study (Godfrey and Denby, 2004) also found daily isolation could lead to depression and this was a more significant risk factor than major life events. As significant as the issues amongst successful ageing so far identified by this cross-national study of older people in long-term care are, the isolation and disengagement that restrict older people in receiving appropriate care to meet their needs is just as vital. This chapter attempts to understand and evaluate current long-term care systems of social inclusion support at the macro, meso and micro levels. It is clear from this research that social inclusion was important to service users. They felt that being supported in their social well-being would improve their quality of life. This chapter is concerned with the impact of policy upon the provision of social inclusion in long-term care services. First it will explore the actors' perceptions to promote social inclusion of older people in the three long-term care systems. Second, it will explore the way that care systems helped older people to remain or become socially included.

7.2 An awareness and vision of social inclusion as part of a broader context

The key findings demonstrated how perceptions of social inclusion were influenced by political ideologies in the three long-term care systems at the macro, meso and micro levels.

7.2.1 The perspective at the macro-level: The views of civil servants and NGO senior officials at the national level and local administrators

The issue of social inclusion at the national level showed great differences between the countries. This might relate to national definitions of social inclusion among older people needing long-term care. The concern for older people in care who tended to be vulnerable in terms of participation and were more likely to have been socially disengaged had been very well addressed in the Netherlands. The Dutch value of "equal rights", "normality" and "coherence" within a wider society (which we will again see in the concept of power and autonomy of older people (Chapter eight) is implied in the concept of social inclusion, stimulating strong state involvement to ensure services availability for dependent people to ensure that they are socially included:

> The vision of the Dutch government is that we want elderly people or disabled people to live as normally as they want in Dutch society. (Civil servant, Ministry of Health, Welfare and Sport, the Netherlands)

> … when they [older people] don't have any one to support them, and they need facilities for care, I think well, they [the state] have to supply them, because otherwise, they [older people] are not equal citizens in society, they can't behave as equal citizens. (Senior official in CSO, the Netherlands)

In the Netherlands, there was an acknowledged national responsibility to promote social inclusion, in Taiwan this was regarded more as an individual or local responsibility. Taiwanese civil servants at the national level confirmed at the early stage of the nascent care system that the state had yet to acquire the capacity to implement a policy of social inclusion. However, the requirements to improve social relationships of older people and to provide them with cultural and social activities and access to the wider community were clearly stated in the following legislation: *Standards of Nursing and Residential Homes Act* (1998:9), *Improving Older People Domiciliary Care Act* (1998:5) and *National Care Services Evaluation Criteria* (1999:7). The interviews with local administrators revealed the local authority's response in co-operating with the service providers to promote dependent older

people's propensity for social activation. In addition, local authority personnel believed that promoting social inclusion was a way of reducing the future demand in social and health care costs:

> We [local authority] believe older people who are involved with society are happier and it helps to maintain their physical health and wellbeing. That's the reason we are actively looking to join in working with the service providers to help older people have trips and social activities. (Local authority home care service developer, Taiwan)

Furthermore, there was evidence that project supplements from both central and local government to service providers had focused on the development of social inclusion services.

In the case of England, social inclusion policy development might seem to indicate a national acknowledgement and support for older people. However, the interview with various participants showed social inclusion had been treated as a problem for care practice. Apart from the fact that all the national participants acknowledged the need for social inclusion, the problem of implementing any programmes for social inclusion was undermined by the fragmentation of the care system (a point further explored in Chapter ten). This was mentioned in a number of interviews. This meant that social inclusion implementation was left to be undertaken by local authorities and the individuals:

> I think there's quite a lot of consensus about the objectives of promoting older people's inclusion as citizens in society, but it is much harder to pull off a detailed implementation of the policy. Because it's complicated and lots of different people have to do things which require [the cooperation of] other departments, then it's not so much a care issue as a transport, leisure,... activities outside care issue to some extent. (Senior official, Commission for Social Care Inspection, England)

Such resistance was further complicated at the local level by perceived conflicts of interest across relevant departments. Supporters of older people's social inclusion claimed:

> ...there's a long way to go... we've got things like local strategic partnerships that's meant to bring all the different organisations in an area to work together but a lot of them haven't put older people as one of their key focuses... there's no great obligation to look at older people... they are often the last groups that are thought of... (Director of Social Services, England)

This implied the English national policy of "social inclusion", "coordination" and "joined up thinking" had not been underlined in statutory services in response to the long-term care of older people. This had contributed to difficulties in the implementation of care practice at meso and micro level, a point that will be demonstrated in the following sections.

One emergent factor was that de-institutionalisation and supporting people to live in their own homes were at the top of the political agenda to promote social inclusion and autonomy of older people in all three nations (see also Chapter three). This study found divided views regarding whether care should better be offered in people's own home or an institution. A Dutch participant argued:

> Living in a care home is in fact also an exclusion, exclusion from society because these care homes have even been considered asylums. (Senior official in NIZW, the Netherlands)

By contrast, all of the English participants at the national level stressed that with inadequate service support, people might be in danger of further exclusion in their own home:

> ... actually living at home is not fun, when you're stuck in your flat or your house and you see somebody very rarely... (Civil servant, Department of Health, England)

Numerous commentators (e.g. Parker 1990) have argued that one can not assume that people are better being looked after in their own home than in a residential/nursing home; rather, it depended on the available support to meet older people's care needs. It is arguable that if people don't receive adequate personal support, the consequence is that instead of living independently, they simply survive in isolation. This view was also suggested by front-line professionals, a point which will be addressed in the next section.

7.2.2 The perspective at the meso level: The views of professionals and service providers

Cooperation between local authority and care providers in promoting social inclusion among older people needing long-term care was found in the Netherlands and Taiwan but not in England. The Dutch service providers had a similar view to the Taiwanese local administrators and service providers that to keep older people motivated and staying active helped them to feel useful and promoted better health and wellbeing:

> Yeah, it's very important. We think that people who stay more active feel better, it's also better when you feel better, it's better for your body and your healths when you have the idea that you do have something useful to contribute. (Nursing home manager of Ms Reginek, the Netherlands)

Additionally, Taiwanese service providers interviewed believed social inclusion could contribute to the power and autonomy (see Chapter eight) of older people:

> Social inclusion is very important for older people to improve their health and maintain satisfaction. It is also significant to avoid the impression that their rights have been over looked and their existence has been ignored. (Home care manager of Ms Fu and Ms Bai, Taiwan)

By contrast, the sample of service providers from England reflected a social inclusion model that was rather passive, resulting in a shortfall between expectation and reality in the care system. Social inclusion was left to the individual's ability and willingness to prevent isolation:

> I think it is good for service users to have social involvement right from the beginning but what I also find is that once they've got all the care packages set up, that's where it ends. (Home care manager of Ms Munro, England)

The interviews with the professionals/assessors indicated that most of the Dutch and some Taiwanese were able to identify and meet the needs of older people to be socially included. By contrast, little identification of need in respect of social inclusion amongst the service users was found in England. Most of the English assessor respondents were concerned about a shortage of choice and poor quality of resources and this meant that it was not always possible to acknowledge the need for social inclusion. In addition, the strict assessment criteria means that services outside personal care would be the lowest priority in the assessment outcome:

> As a social worker [assessor], I think we have a duty to include the clients and to widen their social network as much as we possibly can, but generally, we don't. At the moment, there is no way our services can offer that sort of scope for wider opportunities... only people with high personal and health care needs are able to get our services. (Assessor social worker of Ms Powell, England)

It could be argued that needs might only be identified when some sort of provision to satisfy them already existed (Langan, 1998). But for professionals to ignore a need because there was nothing to meet it, would be remiss. This could cause further problems for the individual in getting appropriate support as well as a slow down in the development of a service.

The greater isolation of English older people, especially living in their own homes, reflected a lack of resources and support for their social inclusion. Many English professionals echoed their national civil servant's view (see above) and claimed:

> People are very isolated in this community. If you're old and you don't have good links locally, if you can't communicate very well and if you can't get out the house, you will almost certainly be very isolated and obviously people don't like that. (Assessor social worker of Ms Becker, England)

One of the most important messages from the English case studies was that the English lack of emphasis on social inclusion was counter-productive. In these circumstances, people who were excluded were more likely to become depressed, more likely to consume mental health services and more likely to become dependent. Therefore, by not emphasising this particular area of concern, the care outcomes were actually preventing older people from remaining independent.

7.2.3 The perspective at the micro-level: The views of service users and carers

Most Dutch older people (8 out of 10), many Taiwanese (4 out of 9) and a few English (2 out of 9) claimed they needed appropriate daily activities and interaction to be able to compensate for individual loss and promote life satisfaction and independence. Nearly all of the Dutch older respondents (9 out of 10) were engaged in various activities in their spare time such as light housework, reading, watching television and religious and recreational activities. Watching television, exercising, socialising and religious activities filled the leisure time of many of the older Taiwanese interviewees (7 out of 9); whereas nearly half (4 out of 9) of English older people had nothing to do but just sit on a chair or watch television most of the time. Even in the latter activity, autonomy could be encouraged. People can watch television passively in the sense they hardly take anything in, and actively in the sense that their minds are working and are stimulated. The autonomy of being able to chose the programme allowed the Dutch and Taiwanese to interact with society indirectly:

> … I watch all the current affairs programmes; I want to know what's going on in the world… (Ms Duijts, the Netherlands)

In England, older people, especially those in residential and nursing homes, shared the television in the lounge and were not able to change the channel. Although people surrounded them they were not socially included:

> … I spend [a lot of time] in the lounge; … you just sit in front the television, look out the window and watch the world go by. (Ms Sempik, England)

Older people were asked what they would like to do if they had more help. Two out of 9 English older participants said they did not know what they could do and they did not think there was anyone available to help. More than half (5 out of 9) the Taiwanese and nearly all (8 out of 10) the Dutch stated their satisfaction with their spare time. For those who indicated their needs were not adequately met, all of the English service users (7), four from Taiwan and two Dutch wanted increased help with social contact and cultural activities. This implied social inclusion could be a

widespread concerns for older people in long-term care and it had been generally been met in the Netherlands, followed by Taiwan with England a distant third.

One Dutch service user also alerted us to the fact that dependent older people were not primarily care receivers, but saw themselves as a diverse group who were able to contribute to society with support:

> I would really like to do my part for the socially vulnerable. I'd like to really offer people a helping hand, to drag them out of their rut, to make them more aware of the opportunities they do still have. You can bring a smile to someone else's face simply by asking how they are. Not always thinking about yourself but thinking about others. And not always projecting everything on yourself but being there for someone else as well. Learn to listen. The fact that someone can talk to you, can solve half their problem. (Ms Flipsen, the Netherlands)

Formal carers' willingness in helping older people to be socially included was well evidenced in the three countries, based on the carers' recognition of the importance of improving or decelerating older people's physical and mental frailty. However, nearly all of the English formal carers interviewed (4 out of 5) said they did not know how to socially include older people, because there were no clear guidelines and a lack of human and service resources to encourage older people who needed to become socially included:

> [laughter] I don't know.... I've never asked... I'm not quite sure how that stands, actually, maybe four or five years ago, we were told, we haven't got the resources to do that... so there's no point in asking [the service users]. (Home carer of Mrs Holmesr, England)

By contrast, formal carers in the Netherlands and Taiwan showed awareness and initiative in meeting their service users' needs. Nearly all of the formal carers in the Netherlands (7 out of 9) and Taiwan (8 out of 9) had provided examples in practice which will be dealt with in more detail later.

This analysis has demonstrated that the need of older people in long-term care to be social included is universal across the three countries. The findings showed the Dutch and Taiwanese had more awareness and vision of social inclusion in their care systems than the English model. Social inclusion had been promoted consistently

from top to bottom in the Netherlands with strong state intervention. Similarly in Taiwan, various regulations together with the culture of valued senior citizens and professional belief in health promotion, had contributed to meso and micro support. In contrast, in England, although there was evidence of social inclusion objectives at the national and local levels, in practice, little attention was given to the issue.

7.3 Social inclusion in practice

The literature research uncovered four main components that demonstrated the success or failure of social inclusion policies in practice:

(1) Economic well-being,

(2) Social relationships,

(3) Accessible basic services and neighbourhood inclusion,

(4) Culture and leisure activities.

This section will further explore how the political ideologies and awareness mentioned above promote the achievement of these four components of social inclusion in practice. This section will also examine how each country promotes or appears to promote social inclusion in overall practice.

7.3.1 Economic wellbeing

Chapter three showed us that one of the key components of social inclusion was having sufficient money to be able to do certain things to make people feel included. We saw in Chapter two that the poverty rate for older people in Taiwan was highest, England came second and in the Netherlands it was relatively low. This section will further examine the financial situation of those receiving long-term care in the three countries. There were different types of financial support from the state in the countries studied. In England there was a system of state provided minimal income for older people. In Taiwan it was only just being introduced. Previously Taiwanese older people had to rely on families' financial support but there was no safety net

provision. In the Netherlands, they had generous pensions and financial support for older people. There was of course, a clear distinction in responsibility for care financing in the three countries: family in Taiwan, state in the Netherlands and a mix of private and state in England. Most of the older people interviewed in Taiwan (7 out of 9) had fully funded their own care in comparison with the respondents in England and in the Netherlands, all of whom had been partly funded by the state. Although the numbers of the older people in this study were very small, the funding arrangements of the older people studied represented the three systems. All of the Dutch service users in this research were comfortable with their financial situation and the state pension (AOW) and statutory health insurance (AWBZ). Indeed, nearly all of the Dutch contributors at macro and meso levels stated that financially less well off older people lived in the care home, but under conditions of good care. Overall, there were very few older people needing care who were living in poverty in the Netherlands. The case of the Netherlands indicated that a good state pension and financial support could be very useful and often reduced the poverty of older people in care. However, we also learnt that such a comprehensive state system had become fragile in the face of increasing care demand and required readjustment as regards the balance of responsibilities between the state and the individuals:

> We have to make a choice, we can't do it all any more in the future... it may be that we have to be more clear about what the job of the government is and what is the job of the people themselves. This will be a very important social discussion for the future. (Civil servant, Ministry of Health, Welfare and Sport, the Netherlands)

There was substantial evidence of Dutch welfare retrenchment. During the interview on 2004, a policy officer from the local authority commented on the forthcoming *Social Support Act* (WMO) which was later became legislation in 2006:

> At the moment everything is changing. In the past the central government took care of everything... if the new law [WMO] is coming, when you have a problem, you need to ask family, friends and neighbours to help you. It's also the responsibility of civil society... the responsibility of family and volunteers will be burdened and there is a risk of losing them. (Local authority policy officer, the Netherlands)

Dutch state welfare retrenchment toward mixed welfare has created a chain-reaction in care provision. According to the service providers, professionals and formal carers, less money from the state means that care providers will start to cut staff, and this will impact on the number of hours and support each individual can receive from care. In addition, the increase in individual contributions means it could reduce the acceptability of preventative care if the individual refuses to pay for their own costs:

> If you make [domiciliary care] more expensive then people will say no to that kind of care… that means that they can't support themselves, so they are going to need other kind of care and it may be care in a care home instead of living in their own home, with a little help. (Home care manager of Ms Flipsen and Ms Boersbroek, the Netherlands)

On the other hand, if it is to be argued that care is expensive and that the Dutch taxpayer won't support it, the state may offer only limited support which may result in a trend towards the English care model.

Unlike the Netherlands, nearly half of the Taiwanese (4 out of 9) older people faced financial difficulties and most of these lived in a care home:

> Who can I talk to if I worry about my financial situation? We [my children and I] just talked about how much we still need to pay… all the money comes from my children. My youngest son has to work day and night but he doesn't earn much. (Ms Li, Taiwan)

Some English (3 out of 9) older people emphasised their experience of worrying about their daily living cost and two of these lived in their own home:

> Oh, very often. I need to work out how much it charges me for home care and I've got to pay for the gas, electricity and the telephone, pipe life line… and I got to save my pennies for the gifts to grandchildren… (Ms Owen, England)

The social security system was one of the main concerns of senior officials from NGOs in England and Taiwan regarding the causes of poverty for those in long-term care. A senior official from NGO in Taiwan commented:

> There is a need to modify the social assistance criteria... The current lower income criteria takes all of the family members' financial income into account, however there are more and more older people living alone who are not financially supported by family members, who have been excluded from financial support by the government. (Senior official in Disability Welfare Alliance, Taiwan)

Such a family-oriented social security system is obviously problematic for those older people who do not receive sufficient financial support from their family. Similarly, poverty in long-term care in England is partly explained by the state's poor social assistance provision:

> People in care homes being left with £18.10 personal expenses allowance, to buy their grandchildren Christmas presents, and all their toothpaste and everything else, and it is very socially excluding because you're not going to be able to carry on being an ordinary member of the family once you're in care home. (Senior official in Age Concern, England)

In addition, unclear financial advice from local authorities caused financial uncertainty to older people and their families in England:

> I am waiting for the social people to come to see me about [benefit and care charging]. Cos I don't know what's going off now and they're gonna sort it out. And that's been going on for weeks and we ain't heard nothing yet. (Husband of Ms Ward, England)

Schulte (2002) suggested that it was pointless to have social legislation when you were unable to provide benefits for the people who were entitled to them. Social needs would not be met and the law would remain ineffective. I would further argue that many comparative studies examine policy aims and fail to take implementation into account.

England is the only country in the three nations which used an individual's own property to fund their care in a care home. This has caused extensive debate as we have seen in Chapter three and requires further research. In this study, all of the English national participants opposed the policy of people having to sell their house to fund their care:

> Whatever your opinion is, lots of older people do not want to spend the money they get from selling their house on the last few years of their life, they want to leave it to sons and daughters and grandchildren. (Civil servant, Department of Health, England)

During empirical work in England from this research, one service user interviewed was in the process of selling her house after her three months' residential admission. She intended to participate in this research but the interview never took place. According to her daughter and the carers at the nursing care home, Ms Pool had developed depression and was being seen by a psychiatric nurse. Although Ms Pool's case could not be part of this comparative study her experience exposed how the loss of a house which was used to fund life-care could cause grief and have a significant effect on the individual's well-being in the process.

Another problem of relying on older people being able to sell their own homes to pay for their care is that more people are taking out equity release. When they sell their homes there is not much left after paying off the loan. One senior official at the national level pointed out some practical reasons why the value that capital contributed to the care system was not fully realisable:

> There's a real danger at the moment, with the government looking very much at houses... the house market is volatile and could just not work for people. People are taking out equity release because their pensions aren't good enough and some older people will still have their mortgage in their eighties... they're not going to have equity left to pay for their care. (Senior official in Age Concern, England)

Long-term care is costly and funding care is a complicated and challenging matter for all countries. Our findings in the case of England suggest that government can't assume that the money from a person's property will be there to resolve care funding issues in the future.

Moreover, one of the striking problems raised in the English interviews was that individuals and families in particular had been required to top up what the state paid for institutional care (so called third party charge). In principle, the English system does not recognise third party contributions but in practice, the pressure of the care

market shortage has forced individuals and their families to pay an additional care cost:

> Under guidance, the local authority should always be able to give you a choice of homes at the price they're prepared to pay as if the third party didn't exist. But we get loads and loads of queries from relatives saying we can't find a single home at the local authority price, or if they can find one, it hasn't got any vacancies. (Senior official in Age Concern, England)

Ms Simpik's son was anxious and felt powerless when talking about the reason why he had to pay additional money for his mother's residential care:

> I pay, because it is the only way my mother can stay in the home. But, if you get to the stage of life when you can't get a room which should be a standard price, which is wrong. Because at that stage of life, you've done your bit, you've paid your taxes, I think you should be offered a minimum, basic standard of room and it should be done. (Son of Ms Sempik, England)

There is substantial evidence from this study that social workers were making considerable efforts to negotiate top up charges with care homes, placing older people wherever possible in places which met their needs. However such arrangements were sometimes fragile:

> There are times when I assess someone as needing a particular home, and because of the third party [e.g. family members], it's not been possible to place that person there, and they've had no family or whatever, that really upset me. (Assessor social worker of Ms Powell, England)

A shortage of affordable placements meant that there could be a long wait and also that older people could be placed out of the authority and be further isolated from their community. This was the case in 2 of 4 English older people in institutional care in this study. It reflected state inefficiency for the financially disadvantaged which is such a worrying feature of the English care system.

Means-testing is another major issue in the financial arrangements for the care of the elderly in England. Although this was not raised by any of the service users interviewed, research by Hancock and Wright (1999) has demonstrated gender

inequalities in that men tend to received higher benefit support than women and single people are more financially advantaged than married couples. Wright (2003) also argued the discrimination against older people who self-funding in long-term residential care. Moreover the benefit system is extremely complicated and many people fail to receive all the allowances that they are entitled to; elderly disabled people are particularly disadvantaged in this respect (Moffatt and Higgs, 2005). The small size of the sample in this study may have been the reason why this issue was not raised.

While many older people in Taiwan and England experienced continuing financial struggle, there were several others in this study who were not worried about their financial wellbeing (5/9, 6/9 and 9/10 in England, Taiwan and the Netherland respectively). All of these in England and Taiwan and more than half in the Netherlands (5/9) were not very knowledgeable about their financial circumstances. All of them in England, nearly all in Taiwan (5/6) and the Netherlands (7/9) had tacitly acknowledged that their families, in particular their children, managed their financial matters. For them, family support offered protection and stability:

> I don't know, ask my son. If someone should worry about money it is my son, he's in charge of my finances. (Ms Sempik, England)
>
> I really don't know, my daughter takes care of that and she gives me the pocket money. (Ms Boersbroek, the Netherlands)
>
> My children are taking care of it. They are able to earn the money, I can't. (Ms Tsai, Taiwan)

This research further indicated that many older people's financial wellbeing was not only older people's business but had some effect on their families' financial state. Families were more likely to share their income with their elderly family members in Taiwan followed by England and to a lesser degree in the Netherlands. The problem of the Taiwanese system was that without families' support, older people might be excluded from care.

England was the only country where informal carers had a means tested social right to financial support. However, the stringent means tested Carer's Allowance meant that many carers had been excluded from appropriate financial support. Again,

although the numbers were very small, none of the informal carers (4) in this research were entitled to Carer's Allowance even though they were experiencing financial disadvantages in being a carer:

> I get a pension from the government. The Carer's Allowance is less than my pension and you can only have one. You can't have both... Well it is a pressure, yes. It's a worry that I could do without, you know, I mean there isn't only petrol, I do things and shopping for them. Sometimes, not purposely, they forget to pay, you know. I did some shopping 3 weeks ago and it was nearly £50 and mum just forgot to give me the money and I can't bring my self round to saying anything to her. (Daughter of Ms Bames, England)

However for those who had received Carer's Allowance, the amount of supplements were far from sufficient and the contribution of informal carers still failed to be recognised. As one social worker commented:

> [Informal] carers definitely feel undervalued and underpaid. One was telling me the other day he was on 2p an hour when he worked it out by the amount that he could get from Carer's Allowance to help him to be a carer. (Assessor social worker of Ms Becker, England)

7.3.2 Social relationship

On very practical grounds, having a social role (as family member, friend, or community member) is a significant protective factor against mental illness, social isolation and loneliness (Cattan et al 2005). Therefore, it is crucial for care services to provide opportunities for social relationships to develop and for personal identity to flourish. Nearly all of the older Taiwanese participants (8 out of 9) were satisfied with their social relationships in comparison with many in England and the Netherlands. Most of the service users across the countries (21 out of 28) identified a good relationship as regular contact and visits by the families. This might indicate that the family-oriented culture in Taiwan strengthened the social relationships of older people. As a result they were more satisfied than the older people from the other two countries.

The concept of social relationship means families are not only carers, but are significant persons fulfilling the lives of older people as "family". On the other hand, the experiential knowledge of the Dutch older people interviewed demonstrated the point drawn from Godfrey and Denby (2004, p213) that ' success in managing the changes that accompanied ageing ... was in large part determined by the extent to which people were able to maintain inter-dependent lives: being able to view themselves as both givers and receivers of emotional, social and practical support'.

> We went through a very rough patch indeed, but during that rough patch I still tried to do all kinds of things with my children, with the means we did still have. That you can still be happy, even with very little. That is something I have learned. (Ms Flipsen, the Netherlands)

The same debate continued around relationships. One of the English service users showed her anxiety about keeping the relationship with her spouse. Her view challenged the out dated assumption that older people's sexual relationships could be ignored:

> Ah, big change [in the relationship with my husband], I mean, there's no love-making or something like that. You can't here [in the nursing care home] can you? (Ms Ward, England)

Family participation also involved indirect financial contributions, such as buying gifts for each other on special occasions as mentioned earlier (p 143) in this chapter. The interviews suggested that this was a greater concern across the whole system in England than in the other two countries.

Furthermore, formal carers had the most frequent contact with older people (especially for those who have no informal care support) in the care system, so it was fundamental to maintain a satisfactory relationship between them. Both the service users and their carers were asked about their relationship with each other. Most Taiwanese, nearly half of the Dutch and some English older people and carers stated they had a good relationship and contact with each other. Yet even the formal care relationship in the Taiwanese family-style model seemed to have more social interaction than formal care in the Netherlands and England. Taiwanese formal carers and older people saw each other as family and regular personal conversation was not an uncommon occurrence for Taiwanese respondents:

We are always chatting and laughing. The care service is good. She always encourages me to be strong and keep doing exercise. (Ms Fu, Taiwan)

I think [my relationship with Ms Fu] is good, because we are like family or friends. We chat about her life, her family and her past very often and it makes us closer. (Home carer of Ms Fu, Taiwan)

Similarly, the preference of having personal conversation in care practice was recognised by formal carers in England and the Netherlands. Most carers in the two countries valued a personal approach in practice and felt it improved the quality of care provision to treat older people as people, not objects:

> ... I like talking to them [clients] and listening and really getting to know them because you forget that they used to be married and they used to have a family. You forget because you just think of them as old people but then if you sit and talk to them, they've actually got loads to tell you and I find that really interesting. (Residential carer of Ms Poole[15], England)

As mentioned in Chapter six, in England and to a small degree of the Netherlands and Taiwan, concern about a shortage of resources was principally a shortage of staff which led to an unmanageable workload for care workers/professionals. As a consequence, older people in England on occasions were left with limited care support or attention:

> I go round to [care] homes on a regular basis, and there's supposed to be one care assistant in the main room at all times with older people. The reality is that sometimes older people just sit there in the main room and there's no carer because they're either doing something or there's not been the right amount of staff on. (Assessor social worker of Ms Powell, England)

A "support saving account" programme was set-up by NGOs to encourage care contributions from healthier older people towards those who needed care support in

[15] The interview of this particular carer has been disregarded in the main data analysis, due to Ms Pool experiencing depression following having to sell her own home to fund the care and be unable to participate in the research.

their own home in Taiwan. The idea was to provide a good-will saving-account for volunteers to build up their own care resources and attain rewards in the future:

> ... for those older people who live alone in their own home, sometimes, without seeing any body all day... there are more and more of the healthy ageing population who are willing to help those people voluntarily. They can have points system, for instance, if they have been a volunteer for 14 hours, they can have similar support from others when they need support in the future. (Assessor nurse of Ms Bai and Ms Fu, Taiwan)

It's too early to evaluate the effect on those volunteers in their later life, but it is fair to say the scheme has provided the opportunity for people to participate in care provision and with a lesser power imbalance between the carers and the care receivers.

Another example in Taiwan was that the "care charging reduction" programme had been introduced by the care homes to encourage family groups to remain in contact and maintain the family identity of older people:

> ...the family will get a reduction with their older family members' care fees, by the numbers of visits they make to their older family members. The family are well involved with their relatives in the home and our residents also feel they are still been cared for by their family. (Nursing home manager of Ms Li, Taiwan)

This programme has worked relatively well and has also helped to provide a better relationship between formal and informal carers. The evidence of most formal carers in Taiwan suggested that they had close contact with older people's families, in comparison with only some in the Netherlands and almost none in England.

In the case of the Netherlands, there is evidence that the role of providers has been maximised by helping educate older persons to continue to make critical decisions independently of them, and organise with persons in similar circumstances to affect the *milieu* in which they live (Thursz, 1995, p xiv). For instance, the care system has shown a way of encouraging service users to receive and be aware of the information on possible social networks in order to make their own decisions and choices:

> I believe it is extremely important that people maintain social contacts... that it is by encouraging the clients to do things for themselves, to arrange and organise things themselves, with support from us when necessary... we have someone here, for instance, who loves to play a particular game of cards, and the social activities worker happened to hear that someone else in the building likes playing the same game. So now she encourages them to contact each other to play together, but she leaves it up to them she doesn't organise or arrange anything for them. (Extra care housing manager of Ms Schoonwater, the Netherlands)

By contrast in the English care system, it was service users' own self-determination and independence that was the significant feature in their success or failure in maintaining social relationships:

> We try and encourage people not to remain isolated and to interact with other people so we do promote that [strength the social relationship] already. (Residential home manager of Ms Powell, England)

7.3.3 Access to basic services and neighbourhood inclusions

For most people and particularly older people, living in a strong, open community was desirable in itself. Access to shops and resources and to be safe on the road without falling are significant factors in being able to participate in the community. Living space was still a private matter in Taiwan; whereas the state in England had emphasised the improvement of the older people's living environment through housing adaptation (SEU, 2006). The interviews with service users found most of the older Dutch participants had the opportunity to visit a wide range of people and places, the Taiwanese came a close second and English again came a distant third. A number of Dutch interviews revealed that the Netherlands gave broader consideration to improve not only housing but also the whole community in which older people were living. This was based on the *City Planning Programme* (see Chapter three, p 59) and joint working between the local authority, an older people's

pressure group, a housing association and service providers to ensure people were safe to go on the road and that resources were geographically accessible:

> ... if you have your house adapted, which is not even the main objective for the inhabitants... people have got to have social activities and involvement because people are more scared of being lonely than of falling. The Government needs to create the type of streets that are in a good state so you don't fall... the whole community is involved in the location of the care centre, shops and welfare activities, so its easy to get access for the older people as well as carers. The carers can't work well with bad travelling conditions... (Local authority policy officer, the Netherlands)

The Dutch placed an emphasis on geographically accessible community resources which had helped some older people reach places independently with limited personal care support. As Photos 7.1 and 7.2 demonstrate, Dutch service users in their own home or care homes were able to go to the local shop independently.

Photo 7.1 Dutch residential residents from Ms Veltman's residential home walk outside the care home.

Photo 7.2 Ms Schoonwater shops at the local shop which is just next door to her extra care housing in the Netherlands.

We will see (Chapter eight) that the belief in 'normalisation' and 'solidarity' in the Netherlands has driven autonomy in practice. Here it has been shown that the Dutch ideology of supporting older people in participating in the community not only relied on available services but a user-friendly and accessible local community was provided for frail older people in which to live and move about normally just like others. In addition, public transportation for the service users was well advanced in the Netherlands:

> Sometimes I visit people for a coffee for instance. I could go out to visit people if I want to. I have to phone the regiotaxi, it is very cheap and I use it a lot, but sometimes you have to wait... my granddaughter said... if I want to [visit her], phone her and she will come and fetch me. (Ms Veltman, the Netherlands)

On the other hand, greater human resources - family, formal and volunteer support - made it possible for older participants to go out when they wanted to in Taiwan and to a lesser extent of the Netherlands:

> Sometimes, I need people to take me out. Sometimes the carer will do it and my son will take me out when he has time. (Ms Tsai, Taiwan)

Unlike the Dutch who had a better public transportation system and a user-friendly access environment for disabled people, Taiwanese older people were more likely to be able to visit family and community through the support of family members themselves and their formal carers. Formal carers assisting older people in visiting people (families, friends and neighbours) and community such as shops, clubs, parks or simply taking a walk in the neighbourhood were not an uncommon practice in Taiwan.

Photo 7.3 A foreign carer takes older people out in the park.

Photo 7.3 shows a foreign carer assisting older people to have a walk in the park with the wheelchair. In Taiwan, the majority of one-to-one care for older people by foreign care workers was mostly in the older person's own home (Chapter two). Nearly all of the foreign carer workers in Taiwan came from South East Asia. One should acknowledge they shared similar or stronger Confucian cultural notions with the Taiwanese which would contribute to the quality of care they provided.

In contrast, the mobility of English service users was restricted by a lack of support according to a few of the older English people interviewed:

> I used to love doing jigsaws but there's no room here...I watch more television than I've ever watched in my life. [laughter] I don't normally like it much, cos I've enjoyed some sports and everything. Well, I had more space there [shelter house], and I could sit out in the garden, wandering round or do all kinds of things. There's nothing I can do here, there's not enough room... Bored out of my mind. (Ms Powell, England)

7.3.4 Cultural and leisure activities

In general, physical restriction can seriously affect older people in the maintenance of their interests and engagement in social activities:

> Well, as one gets older, you know, one does lose a bit of interest... I'm very restricted now with this sight... I liked to do crosswords, but I have difficulty with that. (Ms Holmes, England)

> I don't go to church any more even with the wheelchair taxi. It soon got too much for me, too tiring. (Ms Schoonwater, the Netherlands)

> Sometimes I go to the community centre, sometimes I don't want to, because my legs cannot walk too far. It will be like wood, very heavy. (Ms Tsai, Taiwan)

Nevertheless, most of the Dutch service users (7 out of 10) were able to follow their interests but not in the case of England and Taiwan. One of the issues raised in interview was that Taiwan was the only country where many older people (6 out of 9) did not have a general interest or pastime during their life time due to the traditional long-working-hours culture:

> No, I don't have any interests. When I was young, I worked very hard, whenever I had job I will do it and I was tired most of the time. So when I had time I would rest. (Ms Lin, Taiwan)

These findings from older people in the three countries underlined the challenge in promoting social inclusion among older people including those who had lost their hobbies or had had no hobbies at all. One of the questions we wanted to answer in this study was whether there was a need to support or provide cultural and social activities for older people and how to overcome the challenge of limited participation. As mentioned earlier the ideology of social inclusion which promotes healthy well-being and autonomy was evidenced in the Taiwanese system. This had a significant effect on Taiwanese care practice. Recreational and social activities in both the Netherlands and Taiwan were well organised. Most of the Taiwanese service providers from institutional care (3 out of 4) and all institutional managers in the Netherlands confirmed sound social activities and recreational framework as a responsibility of qualified social workers or activity organisers. Utilising the resources of volunteers, students and families in organising activities for disabled older people who needed attention and assistance worked well in the case of Taiwan and the Netherlands.

Photo 7.4 Ms Jorna has recreational activities daily with 1:3 staff/volunteers' support in a Dutch residential home.

Photo 7.5 Ms Wang joins in music therapy in her residential home.

Photo 7.6 Ms Sempik's care home organised a musician to play music for all residents on occasions.

As the Photos 7.4 and 7.5 above show both Dutch and Taiwanese older people were able to physically participate in the activities with appropriate support from care contributors. In comparing English musical activities (Photo 7.6) with Taiwanese (Photos 7.5), the difference was that Taiwanese older people were making music and physically participating in the event whereas English older people were passively listening. The problem of care provision in England is they aim towards a particular area of culture and general level of interest (such as playing bingo or music performance) which does not necessarily reflect the needs of their clients. It can be argued that older people themselves do not necessarily share a common interest by virtue of age, but they are also deeply divided along lines of socio-economic status, race, gender, religion and locality (Walker and Naegele, 1999, p16; Hsieh, 1997, p70). This study found a choice of social recreational activities was not general practice in England. This was because activities were not within the appropriate staffing resources of many English care homes. Nearly all of the English (7 out of 9) service users were restricted in maintaining their interests because of poor care support:

> There hasn't been any social activities here yet. I used to love doing jigsaws but there's no room here. I used to like knitting, but I went off that. I watch more television than I've ever watched in my life. There's nothing I can do here and I am bored out of my mind [laughter]. (Ms Powell, England)

When English service providers were asked whether they would consider volunteers' contribution in this matter (a practice well used in the other two countries) most of them (8 out of 10) appeared reluctant to consider such an option:

> ...we tend to ask families more than anybody else, because... we're dealing with such a vulnerable group of people (yeah) erm we don't tend to rely on volunteers from outside in the community. We have to go through a criminal check for the volunteers and it gets too complicated. (Nursing home manager of Ms Gould, England)

Social participation through recreational activities was well evidenced in the Netherlands and Taiwan in the sense that the crafts of older people had been displayed in public places in the Dutch care home (see Photo 7.7). Similarly, in Taiwan the pieces of artwork older people made were presented during a community

event while older people were gathering with others. Moreover, while most of the English providers claimed there were few resources for organising recreational activities for older people, in two Taiwanese care homes, all the artwork was for sale to further develop care service provision for the service users (see Photo 7.8).

Photo 7.7 The crafts residents made in Ms Reginek's Nursing home.

Photo 7.8 Crafts which were made by the residents for sale at Ms Yen's nursing home.

In addition the activities organised by care providers in both the Netherlands and Taiwan were not only available for the service users, but there were also some events provided to bring older people and the community together:

> We have recreational activities and social events which take place inside the home or community on a regular basis by social workers, volunteers and students who come from local schools and universities. We have good volunteer resources to take people out to the local churches and temples. Our staffs need to be active to provide the national and local news to the residents and consult with them about what's going on in the community and encourage them to join the activities. (Nursing home manager of Ms Yen, Taiwan)

> ... we are trying to get our clients outside the house, so, we have activities outside the house, but also, bringing people from outside the house into the house. We have schools with very small children, and they had a project in that once a month the school had an activity for four hours in our home. So people had contact with little children and know their needs and their feelings, too. (Nursing home manager of Ms Reginek, the Netherlands)

Regarding the support for older people who lived in their own home, there were almost no examples from English services to assist older people to be more socially included other than for older people to attend a Day Care Centre. As mentioned earlier in this chapter, English attempts at social inclusion primarily depended on families and friends, due to a lack of resources and initiatives from the care system. As a result, many older people who lived in their own homes in England were very isolated:

> You know some people can be sitting in their house for weeks, and all they've seen is their care assistant coming in once a day. (Home care manager of Ms Munro, England)

In contrast, the Dutch and especially Taiwanese services had provided some good examples in practice to socially include older people who lived in their own home. For instance, Taiwanese home care providers organised activities and trips for both the service users and their families in participation with the local authority, community and volunteers. As a local government administrator explained (and this was confirmed by the service providers):

> During big social occasions, the volunteers, carers and social workers from the home care providers will go to the older people's house to help with decorations. Many older people like to join trips because they rarely go out by themselves and they enjoy tourism and the activities we organise for them during the trips. There are also some occasions when we co-operate with the community centre to invite the older people to see a performance presented by the school and community. On one occasion the community volunteers who would cook and provide a party for older people. (Local authority home care service developer, Taiwan)

> The idea is to improve happiness and wellbeing of Taiwanese older people who live at their own home, as well as strengthen the families and community's participation.

7.4 Satisfaction with social life

Social inclusion is a fundamental aspect of citizenship rights. Enabling older people to remain in regular contact with others means their views on and concerns about care are less likely to be undermined. The older people interviewed were asked how satisfied they were with their social life. The results are presented in Table 7.1, scoring four for very good, three for good, two for fair and one for poor, produced average scores of 1.8 for English participants, 3.3 for the Dutch participants and 1.6 for Taiwanese elderly interviewees. This indicated that Dutch older participants were much more active and happy with their social lives in comparison with the English and Taiwanese.

Table 7.1

Service users' satisfaction with their social life

	Very good (4)	Good (3)	Fair (2)	Poor (1)	Total
England	1	1	2	5	9
The Netherlands	5	4	0	1	10
Taiwan	0	1	3	5	9
Total	6	6	5	11	28

Most Dutch, some Taiwanese and a few English older participants had the opportunity to visit a wide range of people and places, when and where they liked. Greater family and volunteer support as well as access to public transport made it possible for older participants to go out when they wanted in the Netherlands:

> Sometimes I visit people for a coffee for instance. I could go out to visit people if I want to. I have to phone the regiotaxi. It is very cheap and I use it a lot, but sometimes you have to wait … My granddaughter said… if you want to come again, phone us and we will come and fetch you. (Ms Veltman, the Netherlands)

Strong family and formal care support helped older participants to go out when they wanted to in Taiwan:

> Sometimes, I need people to take me out. Sometimes the carer will do so and my son will take me out when he has time. (Ms Tsai, Taiwan)

In contrast, a few (3/9) of the older English interviewees considered their mobility was restricted by a lack of support either from their family or services:

> I was able before, but not now, because I can't walk on my own. Oh the staff have got no time, so busy. They always say how busy they are. (Ms Powell, England)

7.5 Conclusion

The chapter has looked at how the circumstances of the sample of people chosen in the countries studied promote or fail to promote social inclusion. We saw that supporting older people's physical/mental wellbeing - which can delay their health deterioration and avoid further care costs – had been well addressed in the sample from the Netherlands and Taiwan in comparison with the elder people studied from England.. The success of the Dutch model in socially including older people had been influenced by their policy principle of "equal rights", "normality" and "coherence". Social inclusion had focused on bringing older people into the community. This had been done with a high degree of state support and ensured the right of older people to participate in society in various ways. Taiwan primarily relied on family and care services to ensure that older people were socially included. Culturally, older people were partly included because they were respectfully treated as a member of the family and the family often substantially supported them. The principle of the policy – the more stimulation older people received the healthier they were – had influence service provision. In addition, the foreign carers who migrated to Taiwan tended to share similar expectations and culture. In the English sample, however, social inclusion was largely ignored and many older people were isolated, especially in their own home. Under-funded care services, weak partnerships between departments, inadequate care services and insufficient and poor quality care staff were key issues in delaying the implementation of policies to promote the social inclusion of older people in long-term care. This was because in England, care was provided as cheaply as possible, and carers had little time to spend on any support outside the provision of very basic level personal care. One extremely important finding to

emerge from this comparison was that exclusion could occur to people who lived in their own home as well as in a care home.

7.6 Key points for policy and practice

- Social exclusion in practice was largely ignored in this English sample. For several decades a stated aim of English social policy has been to reduce social exclusion amongst older. However the generally low morale evidenced throughout the English sample, the lack of attention to inclusion and the different priorities in meeting needs shown by their care actors demonstrate the difficulties of implementing such policies in practice

- It seems easy to blame a lack of resources for the lack of care quality. However, many examples drawn from the Dutch and Taiwanese social inclusion improvements often were not very resource intensive. They tended to relate to support creativity and service imagination. This has provided an important message to English policy makers and care providers that using imagination to make the best of the resources is as important as seeking more money for the system. For instance, England may learn from the Netherlands to be more systematic. It can also learn something about focusing on the family from Taiwan - such as "support saving account" and "care charging reduction" programmes - in promoting social inclusion. The Dutch may have institutional approaches and Taiwan might have personal tactics England can learn from.

- England is experiencing a shortage of human resources in providing care, whereas Taiwan and the Netherlands have a broad and well used base of family and voluntary resources which aids the social inclusion of older people. Perhaps it is worth considering whether family and volunteers can play a greater role in England.

- The migration of carers in Taiwan seems a cheap option for England or the Netherlands to consider. However, one of the problems about migrant carers is that of different expectations. Although such carers have made huge

contributions to our multi-cultural society, the down side is people can't always talk to each other and understand each other.

CHAPTER EIGHT

Power and Autonomy and Quality Control

8.1 Introduction

As identified in Chapter three, one of the key components of successful ageing is autonomy. People who do not have autonomy tend to be more dependent, isolated and depressed. Autonomy means people need to be able to express their views, participating in decision making which concern their own well-being and future. Because many older people in long-term care are vulnerable and frail, they lack autonomy. Doyal and Gough (1991) stated that autonomy requires the service user to have the intellectual capacity and enough confidence to take responsibility for what they do. They also suggested that service users need to communicate with others about themselves. This can best be achieved by empowerment through the provision of a support network, through certain services and assistance to help older people make decisions and choices. As we have already seen (Chapter six and seven) official policy in England, the Netherlands and to some degree in Taiwan, gives broad encouragement to the promotion of independence and autonomy. To complement the analysis of this policy aim, this chapter will also focus on one aspect of *quality of care* which is the sense of power and autonomy older people exercise over the care they receive. For the purposes of this chapter, quality control is broadly defined as the procedures that are explicitly designed to monitor, assess and improve the *quality of care* (Sluijs and Wagner, 2003) – e.g. care service reviews, client satisfaction surveys, complaint procedures, audits, power and autonomy issues. Older people who need long-term care are most likely to be physically and/or mentally frail and they are more likely to be involved with multi care actors. For this reason, it is essential for older people to have a sense that they are able to play a part to ensuring their quality of care is maintained. It also means that securing the autonomy of dependent older people within the complexities of the long-term care system remains a challenge. Therefore, alongside an examination of the effectiveness of quality control mechanisms, this chapter will highlight experiences of social and personal barriers that inhibit older people from becoming more active

socially and politically while in care. It is hoped that by the end of this chapter, we will have gathered some understanding of how each country has empowered older people; how the level of power and autonomy has affected older people's care and well-being; and how quality control mechanisms have contributed to care service improvement.

8.2 Consumer attitudes toward long-term care

We need to explore how far both older people themselves and the care actors who support them expect them to be autonomous and participate in decisions about their future. One of the key factors that stands in the way of the professional empowering older people is the prevalent view that older people are passive and unwilling to participate in decision making. This is shown in the interviews with professionals and the formal carers, but is also confirmed by some of the older people themselves. The loss of health and independence often made older participants pessimistic about their later life in all three countries. Such loss is also the main cause of frustration and can lead to life losing its meaning (6/9, 6/10, 7/9 in England, the Netherlands and Taiwan respectively):

> I don't enjoy [my life]. Every night when I go to bed I think of going away, I always do. (Ms Munro, England)

> It's nice to grow old but not to be old, ... I just find it hard to cope with. If you've always been so independent and travel alone... but that will never return, I've taken a step backwards, a large step backwards. (Ms Jorna, the Netherlands)

> Longevity is misery. If I die early I won't need to be here to suffer... now It's only half a life... I can't walk and my body is very frail. (Ms Yen, Taiwan)

The above views from many service users interviewed across the countries, reflect the importance and need for 'a new understanding of illness that does not leave the dependent person feeling not only like a burden but also diminished by a lack of health' (Sykes, 1995, p 48). In addition, as mentioned in Chapter 3.3.4, in order to be in control of their care, older people have to feel a sense of self-determination and self-reliance which is far from straightforward. In Taiwan many older respondents see their lives in terms of Buddhism. The Buddhist philosophy states that your

present situation depends on what have you done in the past. The social meaning of lost strength for older people is that it is a punishment rather than the natural course of biological ageing. This philosophy has significant negative consequences for many (6 out of 9)Taiwanese service users' self-esteem and autonomy:

> Life is what you have done in the past, now you have to pay back. It's a suffering... (Ms Bai, Taiwan)

Most of the actors concerned with the care of older people in all three countries stated that the current older generation consists largely of passive recipients. In England and the Netherlands, most contributors to long-term care thought the accepting attitude among most older people was the result of low expectations:

> Older people often don't complain... even where we knew we messed people about by changing home care visit times and providers and so on... I think there is this generation of older people who are more satisfied. (Service director, social services department, England)

> They were mostly contented, satisfied people who just accepted what was being provided for them... (Senior official in Arcares, the Netherlands)

This less demanding attitude was related to feelings of dependence and guilt about relying on others (5/9 and 3/10 in England and the Netherlands respectively). Furthermore, many Dutch older participants emphasised that being cared for was a matter of 'getting used to it'.

Some English respondents, however, stressed that being cared for detracted from their privacy and normality:

> I never got used to them coming, they all come in here. Walk in and out. It's like Piccadilly Circus sometimes. I try to keep a low profile, but they won't let me, they're there all the time. (Ms Powell, England)

In both England and the Netherlands, older people had difficulties overcoming feelings of being dependent. However in Taiwan nearly half of the older interviewees (4/9) valued the option of being cared for as it could expand their mobility and independence.

> Someone can look after you, of course is good; otherwise I can't move or do things myself. (Ms Yen, Taiwan)

According to the respondents at the macro and meso levels in Taiwan, the passive attitudes of Taiwanese older people were related to a long history of disability discrimination and a social expectation of self-reliance. When older people were not cared for by their children, society expressed its disapproval of both. This had resulted in low expectations and demands by older people from those outside their families. Older people tried to present themselves and their families as non-problematic and independent in order to meet social expectations. They silenced their own care demands.

Certainly, not all the service users interviewed here were passive in their later life. Those who managed their lives with long-term care successfully (Dutch (3/10), English (2/9),Taiwanese (1/9)) did not necessarily have low care needs, but all of them tended to find a way to deal with their frailness and to enjoy what they had achieved in their life time.

Furthermore, most of the actors and stakeholders in all three countries confirmed there were indications that older people would become more active with better education and a strong emphasis on their rights. Nonetheless, there seemed to be different reasons for the improvement in autonomy amongst older people in the three countries. A senior civil servant in England explained that a demand culture had come in to force in England:

> I think they're increasingly active with every generation that passes. More demanding, less accepting, we're moving from a sort of deferential type culture to a much more Americanised demand culture, and I think that curve will go up, as each generation gets more and more demanding and has higher expectations, they won't put up with no choice of meals and they will demand the ability to say the sort of things you and I would expect in our everyday life. What's difficult is satisfying them; you haven't got the staff to be able to do that. (Senior official, Commission for Social Care Inspection, England)

Indeed, the balance between autonomy for older people and their care service entitlement will be a challenge for the future.

It had. been a policy objective in the Netherlands for individuals to be remain self-reliant and stay active, according to all the officials interviewed at the national level. Nevertheless, they also recognised that not every body was capable of being active and independent. People were different and attention should be given to making sure that vulnerable people, who were unable to take part actively in decisions about their health and social care, were helped to make their own decisions wherever possible. Dutch civil servants also claimed that the rights of informal carers should be taken into consideration more by the state, professionals and social policy.

Taiwan is beginning to show fewer signs of discrimination toward disability:

> There has some improvement but older people are still quite passive in general. A few years ago people tended to see disability as passivity rather than as a result of illness. Older people felt ashamed to come out of the house and the family felt uncomfortable about pushing a wheelchair. But now, we see some disabled older people walk on the street with walking aids. (Civil servant, Department of Health, Taiwan)

It was also noteworthy that in the case of Taiwan, where there had been a strong, social expectation of family solidarity and caring, individuals and their families were initially reluctant to accept state intervention. The recent decline in intergenerational household living had, however, increased the recognition of the need for older people to receive help from outside:

> There is a great improvement in comparison with ten years ago... the family had strongly believed in their responsibility for taking care of their older family members because of the filial piety ideology (see also Chapter 2.4.2). It was difficult for the government to be involved at that time. Nowadays values have changed. It is the right of older people to receive some care from the government. The ideology of 'right' has begun to develop. (Senior official, Association of Welfare of Older people, Taiwan)

8.3 Older people's awareness and choice preceding care

Many quality evaluation measurements (see Chapter 2.6.3) have focused on the period of care provision. However, it can be argued that the pre-care process is equally significant, as receiving the right kind of care can prevent inappropriate care provision and avoid dramatic care changes for older people. One of the concerns of nearly all those who provided care to older people in each of the three countries (98/114) was that older people tended not to think about their potential care needs. A lack of planning for later life restricted the quality of their care:

> Nobody wants to think about old age and disease and death and things like that, so, people are not inclined to design the last phase of their life. (Senior officials in Arcares, the Netherlands)

> We all get old and you don't realise what is going to happen, do you? I mean, it comes to everybody, doesn't it? Nobody's different. (Ms Bames, England)

It has been shown that better information, consultation, advice and effective expert assistance are fundamental to minimise the gap between legal rights and social reality (Townsend and Gordon, 2002). If these supports were available to be utilised in the early stages of intervention and the care placement process, people would be more likely to accept care and to receive care appropriate to their needs. The English and the Dutch assessment models had enabled all the older people interviewed in the two countries to access assessment mechanisms and care options. In England, many (5 out of 9) of those interviewed, had been referred by health professionals and some (3 out of 9) by their children. Similarly in the Netherlands, more than half of the older interviewees (6 out of 10) were referred by their GP and only a few of them by their neighbours, sons and daughters. In sharp contrast, nearly all of the Taiwanese responders (7 out of 9) had approached the consideration of long-term care through informal sources. Our findings suggest that both England and the Netherlands may provide more professional accessibility at the first point of contact in the consideration of long-term care options.

At this point, I was interested to know whether different first contact points had helped older people to gather information about their care options. This was considered to be important as choice based on a lack of information would be

disempowering (Barnes and Prior, 1995). A civil servant in Taiwan raised the importance of accessible information provision:

> The accessibility of information about resources is an important element in the attitudes of older people and their families. Those who are aware of what services are available can be more active in their choice of care. Those who are not aware of the resources are unable to help themselves. They feel powerless when they need help. (Civil servant, Department of Social Affairs, Taiwan)

Ms Bai in Taiwan found information about home care support from a leaflet delivered to her house. Ms Ruiter got to know about care services in the Netherlands from the radio. Promoting care service information through the media can be useful and accessible. Providing more information on long-term care services to the general public before and while they need care could promote less stress and help some people to manage changes in their lives more effectively. Nevertheless, the efficiency of posted leaflets had some limitations as one Dutch local policy officer commented:

> A lot of older people are not well informed... The information is there. Even if it's coming through the post and arriving at their house, they don't read it. (Local authority policy officer, the Netherlands)

My finding suggests that all three countries have limited resources and assessment procedures are partly there to ensure money is spent on those in need. In the Netherlands, there was a formal assessment process which was designed to ensure equal opportunities for accessing the services. By contrast, inconsistencies in the level of care support to individuals across local authorities resulting in a "postcode lottery of care for the elderly" is an concern in England (Kendall and Harker, 2002). Through this process, service users attained greater information about various options on offer. In Taiwan, this process was rudimentary and not very formalised; the result was that families had much greater power in deciding what might be available to meet the care of their older members.

As briefly mentioned in Chapter 6.2.2, evidence from the professionals interviewed revealed less face-to-face contact assessment as a result of the policy aim to improve efficiency. Some professionals in England and the Netherlands argued that face to face contact maximised the ability of frail older people to address their needs

and express their views. It also helped professionals to make an appropriate identification of need:

> ...many older people are hard of hearing, don't understand, and they often don't like to discuss things on the phone. It is often hard enough for them to make themselves clear and it usually works better in a face-to-face conversation... we are talking about a group of vulnerable people with limitations and I don't think it will work. (Assessor social worker of Ms Gramsma, the Netherlands)

When service users were asked whether the care they received was their first choice, all of the Dutch participants said 'yes', but nearly half of the respondents said no in England and Taiwan. In addition, 3 out of 9 English older people said they had no choice at all:

> What do you mean by choice? I didn't view any other homes if you understand what I'm saying. (Ms Williamson, England)

These views of the older people regarding choice were confirmed by their carers and professionals. Many Dutch professionals and carers indicated older people had the right to say how much they agreed or disagreed with the decisions and analyses made by the professionals. In contrast, older people in England and Taiwan only had the right to say "no".

Limitations on autonomy were found in the restricted nature of other actors' attitudes and abilities in England and Taiwan. In addition, England had particularly overstretched social services. In all of the interviews with English assessor participants, it was evident that resources were a great concern in England. Limited care resources restricted the choice and support to meet older people's needs and it was not always possible to promote "empowerment" in practice, although it was supposed to be at the top of the agenda:

> Afraid they don't have a lot because there aren't any to be had. We go out and try and commission something, you come back... to be told, well, we haven't got it. But we haven't got any power over what we can put in. (Assessor nurse of Ms Holmes, England)

Interviews with older people and their assessors across the countries found that consultation and discussion during the service arrangement process was a common practice in the Netherlands and Taiwan but not in England. Much of the consultation was carried out directly between the older people and professionals in the Netherlands, and the service users were generally well aware of what was happening:

> Oh yes, I certainly am! Well, I was assessed and got an indication from the RIO [assessment authority] and they asked if they could send my assessment to [service provider], if they could inform other people who come here, and I said yes... I always think that's the best approach. (Ms Flipsen, the Netherlands)

By contrast, many English assessors (8/11) stated they had more discussion with the families than with older persons, especially regarding financial arrangements. As a consequence, most of the English (5 out of 9) older respondents stated that they had only been informed of the formal decision and were hardly consulted about the care plan by the professionals. Uncertainty and feelings of powerlessness were clearly evidenced in five English older people who had only been informed about their care services:

> I don't know quite what's happening. Nothing's been said... how they decide that I don't know, but anyway, I'm leaving that to the powers that be. (Ms Becker, England)

Similarly, in Taiwan, there was more consultation indirectly between the families on behalf of the older people and the relevant care providers (4/9):

> Yes, my daughter did say she heard from her friends that this home is very good and asked me if I wanted to try... I stayed here one night before the admission. (Ms Pang, Taiwan)

Unlike English older people, most of the Taiwanese older people had appeared satisfied with this kind of process. This indicates that many Taiwanese older people expected their children to arrange care for them. This was probably the result of the Chinese cultural expectation that the family would have a responsibility for older relatives not dissimilar to those that they had for their children.

8.4 Service consultations in care

The support of information, consultation, advice and care assistance were equally important during care provision, because most of the service users had complicated social and health needs which might change. During the provision of care services, most Dutch (8/10) and many Taiwanese (5/9) service users were consulted and informed about the services they were receiving by their service providers and carers:

> Yes,...the carers and the nurse always ask how I am and always come to say hello before they change the shift. My sister who lives nearby will also come to visit and ask. (Ms Wang, Taiwan)

> Yes, the manager asked what I think of things here, and I said, 'I have no complaints'. (Ms der Horst, the Netherlands)

However, one of the main concerns shared by most actors across the three levels in Taiwan was that most of the older people did not raise their voice because of a lack of awareness of their rights and entitlement. This might result in a lowering of older people's care expectations and a lack of motivation in making demands:

> Most of the residents are passive and do not know their rights well... (Nursing home manager of Ms Yen, Taiwan)

Only a few of the English (3 out of 9) stated they had been asked about the quality of the care they received. Although some consultation took place, some English service users found they had been excluded from the conversation and their views had been ignored:

> (Participant:) No, no one asked me what I think about the care. (Researcher:) I thought there was a review?
> (Participant:) Well, if there's a review, I wasn't there... Well, I suppose I was, really, but, I let them get on with it. Normally, they have this meeting My son's there, and his wife, they're all there. So I just let them get on with it.

> (Researcher:) Right. But, don't you prefer to speak for yourself then?
> (Participant:) I do speak for myself. It doesn't go down very well sometimes.
> (Researcher:) Why not?
> (Participant:) Cos they think I'm being funny. (Ms Powell, England)

Boyle (2003) argued that the concept of user involvement in English policy fell short of respecting the right of older people to be, as far as possible, self-determining and autonomous individuals. A lack of recognition could have adverse psychological effects on older people who already lacked motivation and showed a reluctance to register their views and requirements.

The experiences of older people were further confirmed by their formal carers. Many formal carers in the Netherlands but fewer in England (2/5) and Taiwan (4/9) had regular communication with clients. There was a low level of consultation between older persons and formal carers in both England and Taiwan. The big difference was that Taiwanese older people were happier for their children to make arrangements than English people were (see also Section 8.3 in this chapter). Many English formal carers responded by saying that they provided care in accordance with official documents and/or their own observations. This raised a further concern of the English care system where older people were not apparently able to rely on their formal carer who was in daily contact to empower them. In the next section, I am going to explore the power and autonomy of formal cares in their relationships with older people.

8.4.1 Power and autonomy of formal carers

Most of the older people interviewed (6/9, 8/10 and 5/9 in England, the Netherlands and Taiwan respectively) stated they would first talk to their formal carers when they had any concerns or further care needs. This implied that, apart from the families, formal carers were the closest care contributors to older people. It can therefore be assumed that formal carers would be significant persons in exercising older people's power and autonomy. Nearly all formal carers in England (4/5) and the Netherlands (9/9) and many (6/9) in Taiwan considered service users' point of view as more important than their own judgement, but thought that they, the formal carers, had a

better knowledge of the needs of service users than the assessors and professionals. They explained:

> ... they [assessors and professionals] sit in an office and they write this paper, care plan for them [service users], and I think a formal carer has more idea of what goes on, than the lady that sits in the office with her little bit of paper. (Residential home carer of Ms Powell, England)

> My contact with the older people is very intensive mostly. We talk and I see the older people. I see the reaction. So I know the older people very well. (PGB home care nurse of Ms Duijys, the Netherlands)

> I have contact with Ms Fu on the daily basis, so I know her better than other assessors and professionals. (Home carer of Ms Fu, Taiwan)

We now know that because of the regular interaction between older people and their formal carers, formal carers are more likely to be the first contact person for older people when they have further requirements and formal carers are more likely to have a better understanding of service users' daily needs. However, more Dutch (8/9) and Taiwanese (7/9) formal carers than English (1/5) participated in care planning to meet service users' changing needs. The power differences of formal carers between the countries may be due to the hierarchical structure at the micro level. Unlike England, where formal carers have been seen as the bottom of the care system and can only express their views, the Dutch have more multi-disciplinary consultation available in the care home and more consultation between carers and managers in home care services. Similarly in Taiwan, carers were frequent participants in discussions with their managers and professionals. Nevertheless, a few Dutch and Taiwanese formal carers thought that there should be more trust from other professionals in making use of their hands-on knowledge.

8.5 Empowerment and redress mechanisms

The previous section has raised a number of contrasting issues that relate to service delivery in the three countries. Greater reliance on family, for instance, relates to Confucian ideology in Taiwan, the greater integration of older people into wider

society is related to the stronger welfare state in the Netherlands, and the lack of choice and lack of consultation related to the confusion of who is responsible for older people in England. This section takes this discussion forward by exploring the effectiveness of quality control mechanisms at different levels on one hand and the opportunities whereby dependent older people can address their views on care and participate in the care system socially and politically on the other.

8.5.1 Quality control at the macro level: Redress mechanisms and the political power of older people

On the macro level, older people could address their voice indirectly through voting in elections and being a member of a pressure group or lobby. However, as Table 8.1 shows, most of the older people needing care in the three countries were basically inactive in exercising their collective autonomy at the macro level, even though Dutch older people were slightly more active than the others. None of the English service users had ever joined a pensioner or consumer action group, and this might relate to culture and history as mentioned earlier. They said that trying to manage their own lives was hard enough and had no intention of exercising their political power at the macro level. On the other hand, many of the older participants in all three countries did use their power to vote. It was found that older respondents were rather focused on political parties as a whole, or social issues, in general rather than the interests of pensioners.

Table 8.1

Macro political power of the older people from older people's perspective

	Be a member of pensioner or consumer group			Voting		
	Yes	No	Total	Yes	No	Total
England	0	9	9	5	4	9
The Netherlands	3	7	10	6	4	10
Taiwan	2	7	9	6	3	9
Total	5	23	28	17	11	28

Interviews at the central level indicated that Dutch older people had the most channels for exercising their political power in order to influence the state on ageing issues. In the Netherlands, the senior official from NIZW and CSO stated that lobbying and pressure groups had played a significant role in supporting the participation of older people in policy making. In England, the senior official from CSCI said that the political power of English older people was limited at the moment because their lobby was not influential. In Taiwan, many civil servants said there was no existing policy for older people and many of the issues were dealt with under the Disability Act 1980.

In addition, many actors and stakeholders across the countries said that people who received long-term care were more concerned about the actual care they received rather than the "care system" as a whole:

> They said why didn't we have tomato soup today or why have you messed up my bedroom... All sorts of things. It's usually on that level. (Residential home manager of Ms Sempik, England)

> ... when they were not satisfied, it was about the coffee not tasting good or something like that on a very small scale. (Senior official in Arcares, the Netherlands)

> Older people are more interested and involved in their [own] care rather than in the general policy of our agency or government. (Home care manager of Ms Fu and Ms Bai, Taiwan)

Moreover, the civil servant from Social Affairs in Taiwan questioned the importance of autonomy of older people contributing to the quality of their care:

> Why are you asking about the political power of older people? You cannot treat their demand for care as one of political autonomy. The two do not equate. (Civil servant, the Department of Social Affairs, Taiwan)

This attitude illustrates my point. I would argue that micro concerns are significant, and that participation at the macro level can contribute to micro policy planning and evaluation. It was worrying that policy makers could overlook micro level needs and

distance themselves from the ultimate aim of policy implementation - meeting the care and quality of life needs of individuals.

In all three countries, the voice of older people was mainly represented indirectly - by advocacy or lobby groups. The difficulties of involving service users who were more frail was an issue everywhere:

> ...you've always got that big worry that you're talking to the more active older person, because by nature it's much more difficult to [respond to] people who are house-bound. They're not going to get to meetings and this sort of thing, but, I think it is improving,... I certainly think they should be more involved... new technology, tele-conferencing, will help considerably. (Senior official in Age Concern, England)

> It is difficult to gather their views [frail older people] either at their own home or ask them to come to meetings. I have no solution so far, because it is difficult. (Senior officials, Association of Welfare of Older People, Taiwan)

This evidence shows that while the broad issue of ageing has been brought to the political agenda, there is still insufficient user knowledge about policy development for the long-term care of older people. Doyal and Gough (1991) argued that any rational and effective attempt to resolve disputes over needs must take into account both the codified knowledge of experts and the experential knowledge of those who receive care services. However, this study has found that the fundamental difficulties in gathering the views of service users are partly due to not every elderly person needing care wanting to participate in influencing care systems. Also a lack of available support also restricted vulnerable older people from participating openly and directly in making their views heard.

This thesis, so far, has demonstrated that resource limitations are an inescapable feature of English service provision and prevent the implementation of quality services. The point will be further addressed in Chapter nine. Nonetheless, it is evident that at national level there are significant attempts to monitor the quality of care in England (see Chapter three). England has a system of national semi-independent inspection to evaluate the quality of formal provision by care providers and the delivery of care by local authorities. Part of the inspection process is to consult with the service users' views regarding the care they have received. This is

where some of the service users could have the opportunities to contribute their experiential knowledge. A senior official explained how the inspection system worked:

> We [CSCI] regulate care services to make sure that they [service providers] comply with standards that government sets to assess the performance of local authorities in purchasing and delivering care... We inspect care services whoever provides them,... we will make recommendations to whoever's running that service as to what to do to improve, and that's regardless of who runs it... if it's really bad, we can close it down in the last resort. In terms of inspecting local authorities, that's about commissioning services, setting a strategic framework and so on. We will comment on that, and we have league tables where we give them a rating... and that's a fairly strong incentive to improve. (Senior official, Commission for Social Care Inspection, England)

Subsequent to the carrying out of these interviews, England has established a comprehensive set of quality control quangos (quasi non-government organisations) to monitor a broad range of formal care services across sectors. The first full year of statutory inspections of home care services was launched in 2006 (CSCI, 2006a). The results were based on the performance of 150 local authorities. Although these have been very influential, they have also been controversial with questions raised about the perverse incentives involved (Carter et al, 1992; Smith, 1995; Ward and Skuse, 2001). Great improvements were evident in the movement between *adequate* and *good* marks - which were 82 and 50 respectively in 2002 compared with 33 and 73 respectively in 2006. Councils with inadequate standards in 2002 have now improved, leaving no councils performing at the lowest level (SSI, 2002; CSCI, 2006b). Secondly, more than 22,500 inspection and regulatory visits were made between 2002 and 2005 and nearly 5,000 care homes were forced to make some improvements in their care provision in 2004 (CSCI, 2005):

> Whenever our inspectors go into a service, they always talk to the users of those services and ask what they like and what they don't like, and so on, and that builds up a sort of body of knowledge about where things are not going right, or where people feel they're not given enough choice or whatever it is, and you can use that to inform policy making. (Senior official, Commission for Social Care Inspection, England)

The above quote shows that part of inspection procedure was trying to involve the older people by interviewing them. However, older people had no control over the outcome of the inspection and there was no evidence that older people acted as inspectors to carry out the inspection of the care services.

The Netherlands also has a national organisation dedicated to quality control of care services:

> They work for the government, but they are [designated] as independent boards, independent organisations, so we have one for the buildings, one for the tariffs and the money, and we have the health inspectorate for quality. (Senior officials in Arcares, the Netherlands)

In the Netherlands, as various organisations have been involved with quality control at the national level, a shortfall in overall evaluation has occurred:

> They [central government] tried to hand over responsibility to the local partners, parties, like the suppliers and the housing associations ... so, in fact, there is more and more a lack of information at national level about how far we are on the road to accomplish the tasks and the targets. What is in fact happening and what are the shortcomings? (Senior officials in Arcares, the Netherlands)

In contrast, quality monitoring in Taiwan has been left to local authorities with some monitoring by central government. Civil servants from the Social Affairs and Health Departments claimed they were only aware of the services that performed best in local areas. Most inspectors were contract researchers employed by central government for three years. Based upon their information, the best care performers were evaluated for additional funding.

Overall, England would seem to have most comprehensive quality control mechanism, with the Netherlands second and Taiwan a distant third. It is important to have an inspection framework in maintaining standards, particularly when there is a mixed-economy of welfare where all sort of different agencies are providing care. The comprehensive quality control mechanism in England cannot, however, compensate for the chronic lack of resources that impede the development of high quality care also shown in this study.

8.5.2 Quality monitoring at the meso level: Redress mechanisms and the power of older people

At the meso level, according to the local administrators and service providers interviewed, quality monitoring mechanisms could be found in the local authority's contracting powers in England and a service providers' bench mark service evaluation in the Netherlands (equivalent to English preferment assessment mechanism). Regulations were not so comprehensive in Taiwan as evidenced.

De-centralisation in both England and Taiwan meant that local authorities now formed an autonomous level of quality control in the care system. The English local authority held the power of funding in its control of performance in the care market. A service contract officer from an English local authority explained:

> We monitor the homes and contract compliance… if there was a serious breach of contract, … I've give him a period of time to do that, and if I go back and find he hasn't done that then we will have to suspend his contract which means basically we don't make any more placements at the home until he's resolved the problem… and that's the sort of biggest stick we can wave at them really. (Local authority care home contractor, England)

Unlike in England, the Taiwanese local authority had no great funding power in the care sector but played a monitoring and regulatory role. It had been found that the available sanctions were rather too radical to implement:

> It is very difficult to change their firmly established caring culture and behaviours. We can only encourage them to improve their services. The current regulation is so strict that the next action we can take is to close the home. However, this may cause more problems, as older people have to move somewhere else. (Local authority residential care services developer, Taiwan)

Moreover, one of the local administrators pointed out that inadequate central policy had restricted the local authority's power to improve current quality in the care market:

The central government's regulation and policy development has not been able to catch up with the families' demand and the market development. This has meant that service providers have developed care services to meet the needs of families and older people before central guidelines have been established. The care market lacks statutory monitoring and quality varies. Choosing appropriate care is a big problem for families and older people. (Local authority day care services developer, Taiwan)

Older people in Taiwan may have suffered from the way in which regulations lag behind market developments.

In contrast, Dutch local authorities had little involvement in the monitoring of care quality, because of the centralised care system. Monitoring responsibilities were shared between central government and the service providers. However, as mentioned in previous chapters, some caring responsibilities will be transferred to local authorities in the future. Two of the four Dutch local administrators interviewed showed concern about the lack of information about care provision in the local area:

> Providers have more information on what the people need than we do, because they have the field workers and they have their registration system... they give the information to local government and I think that it's important for local government to pay attention and not to be dependent only on the information provided by the providers. (Local authority policy officer, the Netherlands)

At the municipal level, the interviews with local administrators suggested that the Netherlands was the only country where old people had some opportunity of participating in local policy planning through local pressure groups as consumers, families or senior citizens:

> We [older people's association] meet leaders of the local political groups. We also are invited to their meetings when they have a topic concerning older people... the contacts are very good, backwards and forwards. When you need them [local government], they will never say no. (Representative of local older people's association, the Netherlands)

Nearly all of the local administrators in England and Taiwan (3 out of 4 in England and all in Taiwan) said the political power of older people was very limited and rather

indirect. Only at election time did they have voting power to influence local politics. It was very rare for older people to be involved in local planning in relation to care matters. However, grey power in Taiwan had had some influence in local care development. Day care services attracted the election support of healthier older people's groups for local political parties. Similarly, it was healthier and younger older people who were more likely to participate in Dutch local policy planning and national service development.

In terms of channels for older people to raise their voice at the local level, two of the four Dutch local administrators interviewed valued the influence of pressure groups and client councils. English older people in care did not get involved in pressure groups. However, nearly all of the English local administrators claimed that older people could make their complaints to the providers, local government and the PCT under the *Complaints Procedure*. Most Taiwanese local administrators (4 out of 6) said that older people and their families normally addressed their concerns to the service provider directly and few contacted the local authority. One striking finding of this study in both England and Taiwan was that some older people in care used their local politicians to support their rights and needs:

> Loads of them would approach their MP or the usual is they'll threaten you with going to the newspapers, you know. That's their only option really, isn't it? (Long-term care co-ordinator, Primarily Care Trust, England)

> They have voting power and some of them ask for the support of the local MP when they are not happy about the services. There is also an association for older people locally but no family association. (Local authority residential care developer, Taiwan)

This suggests that the Dutch meso redress mechanism is more active and better established than that of the other two countries. England and Taiwan need to improve communication channels between older people and care systems to raise the quality of care and care entitlement.

8.5.3 Quality control at the micro level: the opportunities and support of power and autonomy of older people

Apart from macro-performance assessment, a channel for older people able to express their views is quality control. Additionally, one of the features of autonomy is be able to participate in decision making. Both England and the Netherlands have official channels for clients to express their views regarding their care, but not Taiwan. However, the interviews with the service users showed that most Taiwanese and Dutch respondents felt able to make complaints and to make their voice heard. In contrast, in England, there was power but very little autonomy. They had power to complain, but they were not be involved with participating in decisions about running the care services they received or the management of the care system (see Table 8.2).

Table 8.2

Making one's voice heard: service users

	Being listened to				Able to complain			
	Yes	No	No response	Total	Yes	No	Others	Total
England	5	3	1	9	2	6	1	9
The Netherlands	7	2	1	10	8	0	2	10
Taiwan	7	1	1	9	6	0	3	9
Total	19	6	3	28	16	6	6	28

As Doyal and Gough (1991) argued autonomy of agency requires a range of opportunities to undertake socially significant activities, the Dutch seemed to have a more consistent system. All the Dutch service users said they had a pressure group (either The Consumers Federation for people who lived in their own home or Client Councils for people living in a residential or nursing home) to promote their care interests and needs (as Photo 8.1 showed). A service-user pressure group was established in each institution/organisation where clients were able to raise various issues regarding their care with support from their families and independent legal professionals.

Photo 8.1 Ms der Horst was having a Client Council meeting in the cafeteria in her nursing home.

Ms der Horst was the member of the client council at the nursing home, and she explained how the council worked:

> We [service users] volunteer or are elected as a member of the client board. There is a meeting once a month of just ourselves [members], before that we have to ask around for the views of other residents. Everything in the meeting has to be recorded. We have independent solicitors and administrative support. We meet our provider manager once every four months to address any issues of care. We also meet other client council members once or twice a year to share information and experiences. (Ms der Horst, the Netherland)

This demonstrated Sluijs and Wagner's finding (2003) that the Dutch care organisations had an obligation to set up client councils, and that these had improved the involvement of service users in quality management. They were involved in the policy-making of the organisation through a non-hierarchical structure. Indeed, interviews with Dutch service providers found nearly all of them took views from the client council seriously:

> ... they can have their say in that and it is certainly taken into account and not just swept [under the carpet]... (Nursing home manager of Ms Reinaerdts, the Netherlands)

In England, in the White Paper, *Our health, Our Care, Our Say*, the Government committed itself to develop a comprehensive, single system across health and social

care for older people in care to express their views through a complaints procedure (DH, 2006b, p 160). However, in comparison with the Netherlands, the English complaints procedure was hierarchically structured and made a strong demand on older people's self-determination and independence. Individuals had to complain directly to the relevant care manager or authority. There were no councils and no regular meetings. Most of the English service providers, professionals and formal carers found that few service users used the complaints procedure. For those who did use it, most of them were heavily involved with private sources such as family to advocate their rights:

> We have a complaints procedure... what quite often happens is, the client will say something to the carer... The carer will then pass that on to us for us to look into... if it's a serious complaint it's done in writing... more often than not it comes from the family rather than the actual service user. (Home care manager of Ms Munro, England)

Taiwanese older people are also left to their own devices when making complaints about their care:

> Most of the older people communicate with us through their family whom they feel close to. (Foreign carers agency manager of Ms Chung, Taiwan)

This suggests that there are differences in terms of empowerment. The English complaints procedure (formal procedure) is not quite the same as pressure groups in the Netherlands (beneficial autonomy). The Netherlands, where elderly people are included in running the management of the institutions, is obviously very empowering and that will benefit their sense of independency and autonomy. The sort of arrangement available in England, where there is a procedure, through which complaints can be made, does not necessarily empower people; whereas in Taiwan, older people tend to give their power and responsibility to their families. The Dutch groups, supports and channels have empowered older people not only to express their own views but also to participate in improving care services. England and Taiwan, on the other hand, rely on families to make the needs of individuals known.

8.5.3.1 Power and autonomy of family carers

As mentioned earlier, English and especially Taiwanese older people are heavily reliant on their families to speak for their rights. Furthermore, most professionals expect older people to talk to their carers and families regarding their care needs. This suggests families are expected to contribute their own opinions and be involved in older people's care. Hence, this has raised the question of what is the power relationship between informal carers, the person they care for and professionals? How much power and autonomy do family carers have?

When family carers were asked whether they thought they knew better the needs of the older people than the persons themselves, there was no clear response either from the carers or the older people. Most of the family carers in the three countries, however, stated that what was important were the consultations and support they provided to their elderly family members:

> Yes I do [know more about what's the best for my mum than she does]... because I think I look at it from an age point of view and mum doesn't deal with age. You know, she is still 18 up here and cannot cope... I think she should be calming down and I think this is why she had a stroke but she cannot calm down. She's got to be on this high all the time. She really needs to be subdued a bit otherwise she is going to have another stroke... but mum still wants to be in control. So, although I know best, I still have to do what she tells me to do. (Daughter of Ms Bames, England)

Conversely, when the understanding of needs of individual client between informal carers and professionals were compared, nearly all of the informal carers (8/10) across the three countries acknowledged that while the professionals were the experts and focused on the functions and capacities of a person, informal carers were knowledgeable and cared about the individual elderly family member's personal preference and expectations. Only half of the English informal carers thought they had been fully involved in decision making about the care of their elderly family members. Family members were regularly involved and consulted in the Netherlands and Taiwan. Moreover, the Taiwanese culture of family care and financial responsibility had reinforced the expectation that the family would take over some power and responsibility for older people; whereas in England, most

participants stated that informal carers were consulted only when there was a problem. This was especially true when an individual was also receiving formal care. Senior officials at the national level in all three countries explained that family carers were taken for granted and their rights were of minor importance. None of the informal carers interviewed expected to increase their power and autonomy - both Taiwanese and the Dutch informal carers were satisfied with their current autonomy, whereas nearly all of the English (5/6) felt the shortage of formal carers and their own limited capacity had restricted their chances of gaining greater power and autonomy and would continue to do so.

8.6 Conclusion

All three countries are aiming for better quality of care and more power and autonomy of older people. This chapter explored the evidence of the difficulties facing dependent older people in retaining some control over their lives within a complex care system in all three countries. It sought to find out if the care systems empowered older people, how they did this and why more opportunities came from some systems than others.

Older people in care in all three countries were generally socially and politically passive. The passive attitude was related to personal and cultural history. Nevertheless, the interviews from all three countries confirmed that more active attitudes were on the increase. Contrary to expectations, there is a growing demand culture in the English liberal-conservative welfare system, an increasing awareness of individual responsibility in the social democratic-conservative Dutch system and less disability discrimination and more acceptance of state intervention in Taiwanese liberal-conservative welfare system. However, there are different types of empowerment in the countries studied:

- In the Netherlands genuine empowerment exists matched by autonomy.

- Empowerment but limited autonomy in England, in the sense that people have a formal complaints structure along an inspectorate.

- In Taiwan, more informal facilities for service users and families to raise their voice.

These differences are partly due to variations in national ideologies of care. More generosity and support were found in the Netherlands, based on their belief in normalisation and citizenship. Taiwan retains strong family support and care market competition. By contrast, recognition of the need for support of older people is rather modest in England due to selective and minimal support available. These welfare ideologies are reflected in national practices of quality control. In both England and the Netherlands, older people had much greater access to a wider range of professional advice and information at the first point of contact. However, more consultation is carried out in the Dutch strong state support and Taiwanese family oriented care systems than in England where neither the state or family have dominant responsibility of care. Nonetheless, older people in all three countries may have fewer direct opportunities to express their views when there is a continuing trend for less face-to-face contact between service users and assessors. Dutch older people have more choice regarding their care, followed by the Taiwanese and the English.

During care, older people found it was more practical to talk to their carers when they had further daily care needs. English formal carers, however, found they had less power to participate to empower their clients through inclusive care planning than the other two countries. England has a statutory quality control mechanism at both central and local levels, however, a shortage of resources is a serious problem in England, and this has a significant impact on care quality, the autonomy of the individual as well as the idea of empowerment. This is exacerbated by a focus on complaints rather than service development. The Dutch fragmented quality monitoring system has made it difficult to gain an overall perspective of care performance. However, the Dutch have more accessible mechanisms and channels for older people to exercise their views, especially at the meso and micro levels. In contrast, in England, and especially Taiwan, older people rely primarily on their families to protect their rights and well being. One extremely important finding to emerge in each of the three countries is that the gap in responsibility between the state, individual and family is closing, as older people's rights become more clearly understood. Moreover, the universal failure to recognise the role of the family as mediator between the formal services and older people may well have had adverse

consequences for older people's autonomy and the strength of their support networks.

From the above findings, it may be concluded that there was greater evidence from the interviews that high quality of care of older people was actively promoted in the Netherlands. There was less evidence in Taiwan and very little, indeed, in England. Nevertheless, with the recent arrangements for more extensive quality control, England may well be closing the gap.

8.7 Key points for policy and practice

The findings and conclusions discussed in this chapter raise further opportunities for cross-national learning. Given the small samples of interviewees, the key findings are indicative and should be treated with caution. The following areas - which might be further researched by a more quantitative approach - are based on the views of a wide range of actors in each country:

- All three countries are heading towards a less face-to-face decision making process, which may reduce the inclusion of service users' perspectives in care assessment.

- A lack of overall awareness of the national pattern of care performance may cause some difficulties in policy recommendations in the Netherlands and Taiwan. The example of a central control mechanism has proved beneficial in England and may be worth adopting in the Netherlands and Taiwan.

- The gap in care priorities between micro- and macro- level in England, Taiwan and, to a lesser extent, the Netherlands, may cause inappropriate policy decisions. Involving the service users and their support networks in the policy making process may be beneficial in ensuring that the care systems adequately set out to meet the needs of older people in long-term care.

- The complaint procedures and inspection in England are valuable. However, they give people power without autonomy; they give people an opportunity to say what does not work properly but they do not provide an opportunity to

participate in the better running of the organisation. They do not give service users a sense that their opinions are important. It was noticeable that service users did not like to make formal complaints, because they were worried about worsening the relationship with their carers and providers. The Dutch constantly consider quality of care issues, but in England, they are only discussed when something goes wrong.

- The less hierarchal Dutch model with its channels of communication and consultation may prove beneficial for England's power-imbalanced complaints system. However, policy makers in England should also consider supporting relevant advocacy and advisory services to assist older people to exercise their autonomy.

- Improving care resources may increase the autonomy of older people in the English system. However, there is a widespread lack of awareness concerning the rights and needs of older people. Practitioners and carers are likely to need additional training to clarify the issues and help them understand the rationale behind various approaches.

- It can be argued that professionals, formal carers and families need adequate autonomy themselves in order to empower older people to exercise their power and autonomy. Better resources, less bureaucracy and increasing acknowledgement and trust for those actors are other ways of empowering older people who need support to maintain their autonomy.

CHAPTER NINE

Resources, Resources, Resources

9.1 Introduction

Chapter six, seven and eight have demonstrated the strength and weakness of care provision in promoting successful ageing in long-term care using the concepts of care needs, social inclusion as well as power and autonomy. In particular, attention has been drawn to the issue of 'resources' to achieve successful ageing in long-term care. How do the three care systems afford support for an increasing ageing population? What are the outcomes of the different welfare-mixes in long-term care? How are demand and supply balanced? Are there particular issues to be confronted in extending the capacity for care in an economical way? How can service providers and policy makers utilize current care forces to gain more understanding of the outcomes of their services and identify where improvements can be made to staffing?

This chapter seeks to explore these questions. It focuses on examining the way each country has contributed to the long-term care of older people. It demonstrates the strengths and weaknesses of existing resources. Most importantly, it also considers the capacity and *quality* of the care forces which are likely to have an effect on the *quality* of older people's care, an issue raised in the previous three chapters.

9.2 Welfare-mix: Affordability and responsibility

In the countries studied, the area of long-term care provision and financing is undergoing substantial changes. The framework of care funding between the public and private sectors as well as between departments within the statutory sector has become of greater importance. This study attempts to seek further evidence on whether the rising cost of long-term care has put pressure on the development of the services. It was hoped that the experience and knowledge of the interviewees could be used to fill the gaps in official statistics. However, all of the respondents from central and local government in this research gave rather ambiguous responses to

the question 'what resources are currently devoted to the long-term care of older people?' There was no precise view on how financial resources were currently assigned to the long-term care of older people across the countries. Concerns were raised about, firstly, the difficulties in drawing a line between primary and secondary health care in long-term care; secondly, the complexity of the long-term care system often involved various departments and agencies (see also Chapter five and ten); and thirdly, a rather decentralised decision-making and data-gathering process was in existence in all three countries. Moreover, it was even more problematic to estimate the cost of a 'mixed economy of welfare'. All this made comparison very difficult.

Nonetheless, a number of interviews with various actors - civil servants at the national level, senior officials from NGOs, service providers and local administrators - suggested that the incoming financial resources were as shown in Table 9.1 below.

Table 9.1

Mixed economy of welfare - funding and responsibility for care

	Funding bodies	Family/state/sectors responsibility to care
England	Macro: Majority of funding by central government through the Department of Health and local authorities. Meso: Local authority council tax. Micro: Co-payment for domiciliary care and residential/nursing care in particular, plus increasing requirement for private solutions	Neither clear state responsibility nor legal obligation for family
The Netherlands	Macro: Most public finance via AWBZ based on taxes as well as social insurance contribution. Meso: limited amount of local taxes plus project funding from provincial government Micro: co-payment for residential/nursing care as well as domiciliary care.	A transition from state responsibility to local solidarity
Taiwan	Macro: Majority of funding from central government through the Department of Social Affairs, plus some from Department of Health. Meso: local funding from political parties and charities Micro: private full funding for residential/nursing care, minor co-payment for domiciliary care.	Clear user-fees with family responsibility and obligation

These confirmed that most of older people and families in Taiwan, many in England and some in the Netherlands were responsible for the costs of their care. In the Netherlands, both senior officials from NGOs agreed that the current strong system of state support had provided well for older people, however, whether the state could

afford to maintain current standards of quality was questionable. The affordability of the system had now become an issue in a time of economic decline on one hand and increasing ageing population on the other. For some, state retrenchment in long-term care had become desirable. Senior officials from the Dutch *Care Office* explained the coming changes to the three-pillar funding system which shared the cost of care at different levels:

> First, we have the AWBZ system for people who have a lot of problems and cannot possibly pay by themselves. Second, we have an insurance system for people to neutralise the individual risk. And the third system is for the community itself. In this, local government has to arrange to help people meet less intensive needs of feeling they are comfortable and they have social contacts. So you have got three parts of care needs support: heavy, medium and light side of care. (Senior official, Amicom care office, the Netherlands)

This indicated that to some extent the Netherlands was moving towards the English system of local authority management. The process of state-welfare retrenchment, however, remained attached to the ideal of "solidarity" as the main driving force in reshaping the balance of responsibility between the statutory sector and the individual:

> ... solidarity now and in the future is a difficult issue in Dutch society. On one hand we want older people to have a decent income, on the other hand there is debate about the social security system in the Netherlands and the costs of it.... We have to make choices; we can't do it all any more in the future. Maybe we have to be clearer about what is the job of the government, what is the job of the people themselves. So that will be a very important social discussion for the future. (Civil servant, Ministry of Health, Welfare and Sport, the Netherlands)

From the interviews with various actors in England, it gradually became evident that long-term care was inadequately funded by the English state. This reinforced the debate about the inadequate funding of social care (mentioned in Chapter 7.3.1). In the English welfare system, although there were issues about funding the NHS, it was still largely conceived as a free service from the cradle to the grave to which everyone was eligible. Social care for the elderly, however, was regarded as a Cinderella service and there had always been an issue about how it should be

funded and about who should contribute to it. This is exactly the problem – if the NHS can be persuaded a person comes within their remit, they get free care. However, if the NHS can persuade the local authority the person does not have sufficient health needs then they will fall into a partially funded social care system. It is arguable that under investment in social care is partly the result of a lack of clarity about the different funding responsibilities of the NHS and local authorities:

> We split the cost of social and nursing care, so if we go and assess somebody and say this person needs nursing home-care, it automatically is going to cost social services more money, so we have to try and work together on that one and collaborate rather than dictate. (Long-term care co-ordinator, Primary Care Trust, England)

In terms of English social care funding, nearly all of the central and local administrators (6/7) agreed that there had been under-funding from central government and claimed that resources available for care had been disproportionately directed towards younger elements in the population:

> I think the very fact that we pay less overall for individual older people's services than we do for disabled people's services,... that's not because their needs are less complicated, it's because there are a lot of them, and people have to make their budgets cover that group. It's partly that. It's also partly traditionally (...) the expectation that you can cover older people's needs cheaply and not younger people's needs cheaply, because there is discrimination there. (Civil servant, Department of Health, England)

Whether inadequate public funding for older people had been influenced by political bias towards the young or as a result of bureaucratic distribution, the funding shortage had become more pronounced, according to the interviews. The consequences were a diminution of rights, a lack of choice and inadequate support for older people:

> [The current long-term care system] is not ideal and I think one of the reasons is there isn't enough service sometimes, so that people are rushed. Certainly there isn't enough home care, so it's spread too thinly, so people get a minimum amount of service rather than an optimum amount of service, and it can be pressurised and not very satisfying for the care staff – for the providers.

> I think in residential care, there again, the Government talks about choice but there isn't any choice, it's where there's a vacancy and not many people plan in advance, to go into care, and pick their home. (Assessor social worker of Ms Munro, England).

Furthermore, like the Netherlands, England had experienced state-welfare retrenchment. However, in England, the balance of care in cash between the state, individual and family in England was ambiguous:

> ...I think it's just got to be what does the state want to provide? Where is the dividing line going to be? What the person themselves should fund and what [the state should fund]... we haven't thought that out. What the Royal Commission came up with, the government rejected, it's still all there in abeyance. (Senior official in Age Concern, England)

In Taiwan, as mentioned in Chapter three and Chapter seven, a strong user-fee system existed and was based on the state's assumption that the family would provide support to their older people. In some cases, families were struggling to afford the cost of elderly care and this was overlooked by the state.

> It has to reconsider the family's financial ability. The Social Assistance Act has take all three generation's financial capability into account when assess the older people's financial situation but overlook the fact that there are more and more older people are not living with their family and not receive financial support from all of their family members. The Act has excluded some older people who are in the financial difficulties. (Senior official, Association of Welfare of Older People, Taiwan)

Regarding care in kind, all of the participants at the national level in Taiwan and England placed the expectation on the family with selective support from Taiwanese and English states. A contrary view was held by many of the English interviewees at meso- and micro-levels (service users (6/9), assessors (8/11) and formal carers (3/5):

> Since 1948, the National Assistance Act that we have in this country said that we've got this more or less kind of cradle to grave provision. I think we've outgrown that a little bit but we still stick to the ideal of it. So when it comes to rights and responsibilities, everybody wants their rights maintained, especially

> those that are maybe getting to my age that have paid into the system all their lives, but I think we're slowly moving away from that and government is trying to educate people to make more provision for themselves, so we're kind of on the cusp if you like of change... I think conflict of that tension will always be there. (Assessor social worker of Ms Ward, England)

Such tensions and contradictions in respect of the English care system were considered to be an important factor in public dissatisfaction with care. Different expectations had caused dissatisfaction amongst service users, job disaffection for those employed in the care sector and difficulties of policy implementation.

In contrast, in the case of Taiwan, the civil servants pointed out the difficulties in implementing the policy of offering five hours free home care to older people. While the government was trying to provide the care services that would be received in other countries (such as England and the Netherlands), the policy had again reflected the different expectations of the state and family. In Taiwan, families felt they had been undermined as relatives by the state. Indeed interviews with Taiwanese older people and family carers confirmed that the family preferred rather less state intervention or cash subsidies for care so that individual privacy and autonomy could be maintained.

> I don't know what the government can do for us. Will government help us to find a cheaper Taiwanese carers?... Even there is a home help project from the government, they still required the contribution from us. So we think its not so important to seeking the support from the government.... we can do that by ourselves. If we need the carer we would employ the foreign carers and that is also part of the option that government provide. (Granddaughter-in-law of Ms Chung, Taiwan)

In the Netherlands, the Dutch participants at the national level thought both the families and service providers were responsible for care in kind. Two Dutch senior officials from NGOs believed older people only requested state support when their families were no longer able to cope. This attitude was verified by most of the older people and the family carer interviewed. The Dutch civil servant, one Dutch senior official from an NGO and nearly all of the service providers (6/7) suggested that service providers had the money and the obligation to deliver care. Nevertheless, a process of shifting the responsibility in kind from state to individuals and their families

was revealed in a number of Dutch interviews. Informal network assessment had been enforced to tighten eligibility for public support:

> The service providers do the work which can't be done by volunteers or family or the people themselves. You have to, you have to care for yourself, that's the principle. (Assessor social worker of Ms Flipsen, the Netherlands)

The above evidences from the three countries illustrates the public's perceptions and cultural expectations of what the family should provide and what the state should provide. These were reflected throughout in people's judgements about delivery and services.

9.3 Care services and market pluralism

Parallel with service capacity, other factors often influence care resources. Here, we are focusing on the characteristics of the care market and the kind of support that each service type provided in the countries studied. All three countries presented a mixed-economy care market. The balance between the sectors was, however, different. Overall, care was provided by a mixture of public and private profit organisations in England, mainly non -profit organisations in the Netherlands and mixture of non-profit and profit organisations in Taiwan. Interviews with those who had a good knowledge of overall local resources - local administrators and assessors - showed that nearly all of the Dutch (11/12) viewed their standards of care as good. How to maintain the good work had become the challenge. In Taiwan however, almost all the participants (15/17) suggested that the rapid increase in various services and choices was a positive aspect of the care system but there was concern about the quality of care in meeting the needs of older people. In England, nearly all of the English local administrators (3/4) said the care services had improved through increased local investment, but nearly all of the local assessors (9/11) emphasised the double challenge of quantity and quality in the English care market.

Some research on the general care market suggests that not-for-profit organisations are more likely to provide better quality of provision but that privatisation will stimulate market competition (Johnson 1987, Hutton 1995). However, in the case of long-term care for older people, in the Dutch sample - where most older people had been well

looked after by state-funded care from non-profit care providers - profitable organisations in both domestic care and care homes (examples of care hotels) had begun to grow with even better quality of care provision to meet the needs of those older people who were able to pay more:

> We feel that regular home care is given three times a day (...), but some people think that's not enough. We want more, and they can get more, but then they have to pay for it... sometimes people don't want the regular [non-profit] organisation because the main complaint is that care is delivered by so many different persons in the homes. They want their own nurse, and they can get it but that they have to pay for. (Home care manager of Ms Reinaerdts, the Netherlands)

This suggests that a for-profit organisation could provide more choice when service users were paying more money and when they were competing with a mainly not-for-profit care market. Furthermore, a disparity in income might have a major impact on the quality of care provided and might leave a residue of poor care provision to those could not afford to pay. The Dutch had less income disparity (see Chapter three) and this was reflected in the quality of their public provision because most people used it. Therefore, it was arguable that income differences in the future could become a very important driver in the quality of care from providers across the board.

As in the Netherlands, most Taiwanese care was provided by the not-for-profit sector. However, the for-profit sector was larger than the Dutch. All of the not-for-profit providers (home care or care homes) had substantial financial and human resources from hospitals or religious foundations as well as the state. Apart from home care services which were mostly free, other forms of care in Taiwan were supported by individual and family financial capacity but were not affordable for everyone. The resulting care inequality between the rich and poor was far greater than in the Dutch system. While all of the not-for-profit providers interviewed emphasised the quality of their care in attracting client groups who were able to pay more, most of the for-profit providers (such as some care homes and live-in care agencies) emphasised their lower charges in attracting those financially less well off:

> Many people are not able to afford the high and long-term cost of care. Often, older people have to move to a cheaper home or go back home because they

are no longer able to afford the cost in this care home. (Nursing home manager of Ms Li, Taiwan)

Overall, the foreign carer is the most economical option for people who need 24 hours care at home. It costs them about 20000 NT [333 GB] per month compared with 60000 NT [500 GB] for a Taiwanese carer. (Foreign carer agency manager of Ms Chung, Taiwan)

The three countries also shared similarities in their principle of supporting people to live in their own homes. At the same time, they had quite different approaches regarding the design of their care services - home care for instance. The Taiwanese provided wider support for their clients in terms of time spent on everyday activities such as shopping, cooking, cleaning and going out. The generosity of the services might have been because supply was greater than demand - therefore each client received more support. None of the *home care* services in England and Taiwan provided round-the-clock support, and this reduced the possibility of older people living in their own homes, especially at night. This was a particular limitation in England where many older people lived alone. Dutch home care had very recently introduced a "mobile service" in the night, which operated like the English car break-down service. One home carer explained how the service worked:

> We have a mobile team, which is operated by nurses. They arrive in the night drive the car around the whole town and villages... Some [clients] have to go to the toilet, some need help to go to bed in the late night or some have a fall in the night... when something needs help, [the clients] can call the team. (Home carer of Ms Boersbroek, the Netherlands)

England, however, had a wider spread of respite care in combination with home care service to support informal carers in providing continuous care. Respite care was supposed to provide regular short-term 24-hour care for older people in a residential home (mostly local authority homes[16]), to provide informal carers with a break from their caring role:

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[16] From my experience as a social worker in England, the use of local authority care homes for respite care is such that in the private sector it would prevent the owners from maximising the income they can get from permanent placements.

> Respite care might be required for the carers to enable them to have a break, on a regular basis so that they can continue to give care to their relatives and therefore keep the person out in the community for a longer period of time. (Respite care manager of Ms Munro, England)

The terms "extra care housing" or "housing complexes" were used in England and the Netherlands to describe different services. Chapter 2.6.1 (p 33) described in detail the differences between the type of extra care housing in England and the Netherlands. Although they used the same term, they described very different services. The English extra care housing provide accommodation (single room with a small kitchen unit and en suite), supported from a live-in warden, in addition to some household staff who provided light care during the day:

> Basically we're classed as an extra care unit, which is one step up from warden aided care,... we're on call, but we live here so,... we offer them a mid-day meal – they have to be able to make their own breakfast and tea, or somebody else provides the breakfast and tea for them. And we offer them an assisted bath, once a week... when they do get frail, it's a shame to have to move them on again, that's quite disheartening sometimes but then again, we can't offer that sort of care. (Extra care housing manager of Ms Munro, England)

The provision of English extra-care housing meant if the residents needed additional help, they had to rely on their families or apply for support from other providers. The lack of night-time care from either extra care housing or other services in England was at least partly responsible for a further move for some older people. In contrast, Dutch house complexes provided a wider range of care provision:

> It is an apartment complex, a living-care complex... People here have their own apartment, it is entirely their own home where they determine everything themselves. They retain total authority, complete control of their own lives... We work here with nursing aides and household staff, with various qualification levels from level 1 to level 4, and our service is demand-oriented. So we only provide a particular form of care if the client has requested it, it works on the same principle as home care.... the care staff here all work within [this housing complex] only... The principal factor is that people can live here independently, in their own home, together with their partner... And should one partner die, the

> other can stay living here, they don't have to leave.." (Extra care housing manager of Ms Schoonwater, the Netherlands)

Studies of the Dutch extra care housing arrangements (such as Coolen et al, 1998) suggested that they could substitute, in part, for care home placement, thus reducing the rate of admission into residential and nursing homes. Coolen's research found evidence from the cost efficient perspective, that the cost of these housing schemes was lower than care homes. From a personal respective, it could mean that an individual would be most unlikely to need to move when their care needs increased. Moves themselves could cause further physical or physiological health deterioration or death. I would further suggest that the outcome of being able to stay in a placement for as long as possible could also support an individual's sense of security.

In Taiwan, the foreign live-in care service had also been used to prevent residential or nursing care admission. The principle was to use cheap care labour from South Asia to provide 24-hours one-to-one full-care for the older people in their own homes. In practice. According to (2/3) foreign care agencies, many of these South Asian carers performed domestic tasks for all those living in the same household. This was open to exploitation as there had been incidences of employers refusing to return passports to the foreign care workers or to allow them have any private life. As a result, the government had introduced provisions to ensure that foreign care workers were not placed in situations that verged on modern day slavery. Foreign carer policy had tended to focus on this issue rather than the quality of the care the foreign carers were able to provide. The foreign carer agencies also argued that:

> Most foreign carers aim to leave their family and come to Taiwan for money. They have no place to go and tend to work hard and long hours. Most of them work seven days a week, day and night. For them, the attraction of the work is they can earn money while at the same time accommodation and living expenses are provided by the employer. By contrast, not many Taiwanese carers would stay at night, weekends or holidays because they have their own families here to care for. The language can be difficult in the first few weeks, but the carer will pick up what the employer and older people mean by working with them for a while. We also have interpreters who can help carers and employers. (Foreign carer agency manager of Ms Chung, Taiwan)

9.3.1 The types of care provision for increasingly dependent older people

The types of care provision were another concern. We have already seen that the dividing line between nursing homes and residential homes was often not only found *between* single homes but *within* one home (Ősterle, 2001). Moreover such a clear dividing line was not necessarily desirable. In general there were no clear-cut distinctions between the two types. Interviews with professionals, service providers and formal carers revealed there was a tendency towards increasing dependency and a high level of need amongst older people living in both residential and nursing homes. According to these interviewees, this social change partly related to more people being cared for in their own homes in all three countries and partly to the increasingly strict admission criteria for receiving care in care homes in England and the Netherlands. These changes have raised a challenge for formal carers to provide more appropriate care in the community to meet the increasing demand. The quality of different workforces is discussed later in this chapter.

Chapter six and especially Chapter seven have demonstrated that the character of care provision in English care homes tended to be rather traditional. However, in Taiwan and especially in the Netherlands they provided a wider range of support for their clients. Taiwanese nursing care was able to provide treatment and rehabilitation to clients with a multi-disciplinary team that could relate to hospital professionals, as most of the nursing homes were under hospital organisation. The Netherlands provided more multi-purpose services - short and long-term care, rehabilitation, therapy and recreational activities - in both residential and nursing care settings:

> It's a wing where some people live permanently and some people temporarily to rehabilitate. We have a total of 30 people in this wing, 14 permanent residents and 16 rehabilitation. (Nursing home manager of Ms Reinaerdts, the Netherlands)

In addition, private care hotels in Holland, as we saw (see Chapter 4.5, p 78 of further description about what they are) provided a wide range of care services to meet the residential, nursing and rehabilitation care needs of their clients.

9.4 The adequacy of the care workforce

Chapter eight demonstrated how effective voluntary resources could be in supporting the formal care workforce and in improving older people's well-being in the Netherlands and Taiwan. Furthermore, the adequacy of the formal care workforce depended on staffing levels and stability. It can be assumed that the more adequate staffing levels are and the lower staff turnover rate is, the better each service provider will be able to meet the demands on their services. Interviews with local authority administrators, service providers and assessors in England showed staffing levels amongst public-fund assessors were generally adequate but with high turnover due to job-stress for some. The Dutch publicly-funded assessors were experiencing staff cuts because of recent reorganisation.

In Taiwan, the right to publicly-funded care was not so clearly acknowledged as in the other two countries. Assessment for public funds was often sub-contracted to health professionals who were in a full-time health care position. Such assessment arrangements often took longer to complete and sometimes caused delays in service delivery. It may be desirable to make assessment posts full-time, to minimise the delay in assessment and maximise the importance of needs identification amongst the clients.

The employment of assessors who worked under service providers was fairly stable in both the Netherlands and Taiwan. That was probably due to adequate pay. It created an additional incentive to promote reliability and professional capacity in care in the two countries. Taiwan was the only country of the three to have minimal national standards for the ratio of social and health professionals to work in nursing homes and for assessing the needs of older people on a daily basis:

> Every 15 residents should have at least one qualified nurse,... between 100 to 200 residents should have at least one social worker and for more than 200 residents a care home should have more than 2 social workers, ... a full-time or contracted doctor, physiotherapist and assistance, occupational therapist and assistant, as well as nutritionist should be in place in each care home. (DH, 1996)

The workload, however, was sometimes felt to be difficult to manage because care provisions were strongly bound up with the family unit and community culture. One of the nurses in a Taiwanese care home explained the difficulties:

> The nursing care legislation states every 80 clients required 7 nurses, and it is the rule, but in practice the workload is still high... Because there are many families visiting, so we have to take care of the older people at the same time as talking with the family when they are around. It is worst at the weekend when many families are visiting. If some residents are not well, we have to provide additional care as well as dealing with the family visitors. (Assessor nurse of Ms Li, Taiwan)

In terms of front-line formal carers, none of the countries studied specified the requisite ratio of clients to staff. This might provide employers with flexibility in managing their care employment; however, if an individual carer was covering too many clients, it might cause dissatisfaction for the carers on one hand and poor quality of care delivery for the individual client on the other.

Interviews with the managers, professionals and the carers in the care homes suggested overall that all three countries studied were experiencing the pressure of formal carer shortages. It was difficult for them to quantify workloads. This study, nevertheless, found a better ratio of carers/professionals in Dutch and Taiwanese care homes than in England. Each formal carer was responsible for 10-15 residents per shift in the Dutch and Taiwanese care homes. However, while nearly all of the Dutch providers (6 out of 7) were satisfied with their staffing levels, the workload seemed, in some circumstances, to be unmanageable for Taiwanese formal carers. Part of the reason was the interaction and involvement that staff had with the families (see quotation above).

In English care homes, each formal carer provided care for more than 20 residents on a shift. This appeared to be too great a load and was a major cause for concern in the system. The shortfall of frontline carers was a cause of service inferiority and a source of challenge in promoting needs-led practice. Under-staffing further explained the lack of choice in English care arrangements. Information from English assessors suggested they were often aware that labour shortages meant that assessment was unlikely to meet an individual's personal care preference or needs, even when these were in the care plan. Local authorities were also mindful that national standards

had been set for waiting times for service delivery. These were part of the performance measurement framework for Social Services:

> Users and carers should expect practical help and support to arrive in a timely fashion soon after problems are referred to Social Services. The Department of Health has set targets for 2003-04 that all care packages should be in place within four weeks of assessment. (CSCI, 2004b)

Some packages of services were delivered to meet national timing targets even when assessors knew they were unrealistic. One of the assessors summarised the difficulty as follows:

> ...there are so many people now wanting to receive services and it's our job to facilitate that, but we are desperate for carers and so we will take who we can because otherwise we are not going to be able to reach the targets and its very political. (Assessor social worker of Mrs Holmes and Mrs Sempik, England)

From the perspective of the client, the outcome of such care arrangements was sometimes inadequate. Furthermore, the impact of the carer shortage not only restricted the quality of care but also reduced opportunities for further training for existing formal carers. Therefore, it was no surprise that unqualified carers were one of the major concerns in the English care system. This will be addressed further in the next Section.

More recruitment would seem to be an obvious response to the problem of under-staffing. Van Ewijk et al. (2001) showed that the Netherlands had experienced some difficulties in recruiting care workers. Vacancies in care work in this country stayed at an average of 17% each year between 1995 and 2000. In this study, only a few Dutch providers (2/7) had difficulties in attracting people into the job. The quality of management and employment conditions are important factors in attracting people to the job and encouraging them to stay. These would include, for instance, better consultation between the managers and carers, flexible working hours and adequate pay. For more detail see Chapter 6.5 and Chapter 9.4) .

The demand for formal personal-care support could vary throughout the day and was sometimes seasonal. On a daily basis, there were peak times when personal care support was required e.g. in the morning and night - when clients needed assistance

in getting up, going to bed and meal provision. Seasonally, winter could be the time when more people needed help. Because of the cold weather; older people were more likely to be frail or have a fall. In addition, in England and the Netherlands - but not so much in Taiwan, with its different work culture - older people were more likely to require formal care support when their families went on holiday.

Part-time and temporary work was therefore more cost-effective for the employer and reflected the employment arrangements referred to above. From the service providers' point of view, especially in England, it was economically more sensible to pay carers by the hour. This kind of pay arrangement, however, led to some uncompensated time and additional costs for formal carers. One English home carer expressed her anxiety:

> We only get paid for the hours we go to the clients. When the client is receiving planned respite care, we are able to work by covering other colleagues' work. Sometimes, when we step into the client's house and find out they are not at home because of hospitalisation or other reasons, we don't get paid for the visit. All your time has been wasted like that and you have to cover the petrol by yourself. (Home carer of Ms Bames, England)

Indeed, poor employment conditions for part-time, casual and temporary workers have been well addressed in the literature (e.g. Eborall and Garmeson, 2001; Cameron and Moss, 2002; Lyonette and Yardley, 2003; EOC, 2004). As already addressed in Chapter 6.5.3, most female carers studied in the samples from England and the Netherlands worked part-time. If the analysis in this study is correct, it would confirm Esping-Andersen and his colleagues' (2001, p 239) observation that "Dutch employers essentially recruit part-time workers to strengthen organisational flexibility, not as a means to pursue low price competition, as is the case in the UK".

Culturally, the role of care work was often invisible. It was seen as a "housewife-like" manual task, suitable for "lower-skilled" workers in England and for the "do-gooder", in Taiwan (Wang, 2002). However, in the Netherlands the work was seen as "professional (Korzyk, 2004). The socio-cultural aspect in England and Taiwan implied that care was seen as something any body could do, and therefore could be done by people who could not do very much else. Carers were likely to have poor qualifications and possibly very low skills in the two countries. However, in the

Netherlands, carers were paid more and expected to be professionals. They were likely to have a higher standard of service delivery and this might be one of the reasons that Dutch service users interviewed were more satisfied with the service they received.

The interviews with Dutch formal carers confirmed the finding from Moss and Cameron (2002) that on average Dutch care workers' earnings were comparable to the overall national average with evidence of a relatively strong economic position. In contrast, the wages of formal carers in England and Taiwan were relatively low. In England, formal carers earned far less than the general female workforce and even less than women who did menial work in supermarkets, let alone the male workforce. Added to this, the reduction or removal of income support and family benefits made female care workers reluctant to work more time (see Chapter six). In Taiwan, the wages of formal carers were comparable to those of unskilled workers. Inadequate pay for formal carers could be one of the causes of job dissatisfaction. This study, furthermore, has demonstrated that low pay was closely connected to understaffing in England and Taiwan. In Taiwan, the voluntary sector received more funding from the government and was able to pay their carers more than the private sector. Consequently, they had less difficulty in recruiting and maintaining their employees. In England, local authority home carers received higher wages than those who worked in the private sector and had less problems with recruitment and maintaining staff stability. The lower wages of formal carers in the private sector of England and Taiwan suggested that this was one way to achieve the goal of profitability. There may be concerns that the need to increase profits creates an incentive to employ a very low skilled workforce who do not require a high level of pay and this has an impact on quality of the service providers.

The stability of the workforce was also important. Low staff turnover would have an impact on workload and quality of care. Concerns about stability in the care workforce was addressed by most of the English (7 out of 10) and over half of the Taiwanese (5 out of 8) service providers in two ways: carer's turnover rate and job retention. The high possibility of staff turn-over might lead to repeated training of new staff which was inefficient in terms of cost. An unstable workforce would also make it difficult for carers to form relationships with service users. This might reduce the standard of care delivery. In the English sample in particular, the turnover problem not only increased the unmanageable workload, it also restricted opportunities for post qualification training (see next Section).

The shortage of formal carers in the English sample explained why the care that older people (in particular those being cared for at home) received was usually inadequate and unreliable (see Chapter six and seven). Moreover, some did not receive a service at all according to many English assessors. There is a strong message here for policy makers and politicians to bear in mind - a workable system of care fundamentally rests on appropriate resources.

There was little evidence that a solution could be found for the English participants interviewed:

> We are just about there [in keeping the carer-level], but it's a struggle to keep the number of people. (Service Director of Social Services, England)

> There's not a lot we can do really is there [in recruitment and maintain care staff stability]? (Residential home manager of Ms Powell, England)

In contrast the Taiwanese employed staff from overseas, had introduced a bonus system and had increased salaries to stimulate job attraction and work attendance for Taiwanese formal carers:

> I know some homes have employed many foreign carers. We may consider the option because from what we been told from other care homes, the foreign carers and nurses work harder and more flexibly than the carers in Taiwan." (Nursing home manager of Ms Yen, Taiwan)

> [We] give the additional bonus for staff who never take time off as well as pay more when they work over-time. We also try to find more money to increase their salaries to make the job more attractive." (Residential home manager of Ms Wang, Taiwan)

This study has raised the important point that it is not only important to attract people to become carers but also to get them to stay in the job. Supervision and support, which were explored in Chapter six, are elements in assisting better work conditions for formal carers. Some may suggest that career development would be another way to attract staff (.Eborall and Garmeson, 2001; PSSRU, 2003). It is likely that as medical advances allow more people with complex needs to survive, there will be a

shortage of formal carers with adequate skills. Formal carers are likely to remain as such, but will be expected to acquire more knowledge and perform semi-professional care provision yet have no opportunity for career development. Indeed, the hands-on carers interviewed showed there were very few career development opportunities in England and Taiwan.

The case of the Netherlands also supports the argument above:

> Two years ago, [my employer] asked me to do a new diploma. When I completed the training, I had to do more complex care with people, like giving them medicines. I have studied very hard to get the post qualification level seven, but I was told a few days ago that it wasn't enough, and I have to complete level nine or a ten in order to have promotion. I did everything and now I am still a home carer. And that is frustrating for me. (Home carer of Ms Flipson, the Netherlands)

Many service providers and senior officials at the national and local levels suggested that in the future, there might not be enough people to work as carers. The aim of technological innovation had been to stimulate the quality of life of older people on one hand while preserving human involvement in care on the other:

> They are building new homes for older people to live-in in the long-term... older people can stay at home and they are watched by way of the television... so in the office, they can see if everything is going well. (Senior official, Local Older People Association, the Netherlands)

> ... In the future, we have too few young people to take care of the large amount of older people, but that's a problem all over the world,... the innovative possibilities of using I C T, in a more technological age to do these stupid jobs and so that you can keep the people for the intelligent jobs... that's a challenge of work on using it more... (Senior official, Ministry of Health, Welfare and Sport, the Netherlands)

9.5 The education and training of formal carers

In assessing the quality of life of older people, it is difficult to separate the contribution made by resource shortages on the one hand and the capabilities of formal carers on the other. The ability of hands-on carers was of particular concern in England (see Chapter five and six). This section will further explore the strengths and weaknesses of each country's care education and training.

Each country's training system would seem to have a different purpose. Civil servants, senior officials, local administrators, professionals and service providers interviewed indicated that the purposes of care education were:

- To maintain the quality of care in the Netherlands
- To increase employment opportunities for the care workforce in Taiwan
- To improve the staff quality in England.

It is important to be aware of these initial differences between the countries, because they provide a background to the discussion concerning the quality of the formal carers interviewed for this project. Moreover, this might help to explain why one country has more training problems than others.

Interviews with civil servants, senior officials and service providers showed several governmental departments and service providers had an influence on carer education and training in all three countries. The Dutch training framework involved several departments from central government (such as Ministry of Health, Welfare and Sport, Ministry of Education and Ministry of Culture and Sciences) in clarifying the role and responsibility of each type of care. They also contributed to the organization of pre- and post-qualification training. At the level of care provision, service providers at the local level had a strong obligation and commitment to improving the quality of care practice of their staff:

> We are responsible for staff education. We carry out the staff evaluation as part of care evaluation. The further development of training for each staff is certainly highlighted in the process of the staff evaluation and will be followed up accordingly. (Residential home manager of Ms der Horst and Veltman's, the Netherlands)

This is in line with the findings from van Leeuwen (1999) which showed that strong employer-sponsored training works well. Most of the Dutch service providers (5/7) in this study claimed that carers in general are knowledgeable in terms of needs identification and care provision. Nearly all of the Dutch hands-on carers interviewed had had on-going training and were positive about training standards. However, there were increasing challenges in maintaining staff quality. More professional skills would be needed to meet the needs of increasingly highly dependent clients:

> ... people stay longer at their own homes, so people come here [care homes] with more dependent needs, the demand is higher than before, but the services provide by carers can't meet their high level of need and it affects the quality of care. The carers are not trained adequately to meet high level needs. (Assessor social worker of Ms Reinaerdits, the Netherlands)

In certain interviews with Dutch senior officials and civil servants at the national level as well as service providers, concern was expressed about carers' adaptability to change from the traditional task-centered culture to client-centered practice:

> They are still very much oriented towards intramural care. Here they have to switch to an extramural style of work. You are the guest in the client's home and people are very conscious of their choice of that particular form of care services... (Extra care housing manager of Ms Schoonwater, the Netherlands)

> ... to let staff [hands-on carer] think and act that everything is possible, sometimes, is difficult. Some of the staffs have to leave because they can't do it. (Care hotel manager of Ms Jorna, the Netherlands)

The Dutch case highlighted the need to maintain good quality care for meeting current needs. This was enormously demanding on hands-on carers, it involved a change from traditional skills to the skills of flexibility, creativity and professionalism.

It is clear from this study that both Taiwanese formal carers and the foreign carers in Taiwan were expected to be able to provide 'low-skill' care tasks in order to gain rapid entry into the workforce. As certain civil servants, senior officials and service providers pointed out, there was a requirement of a certain number of hours' basic-skill training in the qualifying programs for carers:

> ... the 60 hours' job training included personal care, mobility assistance and social care, but not nursing care tasks because this requires a qualified nurse. (Civil servant, Council of Labour Affairs, Taiwan)

The Taiwanese training of hands-on carers had been divided into different channels between the Taiwanese formal carers and those from South-Asia. The national and local government in Taiwan provided qualifying training. In contrast, the civil servant from the Council of Labour Affairs stated that the Taiwanese government required foreign carers to have qualifying training in their own countries equivalent to that of Taiwanese carers. As the qualification was awarded in the country itself, the agencies and Taiwanese employers (i.e. the families) had little control over the standard of foreign carers. This suggested that the quality of foreign carers in Taiwan probably varied a great deal, and some of them might be lower than the standard required of Taiwanese carers.

A great division of opportunities for post-qualification training was found between Taiwanese and South-Asian hands-on carers. For Taiwanese hands-on carers this was widespread and took place either in the work-place or in training centre and was supported by government, providers and the Long-Term Care Association:

> The government provides a supplement for our staff-training base on our application. They also organize us to visit other agencies that provide similar care as we do, to learn and exchange different ideas in care. The Long-Term Care Association also provides training sometimes for our staff to attend with some fees required. (Residential home manager of Ms Wang, Taiwan)

> We have a meeting and training once a month. The training involves issues of care by speakers from other service providers or professionals. We also have case discussions with the team and some medical training by doctors from the hospital. (Home carer of Ms Bai, Taiwan)

Recurrent post-qualification training was found to work well for most Taiwanese carers who stated that multi-setting and multi-purpose training enabled them to exchange knowledge and experience with different professionals and carers from other agencies and within their agencies. In contrast, the post-qualification training for South-Asian carers depended on the families of older people. Most of the foreign carer agencies and informal carers interviewed (3/5) saw this option as favorable for meeting the needs and personal preferences of individual older people:

> Before foreign carers come to work in Taiwan, they have to pass the training which includes an introduction and basic knowledge of the Taiwanese care model. Nevertheless, they need further training from their employer [family of older people], because every family has its own house rules, preferences and needs. The first few months are crucial for the employers to teach the foreign carer what care they are expected to provide and how they are expected to provide it... (Foreign care agency manager of Ms Chung, Taiwan)

> Of course I have to teach her [foreign live-in carer]. No one knows what my grandmother-in-law likes more than me. No one else knows what our family life is like. Although we all eat rice, [even in Taiwan] every household cooks meals very differently. I have to teach her how to cook the way we cook. (Granddaughter-in-law of Ms Chung, Taiwan)

Nonetheless, given that Taiwanese carers - but not foreign carers - had continuing formal support for post-qualifying training, there was the strong possibility that in some cases, live-in care was inadequate or poor. The civil servant from the Department of Labour explained the state's motivation behind the quality imbalance between Taiwanese carers and South-Asia carers:

> At the moment, most families prefer to employ foreign carers to take care of their elderly, because they are much cheaper than Taiwanese carers. The problem is that while Taiwanese carers were complaining that foreign carers were taking over their employment opportunities, none of Taiwanese would work for the wage of a foreign carer. The only solution from government is to train our own people to have higher professional skills in competing in the care market. It is hoped that public will be willing to pay the higher price for our own carers... When the time comes, we won't need foreign carers anymore. (Civil servant, Council of Labour Affairs, Taiwan)

Taiwan obviously has a way of doing things. On one hand, the state imported foreign carers to provide 24-hour living-in care at a much lower cost than Taiwanese carer were willing to provide, in order to meet the demands of older people. On the other hand, the state provided formal training support for Taiwanese carers in order to make sure they had enough qualifying standard to be in the job and to be able to compete with lower cost of foreign carers. This option has hardly been used in the other two countries. It is debatable whether service users would prefer a low cost or high standard of care. However, a modern welfare system should be able to ensure that training from other countries, especially the poorer countries, is adequate.

In England, the structure of pre- and post-qualification training had been implemented and modernised in recent years. The *National Care Standards Act 2000* regulated the qualification requirements of carers. The legislation required service providers to take the initiative in ensuring staff quality. As in Taiwan, English local government also provided a training subsidy to service providers. However, this was a modest amount and many providers (7/10) were reluctant to apply for it:

> There are [training] programmes for government funded places that we can claim for... I have only actually claimed one lot for basic food hygiene [training course] back and it was 70 pounds per person... its not much, but you have to fill in lots of forms. (Residential home manager of Ms Powell, England)

Insufficient financial support from the government and a lack of initiative on the part of providers to utilize available resources, could further worsen the funding situation, delay training opportunities for carers and consequently improvements in the quality of care for older people. Moreover, while carers' working conditions remained poor, statutory requirements introduced to raise carer standards could themselves become ineffective due to job dissatisfaction and carer reluctance to seek education and training. As one service provider and a formal carer pointed out:

> Perhaps the last couple or 3 years, we've had more staff coming in and out than we ever have done before... Well, I think it's down to the fact that you've got to have this training and that training and the NVQ and all that business... you'll find that people don't come here [care industry] to make a career of it because it's extremely poor paid. (Residential home manager of Ms Powell, England)

Similar difficulties in implementing carers' education were encountered when service providers needed to tackle staff shortages. This could also mean that staff training was not sought. One of the service providers explained the difficulties:

> ... training is very time consuming... you have trouble trying to cover that person upon a shift... you've got a worker short, they've got to work doubly hard to ensure that people are still looked after. (Nursing home manager of Ms Ward, England)

9.6 Conclusion

A precise comparison of mixed care systems remains problematic. The comparison of conditions in this chapter, nevertheless, has yielded some findings and conclusions concerning resource availability, choice, efficiency, quality of care and training. Both England and the Netherlands have experienced retrenchment in the statutory provision of long-term care. "Solidarity" is the core ideology in reshaping the responsibility between the state and society in the Netherlands, whereas in England the responsibility for care between care actors in the system remains unclear. In Taiwan, state intervention has increased, but it has focused more on stimulating the economy and employment, than on replacing the family as the central care agent. England provides selective state-financial support for older people with the dominant private care market concentrating on safety net provision of variable quality and quantity. Strong state financial support of older people in the Netherlands - in combination with not-for-profit care provision - has provided good quality services overall. However, the increasing private sector in the Netherlands is likely to benefit the better off. In contrast, it is the better off who are more likely to take advantage of the not-for-profit sector, leaving the poor to cheap, for-profit services. It is also the better off families who employ migrant female labour, and this is relatively cheap in Taiwan. All three countries were modernising the types of care to improve the well-being of older people and also enable them to live in their own homes. Nonetheless, both the Netherlands and Taiwan seem to have more creative care services than England in providing more choice for older people. A team of hands-on carers in combination with professionals and care-workers in the Netherlands and Taiwan provides better quality care than in England where hands-on care is primarily

provided by poorly trained or unskilled care workers. A shortage of carers is a matter of concern in all three countries.

Some career development can be found for hands-on carers in each country. Nonetheless, Dutch care workers are paid better and have better job security than in the other two countries. This is related to differences in cultural perspectives of the social status of care workers in the three countries. Furthermore, Dutch technological intervention to tackle the problem of formal carer shortages is underway. Taiwanese providers, on the other hand, are actively increasing the wages of hands-on carers to promote job attraction and worker productivity. The situation in England, however, is modest and has a great impact on service arrangements. High turnover of hands-on carers has been a significant problem in England. This increases the workload of hands-on carers and reduces the carers who are willing to take advantage of post-qualification training. The Netherlands has a more mature training system in place. England has statutory regulation concerning the standard of carers' training but this is difficult to implement due to resource limitations. In contrast, in Taiwan, there was more cooperative involvement in training but no national standard by which to measure training quality amongst hands-on carers in general and foreign carers in particular. All of this explains why the Dutch in general and Taiwanese to some degree are better quality services than the English.

9.7 Key points for policy and practice

This chapter has explored the way in which preventable mistakes and under investment in each country need to be considered in order to provide better quality of care to older people.

- Conflict between public expectations and the state about responsibility for long-term care in England and Taiwan has led to policy implementation difficulties. A more open debate between government and the public to achieve a consensus about the way forward for the system may prevent unnecessary social costs.

- Some older people in England and Taiwan feel frustrated living apart from their partners due to care home admission policies. Also in England, people have to move from one home to another when they become so disabled their arrangements cannot cope with them. Dutch extra care housing is more cost effective than care homes. Fewer moves are likely to contribute to older people's well-being. Moreover, partners can live together and maintain a desirable family life.

- Funding shortages have led to inadequate staffing and service shortages in England. Interviewees suggested that a redistribution of state funding could provide resources for pay and benefits, more training, a restructuring of jobs to create more attractive careers and a stable income for employees.

- The Taiwanese model of immigrant carers provides a cheaper option to alleviate the shortage of formal carers (until there are enough indigenous formal carers or technological advances to replace human involvement in care). This conclusion is difficult to draw in the content of international learning between the countries studied, because the empirical evidence is as thin as a silk thread – there were no overseas workers in the English and Dutch samples. No doubt there are many migrant care workers in the English and Dutch systems; nevertheless chronic staff shortages suggest that the Netherlands and England might, perhaps, consider the Taiwanese policy of specifically recruiting immigrant carers, with regulations to protect home employment opportunities and provide specific training for migration carers to ensure they are able to adopt the culture of care.

- English respite care has provided support to informal carers. This is particularly helpful in preventing informal care from breaking down.

- It seems clear that increasing staff stability can increase long term care cost savings in England and Taiwan. This study suggests that improving the economic and professional status of hands-on carers is likely to improve the quality of care. Decent-pay, a better-supported and better-trained workforce will provide better care, which should be the ultimate goal of all three countries.

- England might consider the Dutch and Taiwanese practice of professionals joining with care workers to provide hands-on care. This is likely to improve the quality of care.

CHAPTER TEN

PARTNERSHIP

10.1 Introduction

So far, according to the interviewees in this study, the bottom line of long-term care - the fulfilment of older people's basic needs - has been addressed in all three countries. However, the needs of older people required to be addressed for successful ageing – social inclusion, power and autonomy - have been met in the Netherlands, followed by Taiwan but less so in England. The examination of policy and service resources in each country in Chapter nine further demonstrated the ways successful ageing in long-term care had been achieved. As mentioned in Chapter 3.3.5 fragmented care was a matter of concern in England and Taiwan and to some degree, the Netherlands. This suggests that partnership in the care system should be recognised as a vital component if successful ageing in long-term care is to be promoted. Although partnership is not an entirely new phenomenon; there is as yet no widely accepted model in operation. What this chapter hopes to achieve is to outline the approaches that each country has adopted and the difficulties that they are facing.

Partnership in English policies usually refers to getting different sectors working together on the same project. Partnership in this chapter is used in the sense of "cooperation", to see whether relevant actors were sharing the same goals, whether they communicated well with each other and whether they were working together with

the service users. To begin with, within each country there must be shared understandings and goals for partnership to work. This chapter first explores these goals at the policy level and then moves on to examine partnership horizontally (strategically and operationally) and vertically. Through horizontal and vertical analysis, we will be able to see how and whether partnership in each country studied can achieve better joint-working structures to fulfil the policy intention of providing a seamless long-term care service.

10.2 Expectations and goals

In addressing the issue of partnership, the empirical data in this study had much to contribute to the debate around sharing goals between relevant care actors at the policy level in long-term care systems. Common goals of long-term care across relevant actors are crucial in the context of working in partnership. Goals can be objective (e.g. working towards standards of quality, efficiency and effectiveness), or subjective (e.g. aims, motive and purposes). From the grass-roots level, we have already seen in Chapter six that many older people emphasised the importance of their care needs rather than the system as a whole. Many of them - English service users in particular - expected to receive reliable services. Similar goals and expectations were found amongst informal carers.

10.2.1 Expectations and goals of civil servants and senior officials at NGOs

According to many national participants (8/13) across the countries, the policy of looking after older people in their own home is an important policy goal. Whenever possible this has been reinforced by increasing service and technological innovations - such as housing renovation in England and the Netherlands, technologies such as alarm systems and computing systems, in England, Taiwan and especially in the Netherlands. The following comments of one Dutch national official, however, shows that service and technology integration require considerable planning:

> It is important not inventing new provision again without checking more or less whether it really fits the demands and expectations of people, there is more direct relationship between demand and supply now. There are fewer people really do not need certain services then it fails and it has to stop. Of course, there is always the problem of asking people what do you want, because people react in terms of supply... in fact, indirectly, we will try to find out what is the demand for the future, ... with our decision now for investment in, especially in buildings, but also in people and in electronic infrastructure and we try to think ahead. (Senior official in Arcares, the Netherlands)

Although empowerment and a client-centred approach are also clear goals in the three countries studied, there are a number of other goals within England and Taiwan which undoubtedly exacerbate the vulnerability of some older people in long-term care. Two out of three national participants in England were clear that the goal of trying to guard the basic safety of older people competed with their independence:

We'd look to provide a safe system from the worst of abuses and exploitation but not a safe system that therefore removes all the independence. Actually, we all take risks, so it's about getting the balance right. (Civil servant, Department of Health, England)

In Taiwan, as mentioned in Chapter 6.2.1, one of the national goals is to develop an economic oriented long-term care system which balances opportunities for employment in the care sector and welfare. Government concern to provide employment is not accompanied by a similar concern for the quality of care. The welfare goal may not always be the priority. Nor in Taiwan, will service users' needs necessarily be met by profit-oriented providers.

Nevertheless, many of the national participants interviewed in Taiwan (4/6) and all in the Netherlands (none in England) acknowledged that 'normalisation' is one of the goals in the long-term care of older people. We have already seen that in the Netherlands and to some degree in Taiwan, older people are socially included and that the care they receive is imaginative in meeting individual needs. One of the important issues raised was that, at the time that this study was undertaken, social care priorities in English national policy were subordinated to the needs of the National Health Service:

Sometimes the only way we can make our argument about older people and social care is to demonstrate how it benefits the NHS, it drives us potty. (Civil servant, Department of Health, England)

The quality of long-term care of older people was seen as a costly and negative issue that came into conflict with other priorities:

> One of the things that is happening more frequently now is that money is not ring-fenced....You will find most of the money disappears to children. It's the way the whole of the money is allocated to Social Services...There is always a bigger budget going to the NHS. You're worried about how much of that is actually being spent on older people. (Senior official in Age Concern, England)

10.2.2 Expectations and goals of local administrators

Implementation of the goals of national policy, by and large, depends on co-operation between local authorities and services providers. Nearly all of the participants at the local level in all three countries addressed the importance of promoting improvements in community care services in long-term care. There were, nonetheless, some differences. In England and the Netherlands, the interview data suggested service integration was an important goal. English local administrators were focused on service integration for older people with intensive care needs in the new type of care homes:

> We are certainly moving across members and offices and towards seeing supportive housing as a critical area for development. If people can't any longer manage in their own home, it's best to provide opportunities at least to move into more supported housing so we are trying to put more money into extra housing and working with district councils to change the housing that they

provide so that there's more for people with intensive support needs. (Director of Social Service, England)

However, Dutch local administrators were focused more on the social well-being of older people - whether they lived in their own homes or care homes. This was one of the reason which stimulated joint working with wider local authority departments and relevant agencies:

We have to focus on all the issues. We need to make a happy life for older people ... its not only about the stones for the house, you have to organise health care, education and travelling so that they have some meaning in their day and that they are doing something. They may think they have care problems but they can still do something for the community. All support is about the social integration. (Project manager of Housing Association, the Netherlands)

In Taiwan, most of the local administrator respondents (4 out of 6) stated that an important goal for the local authority was a need to expand accessibility to local services:

We would like to have more accessible care resources locally. We would like to have more day care for those older people who need care. We would like to have more hours in home care support to older people. (Long-term care co-ordinator, Local Department of Health, Taiwan)

However, from the local administrators' perspective, there were difficulties in priorities between the national and local levels. Such difficulties were partly the result of difficulties in the implementation of community care and social care locally. In spite of community care and ageing in the person's own home being clearly stated as a policy goal in all three countries, the interviews with local administrators suggest in practice that their national governments had other priorities. Both English and Dutch interviewees thought health care was the principal priority on the national care agenda.

> ... most of the government's focus has been on hospitals and on waits for going into hospital and so on, so government can in effect set priorities, provide performance targets which may be against some of its other statements and some for the things that locally you want to develop. (Service Director of Social Services, England)

> ... the government has other priorities than we would like them to have... for instance, projects which are short term, should be long-term but because they have other priorities... they are busy with care about illness. (Senior official, CSO, the Netherlands)

Whereas in Taiwan, all of the local administrators interviewed agreed that central government's main aim was to focus on the economic implications of long-term care for older people:

> Central government is focused on increasing care employment and stimulating the care market rather than on the care needs of the older people. (Local

authority home care developer, Taiwan)

Furthermore, they thought the rapid increase in various service resources and choices were positive signs in Taiwanese care development at the moment but that an important goal for the future would be the need to focus on the expansion of mental and social support if the quality of the care was to be improved:

> There is little doubt that the rapid increase in numbers of service types and resources have helped families,...personal care is good, but social and mental support is still underdeveloped... in the future if the quality can be improved, it will be even better... (Local authority day care developer, Taiwan)

Similarly, quality of care was a concern in the English local area in which integration was vital to achieve seamless care:

> I think it could be better if there was more of those things around integrated care, which are not there yet. If there were more resources, more quality of homes. We don't provide enough. (Service Director of Social Services, England)

In contrast, nearly all of the Dutch interviewees from top to bottom were satisfied with current standards of long-term care based on older people receiving generous and consistent care support. They were, nevertheless, concerned at the lack of attention to higher needs, such as individual normalisation, autonomy and social inclusion. To maintain current standards of care was the general concern in the Netherlands. Staff shortages - which might adversely affect the future of staff quality - were also a problem mentioned by all participants at the national level, local administrators and

service providers. According to the interviewees, technological innovation was one way of filling the gap of future staff shortages. In addition, maintaining the stability of care staff was another way of preventing increasing care pressures on families.

10.2.3. Expectations and goals of service providers

There were differences in the expectations and goals of different sectors of service provision in each of the countries. In the Netherlands, all of the voluntary sector interviewees thought the responsibility for care, regulating policy and funding, should be shared primarily between central government, service providers and families. In England, most of the providers (8 out of 10) stated that national government should regulate the local authority's responsibility for assessment and accountability; service providers should provide care according to the outcome of the assessment; and families should take the majority of the responsibility before services came into place. In Taiwan, however, all of the participants agreed that the major care responsibility remained with the family; especially for those living in their own homes. All of the Taiwanese institutional providers stated that the responsibility for care should be divided between the government (providing carer training, policy regulating and subsidies); service providers (being responsible for providing the service); with decision making remaining with the families who provided funding and support for older people.

10.2.3.1 Expectations and goals of for-profit service providers

Goals concern not only local authorities and central government, but also different types of care service provision, such as statutory, private and voluntary organisation. Unlike in England - where similar responsibilities were shared by local authorities and private providers - all private sector interviewees in the Netherlands and all foreign care agencies interviewed in Taiwan thought the responsibility for care lay with private providers, older people and their families with little involvement from statutory services. Moreover, all of the Taiwanese and Dutch private for-profit service provider interviewed emphasised that they did not want to have the state interfering in their care provision and wanted to have autonomy.

> I have never thought about that question because I think we will never get anything from the government, because we are private... I prefer also not to get anything from the government, because then the government is in a position to make rules and protocol and things, and, that's what we really don't want. We want to care in our very own way. (Home care manager of Ms Duijts, the Netherlands)

> We would like the government to interfere less with what we do and to keep the market free. It is not appropriate for the government to aim for a free market but interfere with prices at the same time. You won't find it in other industries. There is also no reason for the government to set rules and legislate because they do not provide any financial support to the family... (Foreign care agency manager of Ms Chung, Taiwan)

In contrast most of the voluntary service respondents in the Netherlands (4 out of 5) and Taiwan (except foreign care agencies) and more than half of all service providers interviewed in England (6 out of 10) thought the government should provide more funding and regulation in their care system. This showed that a lack of regulation brought its own problems, such as unclear guidelines that in practice might result in wide variations in care services within each country. It also probably increased difficulties in policy implementation.

10.2.4. Expectations and goals of assessors

The assessors in all three countries interviewed shared similar goals regarding their care systems. Firstly, they felt there was a need for further investment in the long-term care of older people. Assessors stressed that governments should stop emphasising saving money and improve the quality of care. The Dutch assessors thought there should be more investment in updating care services for instance, providing smaller scale service units within an institutional setting. They also thought the Dutch government should consider increasing services for older people and put less expectation on the families because there would not be so many family members available for their older people in the future. English assessor participants would like the government to put much more investment in the improvement of service resources. Service criteria could then be more generous and include many more vulnerable older people who need care. Similar views were expressed by Taiwanese assessor interviewees who emphasised the need for the Taiwanese government to review their funding criteria and processes, so that older people could access funding

support and equipment appropriately.

Secondly, there were concerns about service accessibility. The English assessors stated that problems were closely related to resources (see Chapter nine). The Dutch assessors interviewed felt there was a great need for government to de-centralise the assessment process, to allow professionals to perform their professional skills of personal contact and advising the older people. In Taiwan, it was felt more information should be made available to the public to help older people and their families be aware of their rights, to know what was available for them; and to reduce the cultural barrier of reluctance in asking for help. Moreover, the Taiwanese National Health Insurance should not restrict the range of health care delivered to older people's own homes and communities.

Thirdly, the quality of care was a great concern of assessor participants in both England and Taiwan and to some degree in the Netherlands. English assessors interviewed thought the government should solve the problem of carers' shortage by providing better career paths and pay for carers. Increasing the capability of carers could be achieved by providing good training and equipment for them. Most Taiwanese assessor participants suggested the government should not focus on the quantity of service users but the quality of their care. In order to do so, there was a need to set up comprehensive monitoring criteria and systems. The assessors interviewed in Taiwan also thought there should be more training in their own speciality and in partnership to help them to provide better quality of care. The Dutch assessors interviewed would like to see carers have updated training to meet the increase in high dependency.

Finally, but most importantly for most English and Dutch assessor in this study, it was felt that bureaucracy limited front-line interaction and prevented adequate assessment taking place. They would like the system to be less bureaucratic:

> ...if you have social interaction then you have mutual benefits from the work you do....it's all theory to say this is what professionals should do and put everything in boxes, ... but in practice you need to see each other, you need to meet each other, you need to make this whole thing work together. (Assessor, social worker of Ms Bowman, the Netherlands)

Overall, Section 10.2 has indicated that relevant actors might have different priorities and goals. For instance, the priority of English civil servants was health care, but that was not the case for other actors. The question raised here is that if actors in the long-term care system have different goals and expectations from the start, how can they cooperate and deliver appropriate care services and support to promote successful ageing in long-term care.

10.3 Horizontal partnership

With the above expectations and goals from various actors interviewed in mind, we can now examine horizontal partnership across the board. Horizontal partnership can be divided into two levels:

- Firstly, partnership at the strategic level in which the emphasis is on how the policies, resources and investment decisions are made between national and

local administrators and relevant actors.

- Secondly, partnership at the operational level which is involved with service delivery coordination across various players, such as local authority, older people, service providers, professionals and in/formal carers.

To examine the strengths and weaknesses of partnership in a whole system, the analytical framework used will follow the elements outlined in Chapter three - the balance of power and resources between actors; fund sharing, joint service delivery; and different working cultures.

10.3.1 Partnership at the strategic level

The process of policy-making and legislation in this area is complex. One reason is because the long-term care of older people involves various issues such as housing, transportation, health and social care and no individual department can work alone. Moreover, all three countries have shared the similar challenge of government departments and NGOs at the central level working together with their different interests:

> ...Sometimes very difficult, because we often have a different agenda. Different ideas about how to arrange things... (Civil servant, Ministry of Welfare and Sport, the Netherlands)

> All those government departments are working with us on our Green Paper. I

think its strength would be, overall, I think, you would probably get a shared view of the policy intentions for older people....and a shared understanding of what that would look like... [such as] independence, choice and control going across the government agenda. In terms of weakness, I think we probably still have too many different initiatives going on at the same time, and there would have been quite a lot of mileage in working together. (Civil servant, Department of Health, England)

There is some diversity between [authorities]. Each of them has their own data base to store clients' information. Each of them has their own system to develop long term care.... (Senior officials, Association of Welfare of Older People, Taiwan)

Conversely, there are different models and structures at the strategic level within the countries. This has resulted in different outcomes in policy-making and strategy. The Dutch strategic working framework was evidently involved with a wide range of care contributors from the system at both the national and local levels - not only central government but also insurance organisations, older people and service providers. At the national and local level, the participants interviewed indicated there was frequent consultation and active participation in policy making. As a result, nearly all of the Dutch interviewees at national and local level stated their work was based on shared policies/agreements:

... there is a lot of debate, a lot of contact... a lot of convincing them, they are convincing us, talking, debating and looking for solutions...both parties are happy with... At the moment when you make a deal, based on law, you have to

> do your part of the share of the deal.... (Civil servant, Ministry of Health, Welfare and Sport, the Netherlands)

However, historically, there has not been a strong partnership between central and local government in the Netherlands regarding the long-term care of older people. This was because care had been the main responsibility of central government until 2006. Nonetheless, the interview with a local policy officer did find consultation had taken place between central and local government in the policy making process:

> We have local government representatives who have lots of talks with central government about the new laws [WMO] and about how much money will come from the centre to us and what tasks we [local government] are able to provide locally. Everything will be done in the discussions and every one has to agree with it. (Local authority policy officer, the Netherlands)

This indicated that the Dutch strategy-making process reflected a balance of equal power and involvement within and between national and local actors, as well as clear macro institutional responsibilities. Indeed, all of the Dutch participants involved with strategy stated such joint work worked well to ensure all the parties had an equal say and that their views were taken into account in setting policy objectives and deciding the future financing of care. Nevertheless, the Dutch civil servant interviewed pointed out that a great deal of talking and negotiation could not be avoided in the policy making process. The Dutch experience showed the significance of consultation in partnership working. Time and effort are crucial if a common goal is to be established between actors who have different care ideologies and organisational interests.

Consultation, negotiation and wider care actors' participations in policy making were dominant themes in the Dutch interviews. There was some evidence of this in Taiwan but in England it was rarely mentioned. The English actors' framework at the strategic level reflected a hierarchical partnership. In England, local authorities and Primary Care Trusts created a local care strategy in line with national policy made by the Department of Health. According to the senior official in Commission for Social Care Inspection, policy making sometimes had to be done without agreement between local and national levels:

> Sometimes, central government will do things that local government objects to. And there is, you know, an adversarial atmosphere, but, by and large, it tends to work with, you know, consensus or at least, an attempt to build a sort of agreement about what should be done between the various players, so it's not generally confrontational although it is sometimes. (Senior official, Commission for Social Care Inspection, England)

The funding split between Department of Health and local authority; and the different responsibilities of departments in local government (such as Social Services, Housing, and Transport) also showed some difficulties in partnership and service integration at the local strategic level. The Service Director of Social Services in England interviewed explained:

> ...different organisations...have often got different boundaries so and they've got different sorts of governments and control so you can get people working well together but you can't guarantee it and sometimes authorities, well every

> organisation will worry about their own budget, their own priorities rather than working together. (Service Director of Social Service, England)

Similarly, an unequal budget restricted partnership working at the Taiwanese strategic level. However, unlike in England, where one department was responsible for the long-term care of older people at the national level, in Taiwan, national long-term care strategy was further complicated by the involvement of at least four national departments (see details in Chapter five) under Executive Yean. Different financial interests between the departments have caused difficulties in joint working at the strategic level within the Taiwanese central government. The Council for Economic Planning and Development was appointed to strengthen partnership at the national level. However, all of the civil servants interviewed found joint working between departments especially difficult as the Council did not have a leading role and financial resources were controlled by the Department of Social Affairs and the Department of Health. However, there was some evidence of consultation between various departments at the central level in Taiwan:

> We are consulting and keeping other departments informed of what we do at the central level through regular meetings..... but we do not interfere and pay the respect of what other departments do... (Civil Servant, Council of Labour Affairs, Taiwan)

It is to be argued that the Taiwanese partnership model at the national level seems to provide each national department with autonomy and respect. However such an arrangement could be seen as passive, restricting a closer working relationship within Taiwanese national government. This could cause difficulties in making consistent

national policy.

Furthermore, this study found the partnership between the central and local levels in Taiwan was probably poorer than in England due to a lack of clear central legislation and a shortage of funds and human resources locally:

> There are difficulties in implementing policy at a local level. It is because funding and human resources come through either the Ministry of the Interior or local government itself, which leaves us with no power to negotiate or assist local government when they complain that they have not enough money or human resources to operate a policy. (Civil servant, Council for Economic Planning and Development, Taiwan)

10.3.2 Partnership at the operational level

Now we are going to look at partnership across the board between older people, their assessors, their service providers and their formal and informal carers. To begin with, this study found none of the local administrators in the three countries had a strong association with informal care at the local level, although a small degree of such partnership was evident in the English interviews. The lack of evidence of such partnership indicates that informal carers carry out a massive care responsibility but with no or limited participation and influence at the local level.

10.3.2.1 Assessor partnership

When it comes to working with other assessors, the Dutch and Taiwanese assessors interviewed had similar working environments and organisational structures. For instance, evidence of multi-disciplinary teamwork can be found in care settings in both countries (for details see Chapter five). Most of the Dutch and Taiwanese assessors indicated that different professionals working in the same building and same organisation did encourage (a) a more cooperative working relationship and (b) working towards the same goals and expectations. Conflict between those with different professional backgrounds was rarely mentioned in the interviews with assessors in the Netherlands and Taiwan. Furthermore, in Taiwan, there was some interaction between specialist professionals and service providers concerning their professional practices:

> I also meet nutritionists from other care homes to share our working experience. *The Foundation of Long-term Care* also has regular conferences where we can meet professionals from other providers to share our experiences. (Assessor nutritionist of Ms Yen, Taiwan)

Professional partnership in England was more complicated than in the other two countries because the various assessors were spread throughout different funding bodies – the Primarily Care Trust and local authority Social Services Departments. Much consultation and negotiation was required in the process of assessment and commissioning services. This caused operational difficulties in the British system from the point of view of the professionals. The government has introduced a *Single Assessment Process* to strengthen professional cooperation. However, the

difficulties involved in staff working for different agencies and in different buildings – as well as having extensive differences in working culture - limited the possibility of good communication:

> It's all very well people in high management talking to each other and making policies but it's people on the front line that actually bridge the gap between the service users and the organisation, and if you don't take all those people with you, with your policies, then, you're going to have a hard job creating the change that's needed... but until we're actually based together in one office, I don't think we're sort of going to move the whole way... the essence of our job is communication and yet our own department doesn't seem to understand how important communication is within the organisation... things like email and that sort of thing, are good on one level but they can be abused because it's like a quick way of communicating something which actually should take a bit longer.
>
> (Assessor social worker of Mrs Munro, England)

Furthermore, England was the only county in the three, where – because of the structure of the organisation - almost none of the multi-disciplinary assessors and professionals worked in a care setting. This, was probably one of the factors that restricted the quality of continuous care monitoring of individual care needs.

10.3.2.2 Partnership between service providers and older people

Nearly half of the Dutch providers (3 out of 7) saw the relationship between service

providers and clients as (a) the clients having full autonomy for decision-making and (b) the providers having the role of offering professional advice and acting on what their clients wanted.

> I stay informed. And every so often we have residents' consultation,... [we] explain what has been going on within the nursing home, what developments there are,... So you enter into discussion with the residents. Not so long ago, one of the residents came to me to complain that the toilet paper here was much too hard. You take that on board. You ask yourself what could be done about that? I suggested that when she goes to the toilet, she should ask the nurse to use a flannel instead of toilet paper, especially if they have had a bowel movement. So you encourage the residents to ask us if they have any problems. (Nursing home manager of Ms Reinaerdts, the Netherlands)

In the case of England a few (2 out of 10) providers stated they had involved the client indirectly by sending out a service evaluation questionnaire or by carrying out a care review. This did not really engage older people as true partnership would do (a point previously explored in Chapter eight).

In Taiwan, the strong Confucian culture influenced the familial partnership between older people and service providers:

> We see our residents like families and we play the role of their children or grandchildren as well as their carers. We try to make them feel they are not alone in their later life... (Nursing home manager of Ms Li, Taiwan)

10.3.2.3 Partnership between service providers and informal carers

Some Dutch providers (3 out of 7) believed clients had a primary participant role and that their opinion should be more highly considered than their families' unless they were mentally incapable of making a decision. However, when they worked with families, their needs were considered. Some Dutch providers interacted well by consulting with the family and reacting on the result of the discussion immediately.

> ... I offer a listening ear... And I listen straight away if possible, I don't tell them it will have to wait until tomorrow... Because it's quite a tall order, having to leave your partner behind here and go into a home alone. You have to notice and appreciate that, it's not nothing. (Nursing home manager of Ms Reinaerdts, the Netherlands)

Half of the English respondents (5 out of 10) thought partnership between the providers and the families was good. However, some participants (4 out of 10) said that the interaction with the family occurred mainly when there was a concern about the older person. Participation was in the form of decision-making regarding the needs of the older people following such concerns. Even when participation took place in formal decision making, there was little evidence of continuing engagement and monitoring of older person's care unless there was a crisis.

In contrast, Taiwanese service providers interviewees worked much more closely with the family than with the client, especially the foreign care agencies. Most of the

providers (7 out of 8) said they had regular contact and full involvement with the families in decision making.

10.3.2.4 Partnership between service providers

Nearly all of the service providers in England (9 out of 10) and most in the Netherlands (5 out of 7) stated they had little contact with other agencies in the provision of care. In contrast, the Taiwanese care system delivered much greater partnership between the providers and other agencies. We have already seen (Chapter 9.5, p 218) that Taiwanese providers (apart from foreign care agencies) worked jointly with other providers in sharing practical experiences and staff training resources. Similarly, the foreign carer agencies interviewed stated they had a mutual relationship with the carer agencies in the countries that provided the carers.

> The relationship with our partner agency in foreign countries is good. We rely on each other. We need them to provide and train the carers for us. They need us to import their carers to Taiwan. Normally when we ask for one carer they would provide CVs of a few candidates for us to choose. (Foreign care agency manager of Ms Lin, Taiwan)

10.4 Vertical partnership

We have demonstrated how in each country partnership has worked at strategic *and* operational levels horizontally. In this section, we will further examine how

partnership works vertically i.e.. between different levels.

10.4.1 Social and health care barriers in England and Taiwan

Until 2006, government responsibility for health and social care was centralised in a single department in the Netherlands. Although change is now taking place, at the time of my fieldwork, this was the case. Consequently, there were few problems. However, the partnership between Social and Health Departments had been problematic in both England and Taiwan. As a result there were difficulties in strategic policy making as well as the provision of care (mentioned earlier in Section 10.3). Most of the interviewees from Social and Health Departments at the local level in both countries found that a number of operational difficulties were caused by national policy inconsistencies. In both countries, the national partnership strategy - because of different departmental interests - led to different priorities between social and health care:

> Different organisations have often got different boundaries and they have got different sorts of governance. So, you can get people working well together for a bit, but you can't guarantee it and sometimes authorities, well every organisation will worry about their own budget, their own priorities rather than working together. (Service Director of Social Services, England)

> There are operational difficulties and confusion across the departments between social and health care, which is related with there being no clear recognition between Social and Health Departments at the central level. (Long-term care

co-ordinator, Taiwan)

We have demonstrated in Chapter four that the dependency of older people in residential and nursing care was not clearly defined in any of the three countries. In the case of Taiwan, the mixture of residents within a care home was partly caused by ambiguous policies between social and health departments. Most Taiwanese interviewees at the local level across social and health care (5 out of 6) pointed out that an unclear responsibility boundary between social and health care had resulted in a duplication of services in practice:

> The responsibility between social and health is ambiguous. Sometimes the services provided by both departments are duplicated. Although the Health Department is responsible for health care, it is very difficult to define what health care is and what social care is. All of the residential homes have fewer nurses in charge, but they also provide nursing care to some of the residents. (Head of Social Affairs Bureau, Taiwan)

The barrier between Social and Health Departments also meant there was a barrier to sharing information and resources between assessors from different professional disciplines. Taiwanese local administrators pointed out that currently the primary connection between the two departments was simply through referring a case with no further consultations. A lack of information sharing - as well as a lack of recognition of each other's professional expertise - restricted cooperation between them and prevented a holistic approach to the long-term care needs of older people:

> There are operational difficulties and confusion across the local department

between social and health care, which is related to there being no clear recognition between the two organisations at the central level. Each department has its own criteria and understanding of care. We only can refer the case but there is not much consultation. Our assessments are not recognised by the Social Department and they will carry out their own assessment after we refer a case to them. (Long-term care co-ordinator, Local Department of Health, Taiwan)

Similar barriers between health and social care exist in England. According to most local administrators (3 out of 4), the difficulties of joint working were information sharing and the responsibility for, and understanding of, holistic caring:

> ...We do have a kind of protocol for working with them but at the moment we're having to revise that because of the Data Protection Act. They're saying there's a lot of information they can't give us – about individuals. All we can get now is sort of general information from them, if there's a problem in a home...Health is a bit of a mystery in the way we work... (Home care contractor, England)

Decisions at strategic levels about how tasks should be allocated between health and social care actors may be the product of extensive consultation (see Chapter 3.3.3.2) Nevertheless, on the ground, these were still sometimes perceived as arbitrary by those who participated in this study. Such views were reflected in statements from a number of the English service providers (3 out of 10).

> District nurses at the moment do things that home care staff can't do, but

sometimes they think we should be doing them. But, until it's been discussed and negotiated at higher level, our staff can't do it, you know, district nurses will go in and, they used to give ear-drops which our staff couldn't do, but they used to say, oh, it's easy, just do it. Well, we couldn't. (Home care manager of Ms Bames and Ms Holmes, England)

Furthermore, the unclear boundary between the two organisations not only affected care practice but also produced confusion and unrealistic expectations among the public:

> I think people's perception of what Health should provide and what Social Care should provide is sometimes a bit unrealistic... relatives with older people often think that somebody should pick this up and not the family... they feel that their older people's or older relatives need health care as opposed to social care. (Long-term care co-ordinator, Primary Care Trust, England)

Nevertheless, England appears to be further ahead than Taiwan in improving its joint working between Social and Health Departments. Co-ordination has been stimulated by several national policies, such as the *Single Assessment Act* and the *National Service Framework for Older People.* These emphasised the importance of enforcing local joined-up services. Intermediate care was a prime example of service integration and joint funding between Social and Health. It provided short-term care or rehabilitation for older people who had just been discharged from hospital. The main aim was to help older people recover from their ill health in order to return home and prevent further hospitalisation. The English Service Director of Social Services said there had been intensive negotiation between health care and

social care at the local level, in order to achieve the current level of cooperation. Furthermore, clear guidelines and protocols from the central level - to identify expectations and to help those at local level to know how things could work effectively to reach national targets - were in progress:

> I do know we've had a new medication policy come out recently, it's still in draft form,... there has been a lot of discussion with the health side, over the last year or so, because of the problem that we have to call nurses in to do certain tasks, and I think it will get better. (Home care manager of Ms Bames and Holmes, England)

A policy of health care and social care integration has also been introduced at the local level in Taiwan. For example, the local area is required to have a local drop-in long-term care centre for Taiwanese older people where both health and social professionals work alongside each other to take referrals. However, in the Taiwanese local area studied, there were only staff from the local department of health. This was because there was as yet no general commitment or resources between the two local governmental departments:

> Both departments need to set up a drop-in centre. However, the best for the public is a one-window access to meet their needs. The system has become more complicated... there is no general common agreement at the local level between Social Care and Health Departments. The Social Affairs Bureau was reluctant to have their staff based in the drop-in centre because they claimed they don't have staff available. (Long-term care co-ordinator, Local Department of Health, Taiwan)

A lack of clear and consistent guidelines between social and health care was clearly evident in the restricted partnership working in the Taiwanese long-term care system. The Taiwanese local administrator from the Health Department further argued that partnership could not operate without either clear guidelines or a balance of power between the two government bodies at the local level:

> ... there is a proposal made at the central level that they would combine health and social care into the same department. It will help to improve the situation. However, it has to depend on the individual local authority, because the local authority has its own autonomy to implement the policy and to structure their departmental framework. (Long-term care co-ordinator, Local Department of Health, Taiwan)

10.4.2 Policy integration

The case of Taiwan mentioned above has raised the issue of putting policy into practice which requires cooperation between central and local levels. Similar difficulties were also found in the other two countries studied. Much research into partnership has emphasised the importance of a power balance between actors (see Chapter three). It can be argued that sometimes a hierarchical structure is unavoidable. This issue will be examined further by looking at how the actors at the strategic level work with those at the operational level to implement and improve long-term care.

None of the three countries has strong sanctions to insist either that service providers or local authorities provide appropriate care. Central government tends to use incentives and budget control to implement policies and to improve care services, but closing down poor quality services was done reluctantly.

Both the Dutch and Taiwanese governments had adopted a "subsidy" approach, in order to implement a policy or stimulate creative care services. In the Netherlands, for example, the subsidy was provided by central government to service providers. In Taiwan, local government and service providers received subsidies from central government to implement policies. The difference between the two is that the Dutch government provided a large, stable budget to service providers in combination with subsidies and law enforcement. In Taiwan, most of the funding consisted of subsidies to local authorities and service providers. One of the disadvantages of subsidies was their short-term nature. Some Dutch participants and most Taiwanese participants claimed the weakness of the grant was that most of the providers were not willing to continue the service once the financial support ended or were reluctant to co-operate when funding was not constant. The consequence was that some services were comparatively unstable, especially in Taiwan:

> A lot of care providers say that when the subsidy is ended; they won't do it any more. That's a weakness of our system... we often use accommodation of (power)-management system. So we use a combination of law, of subsidies, of financial incentives and management by speech... we talk a lot in the Netherlands as you probably know. So often it's a combination of more implementation... (Civil servant, Ministry of Health, Welfare and Sport, the Netherlands)

Central government is willing to invest a lot of money to support a subsidy project, but after the project ends it is the responsibility of the local government to arrange the services from their local budget. Most of the local authorities possibly do not want to carry out the project after the funding has ended from the central government... it simply because there is not enough money locally.

(Senior official in Disability Welfare Alliance, Taiwan)

Conversely, all English participants (3 out of 3) at the national level drew attention to the so called "carrots and sticks" approach whereby there was a small degree of subsidy to implement a policy and improve long-term care services. This was based on *star-ratings* of service providers and the local authority. The service provider that had been inspected and judged to be of a higher quality would have a higher star rating. Those rated as having poor care quality would receive advice from the inspection unit or be forced to close down the service. If a local authority received a high star rating it would have more funding through central government and more freedom and autonomy. For the lower star-rated local authority there was less central funding together with close monitoring by central government and quasi-independent inspection units, such as CSCI and the Social Care Institute of Residents (SCI). There was a divergence of views on English strategy between the senior official from Commission of Social Care Inspection and the civil servants from Department of Health. Nevertheless, the strategy has been in place for less than a decade and it remains to be seen which of these is the more accurate view.

... that's a fairly strong incentive to improve [quality of care]... it's sort of by influence... (Senior official, Commission of Social Care Inspection,

England)

... I just get very frustrated because it feels like all of that going on, it really feels very hard to get a real change often, in what the older person gets. (Civil servant, Department of Health, England)

In spite of the debate mentioned above, it could be argued that it seems contradictory to promote partnership which includes a more equal balance of power on one hand, with a punitive strategy which implies an unequal power balance on the other. The punitive strategy is probably the way forward to monitor and ensure the quality of care. However a more equal partnership might be needed to emphasise joint-working to help those poor providers and professionals searching for ways of improving their care service delivery.

10.5 Conclusion

Partnership is one of the means whereby successful ageing in the long-term care of older people can be achieved. It was therefore important to address it in this study. One of the important findings was that the Netherlands seemed to have higher degree shared goals for making efficient partnership more feasible. One of the reasons for the success of Dutch policies and programmes throughout this study, perhaps, is that Dutch care actors work to the same goals. While it was also evident that English and Taiwanese participants might have some shared goals, they were neither explicit nor clear. It was therefore difficult for this study to identify them.

The Dutch partnership model clearly provided greater consultation within a care system based on fewer power barriers and a more transparent care strategy between the actors from top to bottom. Taiwan and especially England, however, had cooperation difficulties between various departments, especially between health care and social care. These were demonstrated in the difficulties faced in professional practice and service delivery. Nonetheless, both professional partnerships in the Netherlands and in Taiwan benefited from multi-disciplinary working in the same team. Taiwan was the only country of the three where the sample of service providers actively cooperated with other service providers and organisations. This enriched their organisational resources and quality of care. This went some way to narrowing the gap between Taiwan and the other two. Both England and the Netherlands had a combination of mixed strategies in implementing policy which had been shown to work better than in Taiwan. However, the Netherlands and Taiwan focused more on subsidies to stimulate new ideas in care services. However, stability of service availability was an issue - especially in Taiwan. The English 'carrots and sticks' approach seemed to ensure a consistent standard of care services.

10.6 Key points for policy and practice

- This study has shown that for partnership to occur, some work has to be done to recognise that people have different priorities. Therefore, England and Taiwan could learn from the Netherlands institutionally and through policies to ensure relevant actors have similar goals. This would help to achieve successful ageing in long-term care.

- The unclear boundary between social and health care at the national level has brought about difficulties policy implementation at the local level both in England and, especially, in Taiwan. England has shown some positive action in joint working to improve the situation. This might be a good example for Taiwan. The strong message from the local to the central level in both England and Taiwan was a need for consistent policy and guidelines as well as appropriate funding.

- The barriers of working in partnership between assessors was clearly demonstrated by English interviewees. From the case of the Netherlands and Taiwan, we learnt that working in a multi-disciplinary team under organisations with the same funding, in the same buildings and working under the same agencies helped assessors from different professional backgrounds to share goals. English assessors and professionals structures could take Dutch and Taiwanese experience into account to extend such multi-disciplinary practice not only through the public funding mechanism but also in the care setting.

- The Dutch themselves have begun to shift some social care responsibility to the local authority. It could be argued that the Netherlands should learn from England and Taiwan that there are huge difficulties for local organisations to implement care when there is a shortage of resources or when there are many policies introduced by different authorities on different levels. This suggests a unified policy in social and health care is vital and that good partnership across various actors is crucial.

Part Four

Conclusions

CHAPTER ELEVEN

Key Findings, Conclusions and Cross-National Learning for Policy and Practice

11.1 Introduction

My interest in carrying out this study lay in the possibility of discovering successful innovations in different welfare systems. Specific questions arose around what, why and how each country had promoted successful ageing in their long-term care systems, what they had achieved and what difficulties they faced. It is hoped that the perspectives of those interviewed from bottom to top of three care systems might provide lessons not only for the actual countries studied but other countries as well.

A framework based on Esping-Andersen's typology of welfare systems and the concept of successful ageing in the context of globalisation (see Chapter two and three), was chosen for its potential to reveal similarities and differences in the quality of care achieved by long-term care policies and provision in the countries studied, and then to raise the possibility of cross-national learning. In this final chapter I summarise what has been learnt from addressing each of the research aims identified in Chapter one.

This chapter begins by revisiting the aims of the study and providing a summary of the key findings presented in this thesis. The key findings include an overall comparison of the three long-term care systems. They also provide a basis for possible improvements

in implementing successful ageing in the long-term care of older people, including sections on further lessons for policy makers, social care work training and practice. However, before highlighting the key findings of this study, it is important to remind the reader that as with much other research, this study has some limitations. The nature of the sample has meant that the findings primarily reflect the different circumstances of the people studied and are not necessarily generalisable. Comparability is restricted by differences in the terminology used in each country studied, and the structure of their care systems. These have been identified in Chapters four and five. Nevertheless, the findings from the sample studied in the three countries have provided many valuable views in promoting successful ageing in long-term care and this chapter concludes with suggestions for future research.

11.2 Revisiting the aims of the study

This study centres on older people who were receiving some sort of formal long-term care support in three countries with different welfare regimes: England (liberal-social democratic), the Netherlands (social democratic-conservative) and Taiwan (conservative-liberal). I sought to find out what quality of life and care the older people studied had and how successful ageing in long-term care had been supported. Evidence of the capacity within each care system was sought to discover why some countries were able to meet the needs of older people more than others and what successes and difficulties each country experienced in promoting successful ageing in long-term care.

To answer the above questions, a comparative framework was developed. To age

successfully, individuals, their families and society have to be able to meet older people's needs. The needs of older people in care were identified from various theories of need such as the psychologist Maslow's notion of a hierarchy of needs (Maslow, 1943), the political economists' Doyal and Gough's human needs theory (Doyal and Gough, 1991) and gerontologists' concept of successful ageing (such as Havighurst, 1961; Rowe and Kane, 1987, 1997). The needs identified were - the need for basic personal care and daily living, the need to participate in the society, and the need for older people to be able to make their own decisions and be consulted. In order satisfy these needs, a number of key factors in policy development and service delivery had to be present if successful ageing was to be promoted. These included all the care actors being able to work together with older people, and adequate service and human resources to deliver care and support.

A wide range of documents, including national and international statistical data, published conceptual and empirical research articles were used. I also interviewed 28 older people together with those whose actions affected or supported them - informal carers, formal carers, professionals, service providers, local administrators and civil servants – 142 participants altogether. The range of participants' involvement in this research has supported by Doyal and Gough's argument that any rational and effective attempt to resolve disputes over needs must bring to bear both the codified knowledge of experts and the experiential knowledge of the users whose basic needs and daily life world are under consideration (Doyal and Gough 1991, p48 and 141). In addition, visual data-photographs were utilised in this study to reinforce the views of the participants. These data sources formed the basis for the comparative analysis undertaken.

11.3 Key findings

11.3.1 The scope of successful ageing in long-term care

The crux of the welfare system structure lies in political, governmental intervention in the market (Esping-Andersen, 1990). In order to discover how welfare systems try to help people who need care to age successfully, it is necessary to look at the components of need. At one level we looked at whether older people in care were adequately fed, adequately housed, protected, and had security, and proper health care; whether professionals, assessors, and in/formal carers were able to provide care for older people. As demonstrated in Chapter six, seven and eight, the care system in the English liberal-social democratic welfare regime provided a high threshold of care entitlement with the emphasis on personal care. This was reflected in resource-led care provision and a restricted living environment for some. In contrast, Chapter two showed that the Dutch were spending and providing more types of service and had a more generous attitude. The empirical chapters reinforced this. The care system in the Dutch social democratic-conservative welfare regime provided a more generous threshold of care entitlement and living environment for older people, under the state leadership and by ways of payment of social insurance. A reliable and needs-led service was evidenced in the Dutch case. In the Taiwanese care system, older people were predominantly reliant on family resources with state welfare development driven by economic goals. The living environment of older people was seen as a private matter. However the state had become involved in adapting homes and re-housing to meet older people's needs. The quality of the care service was driven by strong family involvement and a care market that reflected the conservative-liberal welfare regime. As female care workers in Taiwan were likely to be employed full-time, it was possible for service users to enjoy more

consistency in their carers.

Additionally, the data suggested that the wellbeing of professionals and in/formal carers was important if successful ageing in long-term care was to be achieved. Different welfare systems reflected their different caring and wellbeing conditions. Dutch professionals and in/formal carers were more satisfied with their conditions based on more generous state support for service users and greater professional recognition. This explained why older people were more likely to receive a professional standard of care in the Netherlands. In Taiwan, the system was characterised by a wider family support network for informal carers. In comparison, in England neither kind of support was as strong.

One of the things about old age is that it is very easy to give people a minimal amount of help, income and basic support so that people can survive. This study hoped to provide findings which would promote a richer and more active life for older people in care by using the concepts of successful ageing and participation. This was done through an examination of need assessment, service arrangements, care provision and the choice and support older people had in each country. The findings suggest that in Taiwan and the Netherlands - but not so much in England - the care system often took into account people's social needs, their need for inclusion, and their own and their families' need to make decisions and be consulted.

In terms of social inclusion, we considered the debate between objective and subjective aspects of social exclusion. Several older people in the study were clearly dissatisfied with their social life and hardly had any opportunity to participate in the wider society. By these criteria, they appeared socially excluded. With this in mind, this study

demonstrated that social inclusion was a problem in each society. However, a social democratic welfare system like the Netherlands, with its high social expenditure and great emphasis on universal services was able to tackle the social inclusion problem more generously than conservative Taiwan and liberal England. In the Netherlands, there were several activities available for older people and fewer older people who needed care were in poverty. Similarly, Taiwanese older people were socially included with decent financial provision if family support was available. In contrast, in England, neither situation could be found. In terms of measures to improve social inclusion, the Dutch system, based upon their ideology of normalisation appeared the most supportive. The Dutch were able to provide opportunities and support for participation and inclusion in local communities. Although social inclusion in the literature (Chapter three) stressed the importance of service users' self-reliance, the evidence in the English case was that older people were seen as frail and unable to take advantage of social participation. In the other two countries studied, the need for support to promote social inclusion was acknowledged.

Regarding the power and autonomy of older people in the three care systems, the Dutch service users again received more choices, consultation, and opportunities and assistance with decision making than the Taiwanese and English. Taiwanese older people had strong family support to ensure their rights and choices were maintained, whereas in England, the recent strengthening of the national quality monitoring mechanism might increase the power of older people but not necessarily their autonomy. This might close the gap with Taiwan somewhat. One extremely important fact to emerge in each of the three countries was that the gap of responsibility between the state, individual and family was closing. There was a tendency for the Eastern country to seek more state involvement while the two European countries were increasing family and

private responsibilities for care. Nevertheless, in England there was less clarity concerning responsibilities between the actors. This could account for the imbalance between public expectation and service provision.

11.3.2 Resources and partnership in implementing successful ageing in long-term care

Resources (service availability, capacity and quality of front-line workers and professionals) and partnership are key factors in policy development and service delivery in promoting successful ageing in long-term care. The demographic trends shown in Chapter two suggested there was a concern about staff shortages in the care systems of all three countries. The Netherlands and Taiwan experienced fewer human resource difficulties than England, because both countries had a greater utilisation of informal and voluntary resources and had a younger population. Additionally, in both Taiwan and the Netherlands more imagination was put into meeting an individual's care needs. This was one of the factors behind their superior quality of care. As more people are growing older, a higher proportion are disabled in all three countries. The Netherlands seemed to have recognised this and had adjusted the care workforce to be more professional and more highly skilled. In England it was rather hoped that the problem would go away and that a higher skilled workforce would not be required. In Taiwan, probably because of the different nature of its policies, the need for a highly skilled workforce had not been acknowledged.

The studies examined in Chapter three on partnership seemed to be conceptual rather than empirical. The empirical aspect of this study, however, showed that coordination,

integration and consultation were very important in implementing partnership. In spite of the continuing debate about whether pillarization culture was still strong in the Netherlands (Chapter two), this study found clear evidence of a cultural difference between the care systems in which the Dutch benefited from closer joint-working with clear responsibilities between actors than the other two countries. The English system reflected difficulties in the health care funding system and in partnership arrangements. Empirical findings confirmed that a 'Berlin wall' (Hudson, 1999) separated two primary care system (social and health care) in conflict with one another. However, empirical work also found examples of service integration, suggesting that partnership in the English care system was improving.

Although in some ways the Taiwanese had a more private system, this study provided some evidence (Chapter ten) to suggest that there was sound partnership between various actors. England was the only country which had a strong policy implementation mechanism in this field. In the Netherlands each actor had more or less equal power and autonomy. Therefore, as other research (such as Kümpers et al, 2002) had already shown, this study concluded that it was difficult to identify which model of partnership was more desirable than the others as each of them had their own strengths to meet their own care system requirements. Nonetheless, the lack of involvement of formal carers in decision making had resulted in weaknesses in participation in all three countries. Let us return to Esping-Andersen's welfare systems, this study agreed with his argument concerning the three anchors of: individual self-sufficiency (predominantly in the English liberal-conservative welfare system), family (predominantly in the Taiwanese conservative welfare system) and society (predominantly in the Dutch social-democratic welfare system), and that we should move toward a new balance that would (1) give less emphasis on security through families without setting the family avenue aside, (2) give

greater role to societal level provision while paying attention to their cost: service provision, adequacy and quality of the care workforce, and (3) continue to promote quality of care knowing that this includes a collaborative model (co-providing).

Overall, this study has demonstrated that successful ageing in long-term care is a complex matter. Each of the major themes was inter-related and over lapped with the others. This suggests that successful ageing in long-term care must meet all the needs with which this study has been concerned.

11.4 Operationalizing successful ageing in long-term care

The previous sections have raised a number of issues that relate to whether and how successful ageing in long-term care has been promoted in each of the countries studied. This section takes these findings forward by suggesting possible options that each country might consider borrowing from the others. The suggestions made include lesson for policy, practice and social care training.

11.4.1 Lessons for policy makers

Policy in England, in comparison with the Netherlands and Taiwan, is neither as imaginative nor as supportive. It is about meeting basic needs and formal carers had little time to do more than that. There is evidence however, that prevention of social exclusion and isolation would be economic as there would be a reduction in the need for formal care. This might appeal to English policy makers. England does not have either

strong family support as they do in Taiwan or strong state support, as in the Netherlands.

In England and the Netherlands it is official policy to include service users in decision-making about their lives. However, this study suggests that it is not enough simply to ask people to fill in questionnaires, as service users often say things are fine when they are not because they do not like to complain. We need to get beyond the surface of what people say to what they really think.

One of the lessons England and Taiwan might learn from the Netherlands is their inclusion of older people in decision making. The forums and pressure groups in the Dutch system have, empowered older people participate in service provision and development. The system is dynamic and does more than pay lip service to the idea of participation. The structural, semi-independent, central quality control mechanism in England is a valuable point which the Netherlands and Taiwan might take into account. This study has shown the English system had reinforced quality improvement in some degree since the mechanism was implemented.

Many older people in England and the Netherlands live alone with only a few hours a week of formal care support. Although it may be desirable and economical to keep them at home, we have to acknowledge that many people who live on their own can be very isolated and need care support for them to be socially included.

It is important that all actors work together to provide adequate care as part of joined up national and local policies. In the Netherlands, it seemed they did talk to each other and did have better joined up policies. The Dutch system was based on insurance companies holding the whole budget for both social and health services, so they had no

great argument about who paid. In England there was huge conflict because the NHS was free at the point of delivery but social care was not. Similarly, a lack of clarity about different departmental responsibilities resulted in great difficulties in implementing policy in Taiwan. The key message from this research was that if government ministries could not work well together to create a unified policy, this would adversely affect the experience of service users and other care actors.

If it is true that issues of cooperation and control are becoming more and more important in long-term care, then we are also witnessing two trends that further demonstrate the complexity of existing arrangements. These are the replacement of qualified by less well-qualified labour and the contribution made by foreign and/or illegal care labour. In this study, Taiwan widely utilised foreign care workers. Although we did not find any foreign care workers in England and the Netherlands in this study, other studies have shown an increase in foreign care workers in the English health care and social services systems (e.g. Redfoot and Houser, 2005; Kofman, 2007). Dustmann's study showed the percentage of foreign care workers in the English health sector increased from 10% of sector employment in 1979 to 23% in 2000 (Dustmann et al, 2003). It can be assumed that foreign labour is also employed in long-term care. One of the fundamental aspects of this phenomenon was that England and Taiwan were training too few people in this field. The problem for the Netherlands was not so great. However, as the population ages, the shortage of labour in the care market will worsen. Taiwanese foreign care might be desirable for service users who pay a minimal wage to carers to provide 24-hour support as it is cheaper than care homes. Nevertheless, the Netherlands and England might learn from the Taiwanese experience that the state also needs to monitor the quality and training of care workers who are employed by service users, to ensure an adequate standard of care knowledge and skills. The last point is

particularly important since there is a tendency in the Netherlands and England for service users to be expected to take more responsibility for their care through the English *Direct Payment* scheme and the Dutch *Personal Care Budget*.

When we examine welfare systems, its difficult to get behind the ideology to the reality of everyday experience. A term like 'family welfare' sounds wonderful but the reality is that in the future there will be fewer young people in the family to look after the old. The concept of family welfare might be more an idealised reflection of how things worked in the past. From the case of Taiwan we can learn that family welfare does not necessarily mean the family is actually *providing* the care but that the family *takes the lead* as a consumer in purchasing care privately. If there is good cooperation with the service provider, this can be effective.

11.4.2 Lessons for practice and training

One of the valuable lessons about the Taiwanese experience for the Netherlands and England might be having carers come to support older people on an almost full-time basis in their own homes. This can help older people to remain in their own homes and prevent them having to move.

Whether in the purchase or provision of residential care or support for people who choose to remain in their family home, it is quite clear that resourcefulness and creativity can maximise service users' independence – something England can learn from the Netherlands and Taiwan.

There was also evidence about the disempowerment that family carers experience from care services. England is the only country which officially values the contribution of family carers. This study found that the important role of informal carer as a mediator for older people has yet to be recognised or valued in all three countries. Similarly, there were issues for formal carers, who sometimes found they had not been taken consideration in day-to-day care decision making about service users. For those families and formal carers who had been involved with services users, this would, in effect, have reduced the power and autonomy of service users.

This study also raised questions about the nature of partnership. In the study discussed in this thesis, some assessors, England in particular, found themselves to be very unequal partners and expressed their frustration through actions that caused further delays in policy implementation. Better skills in communicating between policy makers and assessors and greater transparency in the authority's expectations both of why policy needs to be modernised and how the policy can be implemented, might lead to closer partnerships and less disruption.

There was also evidence on professional quality and partnership between different professional backgrounds. The findings from this study reinforce another message for English managers and practitioners: The examples of the Netherlands and Taiwan suggest that a multi-disciplinary team working in the same care setting, in the same building, under the same organisation with its own funding mechanism, strengthens the quality of the care and assessment.

Finally, this study has many lessons for the training of professionals and carers. Having a social relationship between service users, professionals and carers was a common

thread in the analysis of service users' views across the countries. Users believed, and the findings of this study suggest, that social care workers needed to devote time to listen and engage with them in a respectful way, and felt that they often did not have this due to the demands and pressure of their respective workloads. The tension between the demands of case management, having an overview and fulfilling administrative responsibilities on the one hand, and the user's appreciation of relationships developed through face-to-face contact on the other, needs to be addressed. In addition, the tendency of increasing telephone assessment in all three countries, was not necessarily an advance and could be counter productive. For formal carers, the personal approach was as important as the task-centre approach, if the quality care was to be maintained. Taiwanese care relationships have benefited from the extended family culture. Nonetheless, the English could take into account the Dutch example of client-centred skills being explicitly encouraged in the training of formal carers.

In spite of the extensive care carried out by families in all three countries, this study found that informal carers saw themselves as close family members rather than carers. Self-identity as a family member rather than as a carer reflected their great willingness to be responsible and respectful towards their older family members. Moreover, informal carers in the three countries were more willing to make compromises with their own well-being in comparison with other actors. Informal carers across the countries, however, experienced difficulties in looking after their older family members when they first took on the caring role. Although the state relies heavily on informal carers in the three countries there was evidence that it has left informal carers out of the care training system. This may have had some impact on the quality and safety of the care that older people receive.

11.5 Suggestions for future research

There were strengths and weaknesses in all of the welfare systems studied here. Basically, the Netherlands appeared to be the most supportive. However, there were many advantages in the Taiwanese system, particularly; the expectation of families to provide support. However, this will run into difficulties as the workforce changes and families grow further apart. The English system benefited from greater inspection and a more structured quality control mechanism. But there was much evidence to suggest that English system had not met the needs of their older population. In particular, it has not changed to meet the challenge of an ageing society.

This has been a qualitative study – based upon 28 older people and the support system surrounding them - the findings of which need to be verified by more quantitative research. That would include the finding that the Dutch system was better at providing for social inclusion than the English system; and whether the Taiwanese system could provide valuable lessons for the West. Further research might examine how different political, economic and cultural structures and mixed-economies of welfare shape long-term care systems; what elements and structures of care systems support or fail to support quality in later life; and how and what countries can learn from each other. At the outset this study discussed how concepts from gerontology and social policy could be combined. Further research could further test these concepts within specific areas of comparative study, for example, health and mental health provision. Moreover, as identified earlier in this chapter, a top-down approach involving the whole range of relevant actors in a single research project can provide a broader context and comprehensive understanding in policy and practice that is worth developing.

11.6 Concluding statement

We have learnt that a successful long-term care system is about meeting people's needs when they old, ill, or frail. The important questions are: are older people being well looked after, are they being socially included, are they able to make choices with support? Prior to this research project, Taiwan seemed from the literature to be stuck in the past and far more underdeveloped than England and the Netherlands. The interviews found the strength of a supportive care system lies not only lies in welfare regime, but instead the cultural factors of care go side by side with structural ones. A modern dynamic economy adapts to the country's welfare needs in different ways. For example: the Dutch benefit systematically from a strong solidarity ideology in their society, the English have more state support than Taiwanese to ensure most older people are able to receive care services when they are in need. Taiwanese strong family support derived from Confucian culture means respect for older people is part of the system.

What this study has clearly shown is that the experiences across the various participant groups in the Dutch sample were of a much more thorough, more generous and more organised system than that found by the participants from the other countries; and in some ways it appeared to reach parts that other systems did not. This has reinforced Esping-Anderson's finding that social democratic or Scandinavia type welfare regimes were more supportive than others. This study has also shown there are some overlaps between the systems. Unlike Esping-Andersen's ideal types of welfare regimes, the sample of countries studied here were of a hybrid nature. The degree of overlap between them means that the potential for cross-national learning becomes greater.

Before this can be achieved more attention will need to be devoted to the complex relationship between policy, practice and the whole range of background factors.

APPENDIX ONE

Box Overview of Long-term Care Services

Service	Country	Main Providers	Provision of services	Medical referral required	Assessment of needs	Funding of organisation	Co-payment by clients
ome care	**England**	Home nursing: Part of NHS Home help: Social services of municipalities and private organisations (both for- and non-profit)	Home nursing: Needs assessment, hygienic and other personal care, routine technical nursing procedures, more complicated nursing activities, **patient** education, psychosocial activities, encouraging help and evaluation of care. Home help Housework, hygienic and personal care.	No	Home nursing: by the team leader (a qualified nurse) No national standardised forms Home help: by care manager (social worker) No national standardised forms	Home nursing: free-for service by NHS Home help: Social services: budgets Private and local authority providers: fee-for-service	Home nursing: No Home help: Yes, different regulation exist base on the hours of needs and financial means-tested
	Netherlands	The National Association of Home Care which consist of regional across associations or home-care organisation (all are private non-profit)	Home nursing: Needs assessment, hygienic and other personal care, routine technical nursing procedures, more complicated nursing activities, **patient** education, psychosocial activities, encouraging help and evaluation of care. Home help Housework, hygienic and personal care, moral support, psychological support	No	Home nursing and home help: social worker, physical therapy or nurse at Independent Regional Assessment Team Then Home nursing: by home care nurse Hoe-help: manager or special team in home care organisation No national standardised forms	Home nursing: Fixed budget based on the number of personnel Home help: Fixed budget from central government based on number of inhabitants and age distribution in catchments area	Home nursing: No Home help: Yes, dependent on income and household composition
	Taiwan	Home Nursing: Part of NHI Home help: Private organisations (all are non-profit and part of foundational hospital)	Home nursing: Needs assessment, hygienic and other personal care, routine technical nursing procedures, more complicated nursing activities, **carer** education, psychosocial activities, encouraging help and evaluation of care. Home help: Housework (cooking or ready meal), hygienic and personal care, social activities, moral support, escort when client need to go out.	Yes for home nursing	Home nursing: by the team leader (a qualified nurse) No national standardised forms Home help: by the government contract assessor (nurse), then manager or social worker in home care organisation No national standardised	Home nursing: fixed budget base on the number of hours Home help: Fixed budget from central government and in a small degree local authority	Home nursing: Yes, free for certain hours and charge according to the additional hours out of free service Home help: Yes, free for certain hours and charge according to the additional hours out of free service

Service	Country	Main Providers	Provision of services	Medical referral required	Assessment of needs	Funding of organisation	Co-payment by clients
Residential care	**England**	Social services for municipalities and private organisations (most for profit and a few for non-profit)	Accommodation (most single room increasing number with en suit and share communal space), personal care, meal and in some degree recreational activities	No	By local authority care manager (social worker) No national standardised forms	Local authority	Yes, depends on capital including house and savi There are increasing cas of top up fees required fr clients and their family to pay the cost which is not being paid by local authority
	Netherlands	Private organisation (nearly all are non-profit, a few for profit from recent development)	Accommodation (private living room, kitchen, bedroom, shower and toilet and communal space), personal care, meal and recreational activities	No	By independent Regional Assessment Team (social worker, physical therapy or nurse) National standardised forms Then Manager or special team in residential care home	AWBZ	No in general There are increasing number of client chose co-payment to live in care hotel (private for profit)
	Taiwan	Private organisation (many for profit and some for non-profit)	Accommodation (few single room most share room and communal space), personal care, meal and recreational, social activities	No	By manager, nurse or social worker in residential home	Near all are self-funding Few who have minimal income found by national	No

Service	Country	Main Providers	Provision of services	Medical referral required	Assessment of needs	Funding of organisation	Co-payment by clients
Nursing care	**England**	Private organisations (most for profit and a few for non-profit)	Accommodation (most single room increasing number with en suit and share communal space), personal care, meal and in small degree recreational activities	No	By local authority care manager (social worker) No national standardised forms	Joint funding by Local Authority and Primary Care Trust	Yes, depends on capital including hou and saving There are increasing cases of top up fees required from clients and their family to pay the cost which is not being paid by local authority
	Netherlands	Private organisation (nearly all are non-profit, a few private from recent development)	Accommodation (most share room with 2-4 residents and share with public facilities), personal care, nursing care, meal and recreational activities	Yes	By independent Regional Assessment Team (social worker, physical therapy or nurse) National standardised forms Then Manager or special team in residential care home	AWBZ	No in general There are increasing number of client chose co-payment to live in care hotel (private for profit)
	Taiwan	Private organisation (many for profit and some for non-profit)	Accommodation (most share room with 2-10 residents and share with public facilities), personal care, nursing care, meal and recreational activities	No	By manager, nurse or social worker in residential home	Near all are self-funding Few who have minimal income found by national	N/A

Service	Country	Main Providers	Provision of services	Medical referral required	Assessment of needs	Funding of organisation	Co-payment by clients
Extra care housing scheme	**England**						
	Netherlands	Join provision from housing association and home care agencies (all private for non-profit)	Flat (purpose build flat for client and their spouse which content two bed rooms, living room, kitchen, storage room, bathroom, toilet and communal restaurant with shops in walking distance), personal care, medication monitoring.	No	By independent Regional Assessment Team (social worker, physical therapy or nurse) National standardised forms	AWBZ	Rental for the accommodation
Living-in care/Foreign carer	**Taiwan**	Foreign carer agencies (all private for profit)	24-hours foreign care live with clients at their own home, personal care, house work, cooking, shopping, escort the clients when go out	Yes	Doctors from hospital	Self-funding (mainly provide by family)	N/A

APPENDIX TWO

Interview Schedules

I.

Interview Schedule at National Level-
for Civil Servant & Voluntary Organisations

1. Policy

a. The role of central government

- What is the role of central government in promoting LTC for older people?
- Who bears the main responsibility for care in kind and in cost? (family/voluntary organisation/private/central government)
- What are the principal elements in LTC provision?
- What principal factors have influenced national LTC policy?

b. Service delivery or policy implementation

- What resources are currently devoted to the LTC of older people?
- How are policies implemented?
- What needs to be done at the national level to promote LTC for older people?
- Does central government work in partnership with local government or other department and agencies? How?
- How is LTC provided in general and what variations exist in different parts of the county?

c. Evaluation

- How do you ensure that LTC policies are adapted to society's changing needs?
- Who bears the main responsibility for seeing that policy is carried out effectively?
- How well is current policy working? What are its strength and weakness?
- What difficulties and challenges face future policy making in the field of LTC?
- Do you think you need a new set of social policies to cope with the demands of an ageing population?

d. Social exclusion/inclusion

- How should central government tackle the issue of older people in poverty? ***(answer briefly)***
- There are critics who claim that current LTC policies have promoted social exclusion. What is your view?
- Do you think there is a need to promote social inclusion for people who receive LTC? How can this be done?

3. The power and autonomy of older people

- Do you think older people who need LTC and their carers/family are active or passive in society?
- What kind of political power, if any, do older people and their carers have at the present time?
- What kind of political power might older people and their carers have in the future?

- Are the views of older people and their carers listened to?
- If yes, what are their views of current policy?
- Are older people or their carers involved in policymaking relating to LTC? If not, should they be involved and how?

II.

Interview Schedule at County Level-

for Administrators with Responsibilities for Older People

1. The role of local authorities

- What is the role of the local authority in long term care of older people (in kind and cost/provision and regulation)?
- How are things working at the moment (what are the strengths and weakness)?
- In terms of meeting the long-term care needs of older people, what is the balance between, family, voluntary organisations, private, central government and local government?
- What do local authorities need from central government in order to promote the long-term care of older people?
- Does central government consult with local authorities about policy changes?
- Is there any conflict between local interests and national strategy? How do you deal with it?
- What would the local authority like to do in terms of long-term care for older people? Is it possible? If not, why not?
- Describe the working relationship between your department and other departments and public sector agencies regarding the delivery of long-term care for older people.

2. Administration

- How satisfactory and stable is your staffing level? What staffing difficulties do you face? How are you dealing with them?

- How do you ensure that your front-line staff are able to implement the policies appropriately?
- Do you have a waiting list for your services? If yes, how do you deal with this?
- How do you achieve a balance between demand and supply?
- Do you think service criteria may exclude some people who need a carer? If yes, what can be done about this?

3. Finance

- What percentage of the local authority's budget is devoted to the care of older people?
- How does the financial support from central government to your local authority compare to that given to others?
- Are there any problems in financing the long-term care of older people? if yes, how are you dealing with the problem?
- Has finance become a burden to older people or family members? if yes, how can the problem be solved?
- How can you ensure that the budget has been used efficiently and/or effectively?

(Note. In the UK, some charities have financial assistance available for individual. In the Netherlands, solicitor, insurance company and some company are financially sponsor service providers i.e. NH, RH)

4. Other Resources

- In your opinion, how well do current long-term care services for older people work?
- Are there enough carers and professionals to meet local needs?

- If not, how do you cope with the problem?
- What are the most advanced services and what kind of services are still underdeveloped?
- How do you monitor the charge made by the private sector?

5. Providers

- Do you ensure that providers deliver or develop the right kind of services? if yes, How?
- Do you work in partnership with the private sector? What are the strengths and weakness of this relationship?
- Do you work in partnership with the voluntary sector? What are the strengths and weakness of this relationship?
- Do you work in partnership with informal carers? What are the strengths and weakness of this relationship?

6. Power and autonomy of older people

- What political power do older people and their carers have locally? (prompt with 'advisory or consultative committees')
- Do older people and their carers participate in local welfare policies in terms of consultation and decision-making?
- How can older people and their carers express their views?
- Have the views of older people and their carers about their needs been listened to? What were their views?
- Do you think there is a need to promote social inclusion for people who receive LTC? How can this be done?

III.

Interview Schedule for assessors -

(Social Worker, OT, Physiotherapist and Nurse)

1. Providers

- Who are the providers? (social services/benefit agencies/insurance company/health/housing/voluntary sector/friends/relatives)
- How successful is the working partnership between the above providers?
- Are there enough providers?
- Do you have any control over what providers deliver or whether they develop the right kind of services?
- Who bears the main responsibility for seeing that policy is carried out effectively?
- How well is the current LTC system working? What are its strengths and weaknesses? 117.What more should be done to help older people and you as a professional?

2. Administration/Commission

- Is there any department that takes lead responsibility for the LTC of older people?
- Do you have clear guidelines for policy and practice?
- Have you been consulted or informed about any policy changes?
- How do you assess people who need services?
- What is the priority service in LTC?
- Do you have any control over the provision of care to meet the older people's needs?

- What is the most difficult problem in practice?
- What support do you need from the local authority in order to promote/provide LTC for older people?
- For how many hours a week do you work?
- Do you think the caseload you have is manageable?
- What do you like and dislike about your work? Why?

3. Finance

- Can you afford to give services users what they would like/need?
- If not, why not? How are you dealing with it?
- Are there any financial problems facing the LTC of older people? (i.e. Britain has no control of market charging price and third party top up)
- Do you give any financial advice to people?
- Who do you think should give such advice to older people?

4. Other resources

- Who are the other professionals you work with in terms of LTC for older people?
- What are the strengths and weakness of working with those professionals?
- Are there enough formal and informal services to meet local needs?
- If not, how do you dealing with it?
- What are the most successful services and what kind of services are still underdeveloped?
- Is there any conflict between demand and supply?
- How do you deal with the situation?

5. Power and autonomy of older people

- Do you consult with older people regarding the care they need?
- What power do older people have regarding the care they are receiving?
- How do older people express their views or complains?
- Are older people and their carers views listened to?
- If yes, What were their views?
- Do you think there is a need to promote social inclusion for people who receive LTC? How can this be done?

IV.

Interview Schedule for Service Users

1. Background of Old People

age/other people in family (age, gender & occupations)/type of care services/type of accommodation/size of the institution (other residents age, gender, health, reasons for admission)/staffs' numbers, age, gender, work experience)

2. Caring sequence

- When did you start to need some help?
- What happened to make care necessary (sudden or gradually)?
- What kinds of help do you need?
- How frequently?

3. Power and autonomy of older people

- How do you feel about been cared for (dependent/independent)?
- Have you been able to make a decision or choice about the services you have received?
- Have you always have been informed and consulted (by your family, professionals and carers) about the kind of care/welfare you are given?
- Have you been able to increase, reduce or end the services if necessary?
- Who do you think is the best person to express your views and needs, other than yourself, if any?
- Have you ever been asked your opinion about the services you have received?
- Have you been able to complain if you have not been happy with the services you have received? How? To whom?

- Are your views on what you need been listened to?
- Are the services you are receiving your first choice?
- If not, do you have any alternative?

4. Finance

- Do you think you should pay for the care services you are receiving? ***(to delete it)***
- How much does it cost you per week? (***may able to find out from case file***)
- What is your weekly income? Is it sufficient for your needs?
- Do you ever worry about your financial situation?

5. Other Resources

- From where and how did you obtain information about services?
- How satisfactory is your accommodation?
- How satisfactory are the services you are receiving now?
- How satisfactory is your social life?

6. Providers

- Who is your main carer ? **(If they don't like the word carer use the person's name or relationship e.g. daughter)**
- From where do you receive your support services? (social services/health/voluntary sector/private sector/friends/relatives)
- Who initiated these services?
- How good is the relationship with your carers? (closer, distance, relationship changed, feeling about being dependent)
- Do you think you have received enough support?

- What support would you like or what could be changed?

7. Social Needs

- Are you able to maintain your interests and social activities?
- Feelings about life? Aspirations?
- What do you do in your spare time? What would you like to do if you had with more help?

8. Social Exclusion

- Have there been any changes in your relationship with your family and friends before or after you began to receive care?
- Do you feel lonely? Is there a particular time when you feel low?
- Have you been able to visit people and places where you like, when you want to?
- Have you joined any pensioner or consumer action group?
- Do you vote? Why?

V.

Interview Schedule-

Main Carers: informal carers

1. Background of Carers

Age/gender/profession/relationship with OP/

2. Carers' biography

a. Caring sequence & involvement:

- When did you start to be a carer (including other than SU)?
- What kind of support do you provide for the OP (in kind, in cost)?
- How frequently? How many hours per day or per week?
- What is the most difficult task? How do you deal with it?
- Does any one else provide care or perform tasks to the person you are care for?

b. Relationship with OP

- Why did you become a carer? (obligation/moral duty/culture/no alternative)
- How did you get on with each other before you became a carer? How do you get on now? (closer/distance/change/easier or more difficult as time goes by/arguments/feeling about caring)
- Do you think you have a choice of whether or not to be a carer?

c. Current life of the carer

- How do you manage to live? (money issues and work opportunities)
- Do you do other things in your spare time?

- What is your relationship with others?
- How does being a carer feel to you?
- What would your life be like if you were not a carer?
- What is your weekly income? Is it sufficient for your needs?
- Do you ever worry about your financial situation?

3. Power and autonomy

- Do you have a right to receive service support?
- If yes, how satisfactory is the support you receive?
- Do you have a right to decide what kind of service should be provided, how it should be provided and when the service should end?
- Do you think you should have more power to decide what and how the support services provide to you and the person you are care for?
- What would help you to be more in control?
- Do you think you know more about what would be the best for the OP than himself/herself does?
- Do you think you know more about what would be best for the OP than the professionals do?

4. Policy

- Who bears the main responsibility of care for older people?
- What do you think about the current care that your parent/partner is receiving? What are its strength and weakness?
- What change would you like to see regarding LTC for your parent/partner and for you as a carer?

VI

Interview Schedule-

Main Carers: formal cares

1. Background of Carers

Age/gender/profession/relationship with OP/

2. Formal carers' biography

a. Caring sequence & involvement:

- When did you start to be a carer (including other than SU)?
- When did you start to be a carer for my research OP?
- What kind of support do you provide for the service user?
- How frequently? How many hours per day or per week?
- What is the most difficult problem in providing care? How do you deal with it?
- How many hours do you work per week? Do you think your work load is manageable?

b. Partnership

- *Have you been consulted or informed about the needs of the service user you care for?*
- How good is the relationship between you and the person, you are caring for?
- How good is the relationship between you and the previous main (family) carer?

- How good is the relationship between you and other professionals and agencies who work with the service user?

c. Care

- How do you ensure that the care you provide are meeting my OP's care needs?
- What care/help would you like to provide to the service user but can't?
- What support do you need from your employer in order to promote/provide LTC for older people?
- Do you think the workload you have is manageable?
- What do you like and dislike about your work? Why?

3. Power and autonomy

- Do you have a right to be consulted about what kind of service should be provided, how it should be provided and when the service should end?
- Do you think you should have more right to be involved with what and how the support services provide to the person you are care for?
- What would help you to be more in control?
- Do you think you know more about what would be the best for the OP than him/herself does?
- Do you think you know more about what would be the best for the OP than the professionals do?

4. Policy

- Who bears the main responsibility of care for older people? (I.1.a.2; II.1.1; VI.4.1)

- What do you think about current care that your service user is receiving? What are its strength and weakness?
- Do you think there is a need to promote social inclusion for people who receive LTC? How can this be done?
- What change you would like to see regarding LTC for your service user and for you as a formal carer?

VII.

Interview Schedule at Local Level-

Agency/Service Provider for Older People

1. The role of agency/Service Provider

- What is the role of your agency in promoting long term care for older people?
- What are the principle elements in your agency's long term care provision? (personal care, health, social, transport, housing, leisure, etc)
- In terms of meeting the long-term care needs of older people, what is the balance between older people, family, service providers and local government?
- What is your agency's relationship with local and central government?
- What does your agency need from local or central government in order to promote the long term care for older people?

2. Administration

- Describe the relationship with your own carers, what are the strength and weakness?
- How satisfactory and stable is your staffing level? What staffing difficulties do you face? How are you dealing with them?
- Do you have a waiting list for your services? If yes, how do you deal with this?
- With what kinds of care tasks are older people most likely to be satisfied?
- With what kinds of care tasks are older people most likely to be dissatisfied? How do you deal with this?
- In your opinion, how well do current long term care services in your own

institution for older people work?

- What are the most advanced services and what kinds of services are still underdeveloped in your own field?

3. Finance

- How do you normally charge older people with the services they receive?
- What are your agency's financial resources? (SU, family, LA, central government etc)
- How does the financial support from central or local government to your agency compare to that give to others?
- How do you employ your staff? (contract, permanent, temporary)
- Has finance become a burden to your agency? Why, and how you deal with it?

4. Quality of the care services

- Do you monitor the quality of the services you provide? How?
- How do ensure that your agency is able to provide services to meet individual needs?
- To what extent do you believe your agency is unable to meet the individual needs? How you deal with it?

5. Provider

- Do you work in partnership with older people? What are the strengths and weaknesses of this relationship?
- Do you work partnership with their families or informal carers? What are the strengths and weaknesses of this relationship?
- Do you work in partnership with professional workers? Which ones? What are

the strengths and weaknesses of this relationship?

- Do you work partnership with other agencies? Which ones? What are the strengths and weaknesses of this relationship?

6. Power and autonomy of older people

- Do older people participate with you in terms of consultation and decision-making?
- How can older people express their views?
- Have the views of older people and their cares about their needs been listened to? What are their views?
- In your opinion, do you think local people are active or passive politically?
- Do you think there is a need to promote social inclusion for people who receive LTC? How can this be done?
- What change you would like to see regarding LTC for your service user and for you as a formal carer?

APPENDIX THREE

Ethical Committee Approval

Ref No: R04/P27

LOUGHBOROUGH UNIVERSITY
ETHICAL ADVISORY SUB-COMMITTEE

RESEARCH PROPOSAL
INVOLVING HUMAN PARTICIPANTS

Title: Successful ageing in long-term care: International comparison and lesson learning

Applicants: A Gould, HLL Chen

Department: Social Sciences

Date of clearance: 16 April 2004

Comments of the Sub-Committee:

The Sub-Committee agreed to issue clearance to proceed, subject to the following conditions:

- That the investigators consider producing separate versions of the Participant Information sheet, with specific information, for the different participant groups to be interviewed as part of the study.
- That the investigators confirm that the Participant Information sheets and Participant Consent forms would be provided in the appropriate language for Dutch and Taiwanese participants.
- That the section of the Participant Consent sheet relating to medical records be re-phrased to allow for a positive consent to be given: 'I agree / do not agree to the researcher viewing relevant sections of my medical records' rather than 'I understand that the researcher may wish to view relevant sections of my medical records.'
- That the final section of the Participant Consent sheet, requiring a signature from the investigator be removed (the aim of the sheet being to record the participant's consent, rather than the investigator's understanding of how the project was explained.

APPENDIX Four

Research Proposal

Title

Successful Ageing in Long-term Care: International Comparison and Lesson Learning

Purpose of the research

The proportion of people above the age of 60 is increasing in most industrial societies and is a historically unique phenomenon. The main aims of the project are:

- To understand and evaluate current systems of care the study will focus not just upon one part of the care process but the whole of the care system. This will be done by *centering* on the views of local service users *radiating out* to their carers, professional workers, local administrators, service providers, civil servants and voluntary agency officials *within* and *across* each country.
- To discover how long term care for older people is provided in different countries; and how needs are assessed and met.
- To obtain a better understanding of the implications of long-term care for different welfare systems and to identify which factors influence the quality of long-term care for individual service users.
- To assess the impact of policy upon the provision of long term care services in different countries.
- To examine how policy is put into practice.

These aims will be achieved through a comparison between three examples of contrasting welfare systems from the EU and East Asia.

Name/contact of research supervisor

This project forms the basis of a PhD thesis supervised by Dr Arthur Gould, Reader in Swedish Social Policy at Loughborough University. Dr Gould has many years experience of research into different welfare systems. Different projects have

included comparisons of Britain with Sweden, Japan and Germany. (Contact details: see further information below)

How the research will be carried out and the selection of respondents

This study will be conducted by identical research methods in the three countries. Face to face individual interviews will be carried out on three levels in each country: national, county and municipal.

1. Two individual interviews at the national level

The research will examine and analyse how long term care policy has been formed and implemented; how policy sets standards of care; and what is the national influence on local practice. This will involve interviews with one civil servant and one senior official in a national voluntary organisation concerned with older people.

2. Two individual interviews at the county level

These should include 2 Administrators (e.g. Policy and Planning Officer, Deputy Director of Social Services) with some responsibility for older people. The aims are to see how the local authority implements national policy; how the local authority ensures that long term care meets local needs and how it meet national targets; what the local authority thinks are the important issues that need to be addressed to improve long term care for older people; and what the local authority thinks are the important issues that need to be addressed by national government.

3. Around twenty-five individual interviews at the municipality level (the total number of interviews can be managed by selecting service users who share the same carer, professional worker or care home)

- **<u>Service users</u>**

  There will 9 service users interviewed in total. These could be selected from a small town or suburb. The most relevant service users for this cross national research would be females aged over 60, from the majority ethnic group*, who are near the end of a Social Worker's or Occupational Therapist's involvement, in terms of assessment and service arrangements. The aim is to see how much service users have been involved with decisions about their care; what impact services have had on their lives; how they think care

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* A wide range of social groups would not be advisable with such a small sample. It has therefore been decided to concentrate on women from the majority ethnic group over 60 to simplify the range of variables under analysis. Women were chosen partly because of their propensity to live longer than men.

services are meeting their needs; and what service users think should be included in the provision of long term care. Services users should include:

5 service users who live in their own home (these may have the same social worker)
2 service users who live in a residential care home (this may be the same care home and may be publicly- or privately-owned)
2 service users who live in a nursing home (this may be the same care home and be publicly- or privately-owned)

- **Main carers (for example, informal or formal carers)**
  The basis of selection will depend upon who is identified in the service users' interviews as the person providing them with the majority of their care. The aim is to evaluate informal and formal carers' contribution to the care system and to examine the process of assessment from the carers' perspective. How, for example, does the care affect carers' individual welfare in the family and in society? What may be the impact on them in the future? What do they think is important to them as carers? How much have they been involved with the assessment of the older people who they care for? What do they think is important for the long term care of older people?

- **Social workers and other professionals (for example health care workers or occupational therapists)**
  A small sample of social workers and others who have completed the above services users' assessment will be selected in order to collect more detailed data on the process of assessment and outcomes. The basis of selection for an interview will depend on the initial findings from the case files. The aim is to see how the professionals have put policy into practice; how the criteria of service admission and the decisions of a professional system influence the care support that older people receive; how they work in partnership with others; what do they think is the greatest challenge faced by those who provide older people with long term care; and what they think can be done to ensure these challenges are met.

- **Service provider (for example home care managers, residential care home manager and the nursing care home manager).**

A small sample of service providers, who are providing the services to the above service users, will be interviewed. The aim is to examine the process of care provision and management quality; to find out their current staffing and financial situation; to find out their principal concerns; and the quality of their relationship with service users and professional and other agencies.

All the interviews will be ***semi-structured***. Each interview will last for no longer than one hour.

4. Collate and analyse the service users' case files

It would be helpful to have access to case files (with the permission of the service user and the Department), in order to gather a better understanding of the history and process of long term care provision.

- Referral
- Assessment
- Care plan
- Care review

Start and end dates

The interviews should take about 6 weeks in all to complete depending on the interviewees' availability. It would be helpful if the British fieldwork could be carried out during the Spring of 2004 before moving on to Taiwan and the Netherlands.

Who will carry out the research?

Lisa Chen is a social worker who received her M.A. and Diploma in Social Work at Nottingham University in 1999. She:

- Has 4 years' experience of working with older people.
- Is fluent in Chinese and English and is learning Dutch (it is rare for one researcher to be able to use the language of each of countries being studied)
- Has substantial knowledge and experience from having lived in all three countries and has formal and informal contacts in all three countries.

Research advisors

The progress of this project is monitored annually by Professor Saul Becker and Dr Jack Demaine of Loughborough University. Fieldwork preparations have been approved.

Contribution of service users

Service users have not contributed to the design of this project in any formal sense. However, the whole rationale of the study is rooted in the daily professional experience of Ms. Chen.

The following will apply in this study:

- Using information from service users' electronic records or files to contact them (i.e. address, telephone number, relevant practitioners and service providers)
- Analysis of information on service users' files
- Telephone or personal contact with service users through relevant professional worker
- Interviews in service users' homes
- Interviews with carers in a place convenient to them
- Interviews with a civil servant, a voluntary organisation official, local administrators, professional workers and service providers in their own offices

Arrangements for informed consent of carers

Consent for interviews by service users and their informal and formal carers will be sought. Consent for seeing individual files will be sought from the Local Authority and the service user.

The sample of formal and informal carers who will be selected for interview will be drawn from those who have given this written consent. They will be contacted in the first instance by their professional worker to see whether they would be willing to be interviewed. Those that agree to such an interview will then be asked at the interview itself to sign an informed consent form agreeing to be interviewed. They will be given information about how the interview data will be used (with an assurance of anonymity and confidentiality). Informed consent will also apply to all other interviewees (for example, the national civil servant and the voluntary organisation official, county administrators, service users, professional workers and service providers).

Ensuring carers are involved

Informal or formal carers will be consulted directly about their experiences of carer-giving through the research process itself. Their contribution will be helpful to other carers and, hopefully, to future policy and practice.

Confidentiality

All information collected in this study will be treated in strict confidentiality and stored anonymously. The raw data will not be made available to those outside the project. *There will be no need to identify either the interviewees or the Local Authority.*

This research will be conducted to the standards of ethics and research protocols required by Loughborough University and the Social Research Association and the Department of Health.

Outputs and the use of the results of the research

- A summary report will be provided to municipalities, the civil servant and the voluntary organisation. This will include the main findings and examples of policy innovation and good practice in each of the three countries.
- A local seminar in which the findings of the project will be presented to key players in long term care provision for older people.
- Articles in academic and practitioner journals
- Papers to academic and practitioner conferences and seminars

Further information

If you have any queries, or would like to discuss any aspect of the project, please contact either

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APPENDIX FIVE

Informed Consent Form

Successful Ageing in Long-term Care: International Comparison and Lesson Learning

Informed Consent Form

(to be completed after Participant Information Sheet has been read)

The purpose and details of this study have been explained to me. I understand that this study is designed to further knowledge and that all procedures have been approved by the Loughborough University Ethical Advisory Committee and xxx County Council in England.

I have read and understood the information sheet and this consent form.

I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in the study.

I understand that I have the right to withdraw from this study at any stage for any reason, and that I will not be required to explain my reasons for withdrawing.

I understand that all the information I provide will be treated in strict confidence.

I agree to participate in this study.

Your name _____

Your signature _____

Signature of researcher _____

Date _____

APPENDIX SIX

Photography Consent Form

le of Research Project: Successful ageing in long-term care

searcher: Henglien (Lisa) Chen

signing this form,

gree to be photographed during the study. These photographs will be used in ways I consent. any use of the photographs, I will not be identified by name.

initials in the spaces below indicate the ways I consent to the use of the photographs.

Photographs can be studied by the researcher for use in the research project. _____

Photographs can be used for educational purposes

(to be viewed by students and professionals) _____

Photographs can be published in the researcher's Ph.D. thesis. _____

Photographs can be published in any publications based on the research project._____

Photographs can be shown at conferences or meetings. _____

Photographs can be used for academic conference presentations. _____

Photographs can be shown in the classrooms to students. _____

Photographs can be posted to a website. _____

nderstand that I have the right to refuse to take part in this study. I also have the right to hdraw from this part of the study at any time, e.g., before or even after the photographs are de.

so have the right to withdraw my permission for the uses of the photographs at any time, but I nowledge that this cannot apply to uses of the photographs in work that has already been olished.

ave read and understood this consent form. I agree, or consent, to have my photograph taken part of the study.

ave been given a copy of this Consent Form.

_____ _____

nt Name Date

_____

nature

_____

nature of Researcher

APPENDIX SEVEN

Successful Ageing in Long-Term Care: International Comparison and Lesson Learning

Participant's Information Sheet

I am interested in how long term care for older people is provided in different countries; and in how needs are assessed and met.

Who is conducting this study? My name is Lisa Chen. I am a social worker with experience of working with older people. This project forms the basis for a PhD which is being supervised by Dr. Arthur Gould of the Department of Social Sciences, Loughborough University.

What is this study all about? The proportion of people above the age of 60 is increasing in most industrial societies and is a historically unique phenomenon. The aim of this research project is to obtain a better understanding of the implications of long-term care for different welfare systems and which factors influence the quality of long-term care for individual service users.

How will this be done? This study will be carried out on three levels in each country: national, county and municipal. At the national level, this will involve interviews with one civil servant and one senior official in a national voluntary organisation concerned with older people. At the county level, I would like to interview 2 Administrators (e.g. policy and planning officer, deputy director of Social Services) with some responsibility for older people.

At the municipality level I would like to interview 3 service users who live in their own home, 3 service users who live in a residential care home and 3 service users who live in a nursing home. In addition I would like to interview – where relevant - the service users':

main carer who can be informal (family) carers or formal carers

their social workers and other professionals
their home care providers
the residential care home manager and
the nursing care home manager

The most relevant service user for this research would be someone who is a female aged over 60, from the majority ethnic group, and who is near the end of a Social Worker or OT's involvement, in terms of assessment and service arrangements.

All the interviews will be ***semi-structured***. Each interview would last for no longer than one hour.

In addition, it would be helpful to have access to case files (of course with permission of the Service User and your Department), in order to gather a better understanding of the history and process of long term care provision.

How long will the fieldwork take? One of the main aims of my study is to understand the progress of long-term care provision for the 9 service users. There will be around 30 interviews at the county and municipality levels. These should take about 5 weeks in all to complete depending on the interviewees' availability. I would like to do the British fieldwork during the Spring and Summer of 2004 before moving on to Taiwan and the Netherlands.

Will the information collected be treated as confidential? All information collected in this study will be treated in strict confidentiality and stored anonymously. The raw data will not be made available those outside the project.

Will I be told about the result of this study? A written summary of the findings will be prepared for anyone who has contributed to this study.

If you have any queries, or would like to discuss any aspect of the project, please contact either **Ms Heng-Lien Chen** [H.L.L.Chen@lboro.ac.uk] (02476 261614 or 07810 142675) or **Dr Arthur Gould** [A.R.Gould@lboro.ac.uk] (work 01509 223363 or home 01509 266804)

APPENDIX EIGHT

CONFIDENTIALITY STATEMENT – interpreters and/or transcribers

Research Title: Successful Ageing in Long-Term Care- International Comparison and Lesson Learning

I understand that as an interpreter / transcriber (circle one) for a study being conducted by Heng-Lien (Lisa)Chen of the Department of Social Sciences, University of Loughborough under the supervision of Professor Arthur Gould, I am privy to confidential information. I agree to :

1. keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g., disks, tapes, transcripts) with anyone other than the *Researcher(s)*.

2. keep all research information in any form or format (e.g., disks, tapes, transcripts) secure while it is in my possession.

3. return all research information in any form or format (e.g., disks, tapes, transcripts) to the *Researcher(s)* when I have completed the research tasks.

4. after consulting with the *Researcher(s),* erase or destroy all research information in any form or format regarding this research project that is not returnable to the *Researcher(s)* (e.g., information stored on computer hard drive).

Name: _____ Signature: _____

Date: _____ Witness Signature:_____

This study has been reviewed and approved by the Ethical Advisory Committee at the University of Loughborough and XXX County Counsel. For questions regarding participants rights and ethical conduct of research, contact the sectary Chris Dunbobbon of EAC at c.dunbobbin@lboro.ac.uk. And quote Ref No: R04/P27

GLOSSARY OF TERMS

Aids	i.e. walkers, moving and handling aids
Arcarers	Arcarers are the national trade association for nursing and care. The association counts 651 members in the Netherlands. They present 334 nursing homes and 1366 residential and other types of care service providers. (The Netherlands)
Audit Commission	An independent body responsible for ensuring that public money is spent economically, efficiently and effectively in the area of local government, housing, health, and so on. (England)
AWBZ	The General Exceptional Medical Expenses Act (AWBZ, *Algemene Wet Bijzondere Ziektekosten*) is managed through health insurers: the health insurance founds, or private health insurance companies approved by the government. The government is responsible since insurance organisations cannot take financial risk to cover AWBZ. (the Netherlands)
Commission for Social Care Inspection (CSCI)	The single independent inspectorate for all social care service in England. (England)
Commissioning	The full set of activities that local authority and primary Care Trust (PCTs) undertake to make sure that service funded by them, on behalf of the public, are used to meet the needs of the individual fairly, efficiently and effectively. (England)
Community Care	Care or support provided by social services departments and the NHS to assist people in their day-to-day living. (England)
CSO	The national older people pressure group is the cooperation body of give elderly organisations: ANBO, NISBO, NVOG, PCOB and UNION KBO. There were more than 650,000 older people have been dovetailed in the pressure group. (the Netherlands)
Daily Living Tasks	i.e. shopping, medical management and transportation
Domestic Care	i.e. cleaning, meal preparation, laundry, etc.

Tasks	
Fair Access to Care Services (FACS)	Guidance issues by the Department of Health to local authorities about eligibility criteria for adult social care. (England)
Foreign Care Workers	Taiwan has import the foreign care workers from abroad through recruitment agencies and brokers because their own nationals are no longer obliged or inclined to work in underpaid, difficult or exploitive jobs. The foreign care worker in Taiwan is different from British understanding of traditional butler or servant. They perform typical domestic chores such as cooking, ironing, washing, cleaning the house. In addition to replace the role of a nurse in taking care of the elderly people with disabilities. They often are expected to work at least fifteen hours per day and live in the same house with the elderly. (Taiwan)
General Social Care Council (GSCC)	The social care workforce regulator. It registers social care workers and regulates their conduct, education and training. (England)
Green Paper	A preliminary discussion or consultation document often issued by the government in advance of the formulation of policy (England)
Home Adaptation	i.e. ramp, hand rails, etc.
National Minimum Standards (NMS)	Which are standards set by the Department of Health for a range of services, including care homes, domiciliary care agencies. The Commission for Social Care Inspection (CSCI) must consider the NMS in assessing social care providers' compliance with statutory regulations. (England)
National Service Framework (NSF)	Department of Health guidance that defines evidence based standards and good practice in a clinical area or for a patient group. Examples include mental health, coronary heart disease and older people. (England)
Organisation for Economic Co-operation and Development (OECD)	An international organisation with a core membership of 30 countries which promotes democratic government ad the market economy. It is best known for its publications on economic issues and its statistics.

Personal Care	Such as bathing, shower, dress, undress, etc.
Primary Care	The collective term for all services which are people's first point of contact with the NHS. (England)
Primary Care Trusts (PCTs)	Free-standing statutory NHS bodies with responsibility for delivering health care an health improvement to their local areas. The commission or directly provide a range of community health services as part of their functions. (England)
RIO	In 1998 Regional Assessment Institutes (RIO's) were established at municipal government level for independent and comprehensive needs assessment of AWBZ-covered care. Actual care allocation is done by regional care offices (*zorgkantoren*) which are linked to local insurance companies. (the Netherlands)
Single Assessment Process (SAP)	An overarching assessment of older people's care needs to which the different agencies providing care contribute. (England)
Social Care Institute for Excellence (SCIE)	It is an independent registered charity established in 2001 to develop and promote knowledge about good practice in social care. (England)
The Department of Social Affairs	The (local) Department of Social Affairs is responsible for social welfare, social insurance, social relief, community development, social services, rehabilitation of physically and mentally disabled citizens, civil organizations, and other social administration affairs. (Taiwan)
The Ministry of the Interior, Department of Social Affairs	The (national) Ministry of the Interior is in charge of the administration of national social welfare matters while the Department of Social Affairs is in charge of the planning, implementation, instruction and administration of social welfare, public assistance, social insurance, civil organizations and cooperative enterprises. (Taiwan)
Wet BIG	Dutch the Individual Health Professions Act
WGBO	Dutch the Care Institution Quality Act
White Paper	Documents produced by the government setting out details for future policy on a particular subject. (England)

WMO	On 1 January 2007 the Social Support Act (Wet maatschappelijke ondersteuning, Wmo) came into force in all municipalities in the Netherlands. Under the Act, the municipalities are responsible for setting up social support. The policy also emphasising individual responsibility in health care, both at the insurance side as well as the provision of care side. (the Netherlands)
Your Health, Your Care, Your Say	White paper established on 2006. The listing exercise with the public about what their priorities are for future health and social care services.(England)

References

Age Concern (1998) 'Statistics- older people in the United Kingdom', (www.ace.org.uk).

Agich, G.J. (2003) *Dependence and autonomy in old age: An ethical framework for long-term care*, Cambridge: Cambridge University Press.

Alber, J. (1995) 'A framework for the comparative study of social services', *Journal of European Social Policy*, vol 5, no 2, pp 131-149.

Albert, M. (1993) *Capitalism against Capitalism*, London: Whurr Publishers.

Albert, M.S., Jones, K., Savage, C.R., Berkman, L., Seeman, T., Blazer, D. and Rowe, J.W. (1995) 'Predictors of cognitive change in older persons: the MacArthur studies of successful ageing', *Psychology and Ageing*, vol 10, pp 578–89.

Albrecht, M. C. (1954) 'The relationship between literature and society', *American Journal of Sociology*, no 59, pp 425-36.

Alexander, V. D. (2008) 'Analyzing visual materials' in N, Gilbert. *Research social life*, 3rd edition, London: Sage.

Arcares, A. (2002) *Centre of living-care* (http://www.kenniscentrumwonenzorg.nl) [in Dutch].

Aspalter, C. (2001) *Conservative welfare state systems in East Asia*, Westport, Conn: Praeger.

Aspalter, C. (ed) (2002) *Discovering the welfare state in East Asia*, Westport, Conn: Praeger.

Atkinson, D. (1989) 'Research interviews with people with mental handicaps', in A. Brechin and J. Walmsley (eds) *Making connections*, London: Hodder and Stoughton.

Audit Commission (1999) *Children in Mind: child and adolescent mental health services*, London: Audit Commission.

Audit Commission (2002a) *Developing productive partnerships: A bulletin.* London: Audit Commission (http://www.audit-commission.gov.uk/Products/ACREPORT/FA9C615DA5284115BBA06CDF8E7C60CC/DevelopingProductivePartnerships.pdf).

Audit Commission (2002b) *Integrated services for older people: building a whole system approach in England*, London: Audit Commission.

Audit Commission. (1998) *A fruitful partnership: Effective partnership working*, London: Audit Commission.

Baldock, J. and Evers, A. (1991) 'Citizenship and frail old people: changing patterns of provision in Europe', in N. Manning (ed) *Social policy review 1990-91*, Harlow: Longman.

Baldwin, S. (1995) 'Love and money: the financial consequences of caring for an older relative', in I. Allen and E. Perkind (eds) *The future of family care for older people*, London: HMSO, pp 119-40.

Baldwin, S. and Twigg, J. (1991) 'Women and community care – reflections of a debate', in M. Maclean and D. Groves (eds) *Women's issues in social policy*, London: Routledge, pp 117-35.

Balloch, S. and Taylor, M. (2002) 'Introduction', in S. Balloch and M. Taylor (eds) *Partnership working: Policy and practice*, Bristol: Policy Press, pp 1–14.

Baltes, P. B. and Baltes, M. M. (1990) 'Psychological perspectives on successful ageing: the model of selective optimization with compensation', in P. B. Baltes and M. M. Baltes (eds) *Successful ageing : Perspectives from the behavioural sciences*, New York: Cambridge University Press, pp 1–34.

Banks, M. (2001) *Visual methods in social research*, London: Sage publications.

Banks, P. (2002) *Partnerships under pressure*, London: King's Fund.

Barnes, C. (1991) *Discrimination: A case for anti-discrimination legislation,* London: Hurst.

Barnes, M., Blom, A., Cox, K., Lessof, C. and Walker, A. (2006) *The social exclusion of older People: Evidence from the first wave of the English longitudinal study of ageing (ELSA)*, final report, London: Office of the Deputy Prime Minister.

Barnes, M., Prior, D. (1995), 'Spoilt for choice? How consumerism can disempower public service users', *Public Money and Management*, vol. 15, no 3, pp 53-8.

Barr, N. (2006) 'Pensions: overview of the issues', *Oxford Review of economic policy*, vol 22, no 1, pp 1-14.

Bartlett, H.P. and Phillips, D.R. (2000). 'The United Kingdom: Demographic trends, recent policy developments, and care provisions', in.Bengston, V.L., Kim, K, Myers, G. C., and Eun, K., *Aging in East and West: Families, states and the elderly.* New York: Springer Publishing Company, pp 169-190.

Bartlett, H.P. and Wu, S.C. (2000) 'Ageing and aged care in Taiwan', in D.R. Phillips (ed) *Ageing in the Asia-Pacific region: Issues, policies and future trends*, New York: Routledge, pp 210-22.

Bartlett, W. and Le Grand, J. (1993) 'The theory of quasi markets', in J. Le Grand, and W. Barlett (eds.) *Quasi-markets and social policy*, Baisingstoke: Macmillan, pp 1-23.

Baulcombe, S., Edwards, S., Hostick, T., New, A. and Pugh, H. (2001) Asking the experts: A guide to involving people in shaping health and social care services (www.ccnap.org.uk/InvolvingPeople/theguide.htm).

Bax, E.H. (1990) *Modernization and cleavage in Dutch society*, Aldershot: Avebury Gower.

Bax, E.H. (1995) 'Cleavage in Dutch Society: Changing patterns of social and economic discrimination', Paper presented at the 'Political, Economic and Social Racism' Conferences, Thessaloniki, Macedonia, Greece, 14-18 May 1995.

Bebbington, A.C. (1998) 'Assessing the growth in residential and nursing care: The implications for long-term care insurance', Personal Social Services Research Unit Discussion Paper 1431/2, University of Kent at Canterbury, Canterbury.

Becker, S. and Bryman, A. (eds) (2004) *Understanding research for social policy and practice: Themes, methods and approaches*, Bristol: The Policy Press.

Bengtson, V.L. and Putney, N.M. (2000) 'Who will care for tomorrow's elderly? Consequences of population aging East and West', in V.L. Bengtson, K.-D. Kim, G.C. Myers, K.-S Eun, *Aging in East and West: Families, states, and the elderly*, New York: Springer Publishing Company.

Beresford, P. (2003) It's our lives: A short theory of knowledge, distance and experience, London: Citizen Press.

Beresford, P. (2005) Theory and practice of user involvement in research: making the connection with public policy and practice, in L. Lowes and I. Hulatt (eds) Involving service users in health and social care research, London: Routledge, pp 6-17.

Bond, J. (1999) 'Quality of life for people with dementia: Approaches to the challenge of measurement', *Ageing and Society*, vol 19, pp. 561-579.

Bonoli, G. (2000) *The politics of pension reform: Institutions and policy change in western Europe*, Oxford: Oxford University Press.

Bonoli, G., George, V. and Taylor-Gooby, P. (2000) *European welfare futures: Towards a theory of retrenchment*, Cambridge: Policy Press.

Bowring, F. (2000) 'Social exclusion: Limitations of the debate', *Critical Social Policy*, vol 20, no 3, pp 307-30.

Boyle, G. (2003) 'The promotion of quality of life in long-term acre policy', *ESPAnet Conference Paper*, November 2003.

Boyne, G. A. (1998) 'Competitive tendering in local government: A review of theory and evidence', *Public Administration*, vol 76, no 4, pp 695-712.

Bradbury, H. and Reason, P. (2003) Issues and choice points for improving the quality of action research, in M. Minkler and N. Wallerstein (eds) Community-based participatory research for health, San Francisco, CA: Jossey-Bass.

Bradshaw, J. and Finch, N. (2002) 'A comparison of child benefit packages in 22 countries', Department for Work and Pensions Research Report No.174, Leeds: Corporate Document Services.

BSA (British Sociological Association) (2002) Statement of ethical practice. (http://www.britsoc.co.uk/user_doc/Statement%20of%20Ethical%20Practice.pdf)

BSA (British Sociology Association) Visual Sociology (2006) 'Secondary analysis and official statistics', in Bryman, A., Social research methods (2nd edn), Maidenhead: Open University Press.

Cameron, A. and Lart, R. (2003) 'Factors promoting and obstacles hindering joint working: a systematic review of the research evidence', *Journal of Integrated Care*, vol 11, pp 9–17.

Cameron, C. and Moss, P. (2002) *Mapping of care services and the care workforce*, National Report, United Kingdom: Thomas Coram Research Unit.

Campostrini, S.;Garbin, S.;Piva, P.;Di Santo, P.; Tunzi, F (2004) 'Providing integrated health and social care for older persons in Italy', in K, Leichsenring., A.M. Alaszewski (eds) *Providing integrated health and social care for older persons.* Aldershot: Ashgate; pp 371–414.

Carers National Association (1999) *Welfare to work: Carers and employment project evaluation report*, London, Carers National Association.

Carter, N., Klein, R. and Day, P. (1992) *How organisations measure success: the use of performance indicators in government*, London: Routledge.

Cass, B. (1990), 'Gender and social citizenship', Paper presented at the 'Annual Social Policy Association' Conference, University of Bath.

Castles, F. (1985) *The working class and welfare*, Sydney: Allen & Unwin.

Cattan, M. White, M., Bond, J. and Learmouth, A. (2005), 'Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions', *Ageing and Society*, vol 25, pp 41-67.

CEPD (Council for Economic Planning and Development) (2003a) *Programme of care service industry development: Development and implementation guideline*, Taipei: Ministry of Interior [in Chinese].

CEPD (Council for Economic Planning and Development) (2003b) *The project of care industry development: The implementation resources book*, Taipei: Executive Yuan, [in Chinese].

CEPD (Council for Economic Planning and Development) (2005) *Economic development Taiwan, R.O.C., 2005*, Taipei: Executive Yuan (www.cepd.gov.tw.).

Chaing, T. (1997) 'Taiwan's 1995 health care reform', *Health Policy*, vol 39, pp 225-239 [in Chinese].

Challis, D. (1998) 'Integrating health and social care: Problems, opportunities and possibilities', *Research Policy and Planning*, vol 16, pp 7–12.

Chang, M.C. (1997) 'A longitudinal study on health status and functional capacity of the elderly in Taiwan' in Sun, T.H., Chi, S.L. and Lee, M.L (eds) Population ageing and care of the elderly, Taipei: ROC Population Association, pp 237–62 [in Chinese].

Chaplin, E. (1994) *Sociology and visual representation*, London: Routledge.

Chaplin, E. (2002) 'Photographs in social research: The residents of South London Road', Everyday cultures working papers no2, The Open University.

Cheston, R., Bender, M. and Byatt, S. (2000) 'Involving people who have dementia in the evaluation of services: A review', *Journal of Mental Health*, vol 9, no 5, pp 471-479.

Chiagn, L.Y. (1998) *The welfare and social services for older people*, Taipei: Wu-Nan [in Chinese].

Chiu, S.B. (2004) 'Taiwan: compulsory occupational pension still dominate', Paper presented at 'Pensions in Asia: Incentives, compliance and their role in retirement' Conference, Tokyo, 23-24 February 2004.

CLA (Council of Labour Affairs) (2003) *Domestic employment impact from foreign carers and foreign workers*, Taipei: Council of Labour Affairs [in Chinese].

CLA (Council of Labour Affairs) (2004) *Statistical data of social welfare support yearly report*, Taipei: Executive Yuan [in Chinese].

CLA (Council of Labour Affairs) (2006a), 'Statistic data of foreign carers 2003-2005', Executive Yuan: Taipei (http://statdb.cla.gov.tw/statis/webproxy.aspx?sys=210&kind=21&type=1&funid=q13011&rdm=72r410) [in Chinese].

CLA (Council of Labour Affairs) (2006b), 'Statistical Data of Human Resources Monthly Report', Executive Yuan: Taipei (http://statdb.cla.tw/html/nat/94020.htm) [in Chinese].

Clark, D. and Seymour, J. (1999) *Reflections on palliative care*, Buckingham: Open University Press.

Clarke, J. and Glendinning, C. (2002) 'Partnership and the remaking of welfare governance', in C. Glendinning, M. Powell and K. Rummery (eds) *Partnerships, new Labour and the governance of welfare*, Bristol: Policy Press, pp 33–50.

Clarke, J. and Newman, J. (1997) *The managerial state*, London: Sage.

Clasen, J. and Freeman, R. (eds) (1994) *Social policy in Germany*, London: Harvester Wheatsheaf.

Conradson, D. (2003) 'Geographies of care: spaces, practices, experiences', *Social and Cultural Geography*, vol 4, no 4, pp 451-454.

Coolen, J. and Weekers, S. (1998) 'Long-term care in the Netherlands: Public funding and private provision within a universalistic welfare state', in C. Glendinning (ed) *Rights and realities: Comparing new development in long-term care for older people*, Bristol: The Policy Press, pp 47-66.

Coy, D.R. and Kovacs-Long, J. (2005) 'Maslow and Miller: An exploration of gender and affiliation in the journey to competence', *Journal of Counselling and Development*, vol 83, pp 138-145.

Crabtree, B.F. and W.L. Miller. (1992) *Doing qualitative research*, Newbury Park, CA: Sage.

CSCI (Commission for Social Care Inspection) (2004a) *Leaving Hospital – the price of delays*, London: Commission for Social Care Inspection.

CSCI (Commission for Social Care Inspection) (2005) *Commission for Social Care Inspection: annual report and accounts 2004-5*, London: The Stationery Office.

CSCI (Commission for Social Care Inspection) (2006a) *Time to Care? A Overview of Home Care Services for Older People in England*, London: CSCI (www.cisi.org.org.uk).

CSCI (Commission for Social Care Inspection) (2006b) *Performance Rating for Adults' Social Services in England*, London: CSCI. (www.cisi.org.org.uk)

CSCI (Commission of Social Care Inspection) (2004b) *PSS PAF indicator definitions for 2004-05*, London: CSCI.

Davies, S., Nolan, M.r., Brown, J. and Wilson, F. (1999) Dignity on the ward: Promoting excellence in care, London: Help the aged.

Deeg, D.J.H., Beekman, A.T.F., Kriegsman, D.M.W. and Westendorp-de Serrièrre, M. (eds) (1998) *Autonomy and well-being in the aging population II*, Amsterdam: VU University Press.

Degenholtz. H.B., Kane. R.A., Kane. R.L. and Finch M.D. (1999) 'Long-term care case managers' out-of-home placement decisions. An adaptation of hierarchical logistic regression', *Res Aging*, vol 21. pp 240-274.

Delnoij, D., Klazinga, N. and Glasgow, I.K. (2001) 'Integrated care in an international perspective: proceedings of the workshop of the EUPHA section Health Services reasearch', Paper presented at EUPHA Annual Conference 2001, Brussels 6–8 December.

DETR (Department of the Environment, Transport and the Regions) (1998) *Modernising local government: In touch with the people*, London: The Stationery Office.

Dey, I. (1993) *Qualitative data analysis: A user-friendly guide for social scientists*, London: Routledge.

DH (Department of Health) (1996) *National minimal standard of nursing care home*, Taipei: Executive Yuan [in Chinese].

DH (Department of Health) (1997) *Taiwan health information system*. Taipei: Department of Health of the Executive Yuan (http://www.doh.gov.tw)

DH (Department of Health) (1997a) *The cornerstone of care: inspection of care planning for older people*, CI(97)21, London: department of Health.

DH (Department of Health) (1997b) *The new NHS: Modern dependable*, London: The Stationery Office.

DH (Department of Health) (1997c) *National service frameworks and better services for vulnerable people*, EL (97) 62, CI (97) 24, London: Department of Health.

DH (Department of Health) (1998) *Modernizing social services, promoting independence, improving protection, raising standards, Cm 4169*, London: The Stationery Office. .

DH (Department of Health) (1999) *Mental health national service framework*, London: Department of Health.

DH (Department of Health) (2000) *The NHS Plan: a plan for investment, a plan for reform*, London: The Stationery Office.

DH (Department of Health) (2001a) *Research governance framework for health and social care*, London: Department of Health.

DH (Department of Health) (2001b) *National service framework for older people*, London: Department of Health.

DH (Department of Health) (2001c) *Partnership in action: New opportunities for joint working between Health Social Services: A discussion document*, London: Department of Health.

DH (Department of Health) (2004) *SSI performance assessment 2004: Operating policies*, London: Department of Health.

DH (Department of Health) (2006a) *National health expenditure*, Taipei: Department of Health [in Chinese].

DH (Department of Health) (2006b) Our health, our care, our say, London: The Stationery Office.

DH (Department of Health) (2007) *National health expenditure*, Taipei: Department of Health [in Chinese].

Directorate-General of Budget (1997) *Accounting and Statistics (Taiwan): National Income of Taiwan*, Taipei: Directorate- General of Budget, Accounting and Statistic, Executive Yuan [in Chinese].

Doyal, L. and Gough, I. (1991) *A theory of human need*, Basingstoke: Macmillan.

DSA (Department of Social Affair) (2004) *Home care services guide*, Taipei: DSA [in Chinese].]

DSMI (Department of Statistic Ministry of Interior) (2000) *National survey of the condition among the older people*, Taipei: Ministry of Interior [in Chinese].

Dustmann, C., Fabri, F., Preston, I. and Wadsworth, J. (2003) *Labour market performance of immigrants in the UK labour market*, London: Home Office.

Ebbinghaus, B. and Manow, P. (2001) *Comparing welfare capitalism*, London: Routledge.

Eborall, C. (2003) *The state of the social care workforce in England, Volume 1 of the first annual report of the TOPSS England workforce intelligence unit 2003*, Leeds: TOPPS England.

Eborall, C. and Garmeson, K. (2001) *Desk research on recruitment and retention in social care and social work*, London: Department of Health

Emmison, M. and Smith, P. (2000) *Researching the visual: Images, objects, contexts and interactions in social and cultural inquiry*, London: Sage.

EOC (Equal Opportunity Commission) (2004) *The care workforce*, London: Equal Opportunity Commission.

Esping-Andersen, G. (1990) *The three worlds of welfare*, Cambridge: Polity.

Esping-Andersen, G. (1997), 'Hybrid or unique?: The Japanese welfare state between Europe and America', *Journal of European Social Policy*, vol 7, no 3, pp 179-189.

Esping-Andersen, G. (1999) *Social foundations of postindustrial economies*, Oxford: Oxford University Press.

Esping-Andersen, G., Gallie, D., Hemenjck, A. and Myles, J. (2001) *A new welfare architecture for Europe?* Report submitted to Belgian Presidency of the European Union.

Etzioni, A. (1993) *The spirit of community: Rights, responsibility and the communitarian agenda*, London: Fontana Press.

European Commission (1993) *Older people in Europe: Social and economic policies*, Brussels: European Commission.

European Commission (1994) *European social policy: A way forward for the union*, Brussels: Office for Official Publications of the European Communities.

European Commission (1999) *Social protection for dependency in old age in the 15 EU member states and Norway*, Brussels: European Commission.

European Policy Committee (2001) *Budgetary challenges posed by ageing populations: The impact on public spending on pensions, health and long-term*

care for the elderly and possible indicators of the long-term sustainability of public finances, Executive summary, Brussels: European Policy Committee.

Ex, C., Gorter, K. and Jansen, U. (2004) 'Providing integrated health and social care for older persons in the Netherlands', in K. Leichsenring, A.M. Alaszewski (eds) *Providing integrated health and social care for older persons*, Aldershot: Ashgate, pp 415–54.

Executive Yuan (2000) *The report of condition among older people survey,* Taipei: Statistical Department, Executive Yuan [in Chinese].

Finer, C. J. (2001) *Comparing the social policy experience of Britain and Taiwan*, Aldershot: Ashgate.

Flynn, M. (1986) 'Adults who are mentally handicapped as consumers: Issues and guidelines for interviewing', *Journal of Mental Deficiency Research*, vol 30, pp 369-377.

Flynn, N. (2000) 'Managerialism in the public services: Some international trends', in J. Clarke, S. Gerwitz and E. McLaughlin (eds) *New Managerialism New Welfare?*, London: Sage.

Freeman, R. (2000) *The politics of health in Europe*, Manchester: Manchester UP.

Fuller, R. and Tulle-Winton, E. (1996) 'Specialism, genericism and others: Does it make a difference? A study of social work service to elderly people', *British Journal of Social Work*, vol 26, pp 679-98.

Gibson, M.J., Gregory, S.R. and Pandya, S.M. (2003) *Long-term care in developed nations*, Washington: AARP.

Glendinning, C. (1992) *The costs of informal care: Looking inside the household*, London: HMSO.

Glendinning, C. (1998) 'Health and social care services for frail older people in the UK: Changing responsibilities and new developments', in C, Glendinning (ed) *Rights and Realities: Comparing new developments in long-term care for older people*, Bristol: The Policy Press.

Glendinning, C. (2003) 'Breaking down barriers: integrating health and care services for older people in England'. *Health Policy*, vol 65, pp 139–51.

Glendinning, C. (ed) (1998) *Rights and realities: Comparing new development in long-term care for older people*, Bristol: Policy Press.

Glendinning, C. and McLaughlin, E. (1993) *Paying for care: Lessons form Europe*, London: HMSO.

Glendinning, C. and Millar, J. (1991) 'Poverty: the forgotten Englishwoman', in M. MacLean, D. Groves (eds)*Women's issues in Social Policy*, London: Routledge.

Glendinning, C.(2002) 'Partnerships between health and social services: developing a framework for evaluation'. *Policy and Politics*, vol 30, pp 115–27.

Glendinning, C., Abbott, S. and Coleman, A. (2001) '"Bringing the gap": new relationships between primary care groups and local authorities', *Social Policy and Administration*, vol.35, no.4, pp 411-425.

Glendinning, C., Davies, B., Pickard, L. and Comas-Herrera, A. (2004) *Funding long-term care for older people: Lessons from other countries*, York: Joseph Rowntree Foundation.

Glendinning, C., Schunk, M. and McLaughlin, E. (1997) 'Paying for long-term care domiciliary care: A comparative perspective', *Ageing and Society*, vol 17, pp 123-140.

Godfrey, A. (2000) 'What Impact does Training have on the Care Received by Older People in Residential Homes?', *Social Work Education*, vol 19, no 1, pp 55-65.

Godfrey, M. and Denby, T. (2004) *Depression and older people: Towards securing well-being in later life*, London: Policy Press.

Godfrey, M., Townsend, J. and Denby, T. (2004) *Building a good life for older people in local communities: The experience of ageing in time and place*, York: Joseph Rowntree Foundation.

Goodman, R., White, G. and Kwon H-J. (1998) *The east Asia welfare model: Welfare orientalism and the state*, London: Routledge.

Gordon, D. and Townsend, P. (eds) (2000) *Breadline Europe: the Measurement of Poverty*, Bristol: Policy Press.

Gough, I. (1991) 'The United Kingdom', in A. Pfaller, I. Gough and G. Therborn (eds) *Can the welfare state compete?- a comparative study of five advanced capitalist countries*, London: Macmillan.

Gould, A. (1993) *Capitalist welfare system: A comparison of Japan, Britain and Sweden*, London: Longman.

Government Information Office (2004) *Taiwan Yearbook 2004*, Taipei: Government Information Office.

Gray, B. (1989) *Collaborating: Finding common ground for multiparty problems,* San Francisco: Josey Bass.

Great Britain Parliament (1997) *The new NHS: Modern, dependable.* Cm 3807, London: Stationery Office (http://www.officialdocuments.co.uk/document/doh/newnhs.newnhs.htm).

Grundy, E. (2006) 'Ageing and vulnerable elderly people: European perspectives', *Ageing and Society*, vol 26, pp105-134.

GSCC (General Social Care Council) (2005) *Annual quality assurance report on social work education and training 2004-5*, London: General Social Care Council (www.gscc.org.uk).

Guardian (2002) 'Future workforce will cope with growing elderly', 16 August 2002.

Guse, L. W.and Masesar, M. A. (1999) 'Quality of life and successful aging in long-term care: Perceptions of residents', *Issues in Mental Health Nursing*, vol 20, no 6, pp 527-539.

Hamnett, C. (1995) *Inheritance in Britain: The boom that never happened*, London: PPP Lifetime plc.

Hancock, R. and Wright, F. (1999) 'Older couple and long-term care: the financial implications of one spouse entering private or voluntary residential or nursing home care', *Aging and Society*, no 19, pp 209-237.

Hannelore, J-L B. (1993) 'Family care of dependent older people in the European community', Luxembourg: Office for Official Publications of the European Communities.

Hantrais, L. (1995) 'Comparative research methods', Social Research Update, issues 13, University of Surrey: Department of Sociology.

Harding, E. and Beresfords, P. (1996) *The Standards we expect: what service users and carers want from social services workers*, London: National Institute of Social Workers.

Hardy B, Mur-Veeman I., Steenbergen, M., Wistow, G. (1999) 'Interagency services in England and the Netherlands. A comparative study of integrated care development and delivery'. *Health Policy*, pp 48:87.

Havighurst, R. (1961) 'Successful ageing', *Gerontologist*, vol 1, no 1, pp 8-13.

HCHC (House of Commons Health Committee) (2002) *Delayed discharges, third report session 2001-2*, vol 1, HC 617-1, London: the Stationary Office.

Heckhausen, J. and Schulz, R. (1995) 'A life-span theory of control', *Psychological Review*, vol 102, pp 284-304.

Heikkinen, R. (1995) 'Depressed mood among the elderly in Jyvaskyla: A five year follow-up', *Scandinavian Journal of Social Medicine*, vol 53.

Heineke, D., van der Veen, R. and Kornalijnslijper, N. (2005) *A guide to chain cooperation in the Social Support Act (Wmo): Social support in context*, The Hague: SGBO (Research and Advisory Bureau of the Association of Dutch Municipalities).

Hermalin, A.I. (2002) *The well-being of the elderly in Asia: A four-country comparative study*, Ann Arbor: The University of Michigan Press.

Higgs P., Hyde M., Wiggins, R. and Blane, D. (2003) 'Researching Quality of Life in Early Old Age: the importance of the sociological dimension', *Journal of Social Policy and Administration*, vol 37, no 3. p239-252.

Hirst, M. and Baldwin, S. (1994) *Unequal opportunities: Growing up disabled*, London: HMSO.

Hirst, P. and Thompson, G. (1996) *Globalisation in question*, Cambridge: Polity.

Hochschild, A. (2003) *The Commercialisation of Intimate Life: Notes from Home and Work*, London: Berkley.

Hsieh, K.C. (1997) 'The sociological analysis and prediction of the elderly population quality in Taiwan'., Paper presented at 'Leaping for Joy in the 21 Century-National Conference on the Quality of Life and Social-medical Policies for the Elderly' Taipei, 1-3 July, Taipei [in Chinese].

Hsu, H.C. (2006) .Exploring elderly people's perspectives on successful ageing in Taiwan., *Journal of Ageing and Society*, vol 27, pp 87-102.

Hsu, H.C. and Chang, M.C. (2004) 'Successful ageing and active ageing in Taiwan: A multi-level analysis', *Taiwanese Journal of Social Welfare*. Vol 3, pp 1–36 [In Chinese].

Hu, Y.H. (2005) 'Elderly suicide risk in family contexts: A critique of the Asian family care model', *Journal of Cross-Cultural Gerontology*, vol 10, no 3, pp 199-217.

Huang, S.L., Shieh, J.H. and Siew, W.K. (2003) 'The Welfare Organisation of Older People- The Evaluation of Public Own and Private Run', Ministry of Interior Delegation Research Report, Taipei: Ministry of Interior [in Chinese].

Hudson, B. (1999) 'Dismantling the Berlin Wall: Developments at the health–social care interface', in H. Dean and R. Woods (eds) *Social Policy Review 11,* Luton: Social Policy Association, pp 187–284.

Hugman, R. (1994) *Ageing and the care of older people in Europe*, London: Macmillan.

Huijbers, P. and Knook, D.L. (2001) 'Facts and figures: Biological ageing research in the Netherlands', *Experimental Gerontology*, vol 36, pp 1221-1249.

Huijbers, P. and Martin, A. (1998) *AWBZ: Care insurance in the Netherlands*, Utrecht: Netherlands Institute of Gerontology.

Hulatt, I. and Lowes, L. (2005) Introduction, in L. Lowes and I. Hulatt (eds) Involving service users in health and social care research, London: Routledge.

Hutton, W. (2003) *The world we're in*, London: Abacus.

Huxham, C. (ed) (1996) *Creating collaborative advantage*, London: Sage.

Hyyppä, M.T., Mäki, J., Impivaara, O. and Aromaa, A. (2006) .'Leisure participation predicts survival: A population-based study in Finland., *Health Promotion International*, vol 21, no 1.

Jacobzone, S. (1999) 'Ageing and care for frail elderly persons: An overview of international perspectives', Labour Market and Social Papers No. 38, Paris: OECD.

Jacobzone, S. and Oxley, H. (2002) 'Ageing and health care costs', *International Politics and Society*, vol 1 (http://www.fes.de/ipg/ONLINE2_2002/INDEXE.HTM).

Jamieson, A (ed.) (1991) *Home care for older people in Europe*, Oxford: Oxford University Press.

Jehoel-Gijsbers, G. (2004) *Social exclusion in the Netherlands*, The Haug: Social and Cultural Planning Office of the Netherlands.

Johnson, N. (1987) *The welfare state in transition: The theory and practice of welfare pluralism*, London: Harvester Wheatsheaf.

Jones, C. (1993) 'The Pacific Challenge: Confucian Welfare States', in C. Jones(ed.) *New perspectives on the welfare state in Europe*, London: Routledge.

Jonkers, A. and Troisfontaine, N. (2004) 'Policy instruments in the organisation of long-term care and social support', MA thesis, The Hague: Public Administration, Faculty of Social Science, Rotterdam: Erasmus University.

Jörg, F., Borgers, N., Schrijvers, A.J.P. and Hox, J.J. (2006) *Variation in long-term care needs assessor's willingness to support client's requests for admission to a residential home: A vignette* study, London: Sage publications.

Juan, Y.M.(1999) 'The history and development of long-term care', in Y.M. Juan (ed) *Long-term care,* Taipei County: Taiwan National Open University, pp 15-44.

Kayser-Jones, J. and Koenig, B. A. (1994) 'Ethical issues', in J. F. Gubrium and A. Sankar (eds), Qualitative methods in ageing research, Thousand Oaks: Sage, pp 15-32.

Kendall, L. and Harker, L. (eds) (2002) *From welfare to wellbeing: the future of social care*, London: Institute for Public Policy Research.

Kennett, P. (2001) *Comparative social policy*, Buckingham: Open University Press.

Keogh, F. (1996) *Mental disorders in older Irish people: Incidence, prevalence and treatment*, Dublin: National Council for the Elderly.

Kickert, W.J.M. and Vught, F.A. van (1995) *Public policy and administration sciences in the Netherlands*, London: Prentice Hall.

Kleinman, M. (2002), *A European welfare state? European Union social policy in context*, Basingstoke: Palgrave.

Knapp, M., Hardy, B.Y., Forder, J. (2001) 'Commissioning for quality: ten years of social care markets in England', *Journal of Social Policy*, vol 30, no 2, pp 283-306.

Knijn, T. (2001) 'Care work: innovations in the Netherlands', in M. Daly (ed) *Care work: The quest for security*, Geneva: International Labour Office, pp 159-74.

Knijn, T. (2004) 'Challenges and risks of individualisation in the Netherlands', *Social Policy and Society*, vol 3, no 1, pp 57-65.

Knijn, T. and Kremer, M. (1997) 'Gender and the caring dimension of welfare states: towards inclusive citizenship', *Social Politics*, vol 4, no 3, pp 328-61.

Kofman, E. (2007) 'Gender immigrations, policies and rights in the UK', in K. Clarke, T. Maltby and P, Kennett (eds) *Social policy review 19: Analysis and debate in social policy, 2007*, Bristol: Policy Press.

Korzyk, S. (2004) *Long-term workers in five countries: Issues and options*, Washington: AARP.

Kraan, R.J. et al (1991) *Care for the elderly: Significant innovations in three European countries*, Frankfurt am Main: Campus Verlag, pp 233-237.

Ku, Y.W. (2000) 'The survey of economical situation of older people', *Ho-Sing*, vol 12, [in Chinese].

Ku, Y.W. (2001) 'To be or not to be a Taiwanese welfare state: lessons from recent experience' in C.J. Finer (ed) *Comparing the social policy experience of Britain and Taiwan*, Ashgate: Aldershot.

Ku, Y.W. and Chen, H.H (2001) 'Is it safe enough? The planning of national pension insurance in Taiwan', in C.J. Finer (ed) *Comparing the social policy experience of Britain and Taiwan*, Hants: Ashgate, pp 95-112.

Ku, Y.W., Yuang, Y., Chang, Y.C., Lai, M.S. and Chang, Y.S. (1997) *Economic well-being of Tawainese older people and the needs of social insurance system*, Ministry of Interior research report, Taipei: Ministry of Interior. [in Chinese].

Ku¨mpers, S., van Raak, A., Hardy, B., Mur-Veeman, I. (2002) 'Institutions and culture influencing health policies: different ways to integrated care in England and the Netherlands', *Public Administration*, vol;80, no 2, pp 339-58.

Laing and Buisson (2000) *The home care market 2000*, London: Laing and Buisson Publication.

Langan, M. (1998) *Welfare: Needs, rights and risks*, London: Routledge.

Langarm, T.M. (1994) 'Non-profit organisations in the new institutional environment: does sector matter?', Paper presented at the ISTR Inaugural Conference, PECS, Hungary, July.

Le Bris, J.H. (1993) *Family care of dependent older people in the European Community*, Dublin: European Foundation for the Improvement of Loving and Working Conditions.

Leat, D. (1993) *The development of community care by the independent sector*, London: Policy Studies Institute.

Leathard, A. (ed) (2003) *Interprofesssional collaboration: from policy to practice in health social care*, Hove: Brunner-Routledge.

Lee, S.D.(2002), 'Exploring policy and financing options for long-term care in Taiwan', *Journal of Ageing and Social Policy*, vol 13, no 2-3, pp 203-216.

Leeson, G (2005) *Migration and migrants in the European Union*, London: Age Concern.

Leichsenri, K. (2004) 'Developing integrated health and social care services for older persons in Europe', *International Journal of Integrated Care, vol. 4, pp 1-15.*

Levin, E. and Webb, S. (1997) *Social wok and community care: Changing roles and tasks*, London: National Institute of Social Work.

Levinson, D. and Malone, M. J. (1980) *Towards explaining human culture: A critical review of the findings of worldwide cross-cultural research*, New Haven: Human Relations Area Files Press.

Lewis, J. (2001) What works in community care?, Managing Community Care, vol 9, no 1, pp 3-6.

Lewis, J. (2002) 'Gender and welfare state change', *European Societies*, vol 4, no 4, pp 331-57.

Lewis, L. (1993) *Women and social policies in Europe*, Aldershot: Gower.

Lin, C.H. (2003) *Human right of foreign carers: System of foreign care protection*, Taipei: Council of Labour Affairs [in Chinese].

Lin, M.C. and Harwood, J. (2003) 'Accommodation predictors of grandparent-grandchild relational solidarity in Taiwan', *Journal of Social and Personal Relationship*, vol 20, no 4, pp 537-63.

Lindner, A. and Comolet, E. (2007) *National accounts and economic statistics International trade statistics*, Paris: OECD.

Ling, T. (2000) 'Unpacking partnership: The case of health care', in J. Clarke, S. Gewirtz and E. McLaughlin (eds) *New managerialism new welfare?*, Buckingham: Open University Press, pp 82–101.

Lipsky, M. (1980) *Street Level Bureaucracy*, New York: Russell Sage.

Lister, R. (2003) *Citizenship: Feminist perspectives*, Basingstoke: Macmillan.

Little, M. (2002) 'Improving older people's services: Policy into practice, the second phase of inspections into older people's services', Social Services Inspectorate, London: Department of Health.

Liu, B.F., Huang, S.L. and Liu, A.C. (2000) 'The research of registered and unregistered care homes of older people in Taiwan'., in Z.Y. Cheng, *Long-term care,* 19 *New Taiwan Social Development Academic Series 3*, Taipei: Republic of China Public Welfare Development Association, pp 126-180 [in Chinese].

Lo, J.L., Huang, X.L., Mao, H.F., Tsai, I.R., Lin, H.K., Li, S.D. and Chang, Z.Z. (2002) 'Care provision and resident's perspective of nursing care'., *Journal of Occupational Therapy Association*, vol 20, pp 95-104 [in Chinese].

LTC Association (2003) *Long-Term Care of Older People – a three year plan, Taipei:* LTC Association [in Chinese].

Lui-Whang, L.C. (2001) 'From work-rights' perspective to evaluate management of Taiwanese foreign carers', *Labour Relationship*, vol 19, no 8, pp 496-500 [in Chinese].

Lyonette, C. and Yardley, L. (2003) The influence on carer wellbeing of motivations to care for older people and the relationship with the care recipient, *Ageing & Society*, vol 23, pp 487-506.

Mack, J. and Lansley, S. (1985) *Poor Britain*, London: Allen and Unwin.

Marsh, P., Fisher, M., Mathers, N. and Fish, S. (2005) Developing the evidence base for social work and social care practice, using knowledge in social care report, London: Social Care Institute for Excellence.

Maslow, A. (1943) ' A theory of human motivation', *Psychological Review*, vol 50, no 4, pp 370-396.

Matcha, D.A. (2003) *Health care systems of the developed world: How the United States' system remains an outlier*, Westport, Conn: Praeger.

Matosevic, T., Knapp, M., Kendall, T., Forder, J., Ware, P. and Hardy, B. (2001) 'Domiciliary care providers in the independent sector', PSSRU Discussion Paper 1605.

McFarlane, L., & McLean, J. (2003). Education and training for direct care workers. Social Work Education, 22, (4) 385-399.

Means, R., Morbey, H. and Smith, R. (2002) *From community care to market care? The development of welfare service for older people*, Bristol: The Policy Press.

Medical Research Council (1991) *Personal Information in Medical Research*, London: Medical Research Council.

Merchen, C. (2002) *Generation in action: Young and old work together for a liveable neighbourhood*, Utrecht: Netherlands Institute Care and Welfare [in Dutch].

Miles, M. B. and Huberman, A. M. (1994) *Qualitative data analysis: An expanded sourcebook* (2nd), Thousand Oaks:Sage.

Milne, S. (1997) *Making market work: Contracts, competition and co-operation*, London: ESRC.

Ministry of Health. (1997). *Zorgindicatiebesluit* [White paper]. Staatsblad van het Koninkrijk der Nederlanden 447, The Hague: Author.

Ministry of the Interior (1997) *The personal needs of older people*, Taipei: Ministry of the Interior [in Chinese].

MINVWS (Ministry of Health, Welfare and Sport (2006) *Policy for older persons in the perspective of an ageing population,* The Hague: Ministry of Health, Welfare and Sport.

MINVWS (Ministry of Health, Welfare and Sport) (1999) *Werk in uitvoering. Sociale kwaliteit.programmalijnen welzijnsnota 1999-2002*, The Hague: Ministry of Health, Welfare and Sport [in Dutch].

MINVWS (Ministry of Health, Welfare and Sport) (2003) *What does the government do for older people: Information on government policy on older people*, The Hague: Ministry of Health, Welfare and Sport (http://www.minvws.nl/en/themes/senior_citizens/what_does_the_government_do.asp).

MINVWS (Ministry of Health, Welfare and Sport) (2004a) *The policy regarding the elderly*, The Hague: Ministry of Health, Welfare and Sport (http://www.minvws.nl/images/42209_indr_En_7_tcm20-107854.pdf)

MINVWS (Ministry of Health, Welfare and Sports) (2004b) A way to sustainable system of long-term care and social support, The Hague: Ministry of Health, Welfare and Sport, 23th April 2004 (http://www.minvws.nl/images/wmoengelsetekst0107_tcm20-108164.pdf).

Mishra, R. (1999) *Globalisation and the welfare state*, Cheltenham: Edward Elgar.

Mitchell, W.J. (1992) *The reconfigured eye: Visual truth in the post-photographic era*, Cambridge, MA: MIT Press.

Moffatt, S. and Higgs, P. (2005) 'Charity or entitlement? Generational habitus and the welfare state among older people in North East England', The 7th European Sociological Association Conference, Torun, Poland, Sep 9-12, 2005.

Moss, P. and Cameron, C. (2002) *Care work in Europe: Current understandings and future directions—WP6 care work and the care workforce—Report on stage one and state-of-the-art review*, Thomas Coram Research Unit, Institute of Education, University of London, October.

Mullins, L.C. and McNicholas, N. (1986) 'Loneliness among the elderly: issues and considerations for professionals in aging', *Gerontology and Geriatrics Education*, vol 7, pp 55-65.

Munro, E. (2004) 'Mental health tragedies: Investigating beyond human error', *Journal of Forensic Psychiatry and Psychology*, vol 15, no 3, pp 475-493.

Munro, E. (2005) 'Improving practice: Child protection as a systems problem', *Children and Youth Services Review* 27, no 4, pp 375-391.

Mur-Veeman, I., Hardy, B., Steenbergen, M. and Wistow, G. (2003) 'Development of integrated care in England and the Netherlands: managing across public-private boundaries', *Health Policy*, vol 65, pp 227-41.

National Statistics (2006) *Amendment Social Trends No 36*, London: National Statistics.

Nesti, G.; Motel-Klingebiel, A.;Tesch-Römer, C.; von Kondratowitz, H.J (2003) 'The role of family for quality of life in old age – a comparative perspective', in V.L. Bengtson, A. Ariela Lowenstein (eds) *Global Aging and Challenges to Families,* New York: de Gruyter; pp 323–354.

Netten, A., Bebbington, A., Darton, R., Forder, J. (2001) *Care homes for older people: Volume 1 facilities, residents and costs*, Kent: PSSRU.

Nolan, B. and Whelan, C. T. (1996) .Measuring poverty using income and deprivation indicators: Alternative approaches., *Journal of European Social Policy*, vol 6, pp 225- 240.

Nolan, M.R., Davies, S. and Grant, G. (eds) (2001) Working with older people and their families: Key issues in policy and practice, Buckingham: Open university press.

ODPM (Office of the Deputy Prime Minister) (2006) A sure start to later life: Ending inequalities for older people: A social exclusion unit final report, London: Office of the Deputy Prime Minister.

OECD (Organisation for Economic Co-operation and Development) (1994) *Caring for frail elderly people: New directions in care*, Paris: OECD.

OECD (Organisation for Economic Co-operation and Development) (1997) 'Family, market and community: Equity and efficiency in social policy', Social Policy Studies, no 21, Paris: OECD.

OECD (Organisation for Economic Co-operation and Development) (1999a) 'Ageing and care for frail elderly persons: An overview of international perspectives', Labour Market and Social Policy Occasional Papers no 38, Paris: OECD.

OECD (Organisation for Economic Co-operation and Development) (1999b) *A caring world: The new social policy agenda*, Paris: OECD.

OECD (Organisation for Economic Co-operation and Development) (1999c) *Ageing and Care for Frail Elderly Persons: An Overview of International Perspectives*, Labour Market and Social Policy Occasional Papers No. 38, Paris: OECD.

OECD (Organisation for Economic Co-operation and Development) (2003) 'Policies for an ageing society: Recent measures and areas for further reform', Economic department working papers, no 368, Paris: OECD.

OECD (Organisation for Economic Co-operation and Development) (2004) *Ageing and employment policies: United Kingdom*, Paris: OECD.

OECD (Organisation for Economic Co-operation and Development) (2005a) *Ageing and employment policies: the Netherlands*, Paris: OECD.

OECD (Organisation for Economic Co-operation and Development) (2005b) 'Ensuring quality long-term care for older people', Policy Brief March, OECD Observer.

OECD (Organisation for Economic Co-operation and Development) (2006a) 'An age perspective on Economic well-being and social protection in nine OECD countries', OECD social, employment and migration working paper, no 34, Paris: OECD.

OECD (Organisation for Economic Co-operation and Development) (2006b) *Factbook 2006: Economic, environment and social statistics*, Paris: OECD.

OECD (Organisation for Economic Co-operation and Development) (2007a) *Factbook 2007: Economic, environment and social statistics*, Paris: OECD.

OECD (Organisation for Economic Co-operation and Development) (2007b) *OECD Health at a Glance 2007*, Paris: OECD.

Office of the Deputy Prime Minister. (2006) A Sure Start to Later Life: Ending Inequalities for Older People, A Social Exclusion Unit Final Report, London: Office of the Deputy Prime Minister.

Okma, K.G.H. (2001) 'Health care, health policies and health care reforms in the Netherlands', *International Publication Series, Health, Welfare and Sport*, no 7. (www.minvws.nl/documents/staf/folder/healthcare07.phf.)

Orloff, A. (1993) 'Gender and the social rights of citizenship: state policies and gender relations in comparative approach', *American Sociological Review*, vol 58, no 3, pp 303-28.

Ősterle, A. (2001) *Equality choices and long-term care policies in Europe: Allocating resources and burden in Austria, Italy, the Netherlands and the United Kingdom*, Hampshire: Ashgate.

Parker, G. (1990) *With due care and attention: A review of research on informal care*, London: Family Policy Studies Centre.

Parker, G. (1993) 'Informal care of older people in Great Britain: the 1985 General Household Survey', in J. Twigg (ed) *Informal care in Europe*, York: Social Policy Research Unit, University of York, pp 151-69.

Parker, G. and Clarke, H. (2002) 'Making the ends meet: do carers and disabled people have a common agenda?' *Policy and Politics*, vol 30, no 3, pp 347-359.

Parker, G. and Lawton, D. (1994) *Different types of care, different types of carer: Evidence from the General Household Survey*, London: HMSO.

Parreñas, R. (2005) Long distance intimacy: class, gender and intergenerational relations between mothers and children in Filipino transnational families, *Global Networks*, vol 4, pp 317-336.

Pearson, E. M. (1999) 'Humanism and individualism: Maslow and his critics', *Adult Education Quarterly*, vol 50, no 1, pp 41-56.

Pearson, M. and Martin, J. P. (2005) 'Should we extend the role of private social expenditure?', OECD Social, Employment and Migration Working Papers No. 23, Paris: OECD.

Peck, E., Gulliver, P. and Towell, D. (2002) *Modernising partnerships: An evaluation of Somerset's innovations in the commissioning and organization of mental health services*, London: Institute for Applied Health Social Policy.

Penninx, K. (2002) *A city of all ages*, Utrecht: Netherlands Institute Care and Welfare (in Dutch).

Penninx, K. (2002) *A city of all ages*, Utrecht: Netherlands Institute Care and Welfare [in Dutch].

Percy-Smith, J. (2000) *Policy responses to social exclusion: Towards inclusion?,* PA: Open University Press.

Percy-Smith, J., Sanderson, I. (1992) *Understanding Local Needs*, London: Institute for Public Policy Research.

Philip, I. (2006) *A new ambition for old age: Next steps in implementing the national service framework for older people*, London: Department of Health.

Phillips, D.R. (2000) 'Ageing in the Asia-Pacific region: Issues, policies and future trends', In D.R. Phillips (ed) *Ageing in the Asia-Pacific region: Issues, policies and future trends*, New York: Routledge.

Phillips, L. and Rempusheski, V. (1985) 'A decision-making model for diagnosing and intervening in elder abuse and neglect', *Nursing Research*, vol 34, pp 134-139.

Phillipson, C. and Scharf, T. (2004) *The impact of government policy on social exclusion among older people*, Office of the Deputy Prime Minister: Social Exclusion Unit.

Pickard, L. (2001) 'Care break or carer-blind? Policy for informal carers in the UK', *Social Policy and Administration*, vol 35, no 4, pp 441-458.

Pickard, L. (2004) *The effectiveness and cost effectiveness of support and services to informal carers of older people*, London: Audit Commission.

Pickard, S. and Glendinning, C. (2002) 'Caring for a relative with dementia; the perceptions of carers and CPNs', *Quality in Ageing,* vol 2, no 4, pp 3-11.

Pink, S. (2001) *Doing Visual Ethnography*, London: Sage.

Pink, S. (2007) *Doing visual ethnography: Images, media, and representation in research* (2nd edn), Thousand Oaks, CA: Sage Publications.

Postle, K., Edwards, C., Moon, R., Rumsey, H. and Thomas, T. (2002) 'Continuing professional development after qualification – partnerships, pitfalls and potential', *Social Work Education*, vol 21, no 2, pp 157-169.

Powell, J. L. and Edwards, M. M. (2002) 'Policy narratives of aging: The right way, the third way or the wrong way?' *Electronic Journal of Sociology*.

Powell, M. and Exworthy, M. (2002) 'Partnerships, quasi-networks and social policy', in C. Glendinning, M. Powell and K. Rummery (eds) *Partnerships, new labour and the governance of welfare*, Bristol: Policy Press, pp 15–32.

PSSRU (Personal Social Services Research Unit) (2003) *Home care workers: careers: commitments and motivations*, Kent: Personal Social Services Research Unit.

Qureshi, H. and Henwood, M. (2000) *Older people's definition of quality services*, York: York Publishing Services.

Ramakers, C and Miltenburg, T. (1993) *Budget – en naturacliënten vergeleken. Ecperiment Cliëntgebonden Budget, Verzorging and Verpleging III*, Nijmegen: Institute for Applied Social Sciences (ITS) [in Dutch].

Redfern, S., Hannan, S., Norman, I., Martin, F. (2002) 'Work satisfaction, stress, quality of care and morale of older people in nursing home', *Health & Social Care in the Community*, vol 10, no 6, pp 512-7.

Redfoot, D.I. and Houser, A. N. (2005) *'We shall travel on': quality of care, economic development, and the international migration of long-term care workers*, Washington DC: AARP.

Reid, D., Ryan, T. and Enderby, P. (2001) 'What does it mean to listen to people with dementia', *Disability and Society*, vol 16, no 3, pp 377-392.

Room, G. (1995) *Beyond the threshold: The measurement and analysis of social* indicators: Alternative approaches', *Journal of European Social Policy*, vol 6, pp 225-240.

Room, G. (1998) *Social Exclusion, Solidarity and the Challenge of Globalisation*, Bath Social Policy Papers, No.27, University of Bath.

Room, G. (2000) 'Social exclusion, solidarity and the challenge of globalisation', *International Journal of Social Welfare*, vol 9, no 2, pp 103-119.

Rose, G. (2006) *Visual methodologies: An introduction to the interpretation of visual materials* (2nd edn), London: Sage.

Rose, M. (1997) *Building effective partnerships: Practical guidance for public services on working in partnership*, London: CIPFA.

Rowe, J.W. and Kahn R.L. (1998) *Successful Aging*, New York: Pantheon Books.

Rowe, J.W. and Kahn, R.L. (1987) 'Human ageing: Usual and successful', *Science*, vol 237, pp 143-149.

Rowe, J.W. and Kahn, R.L. (1997a) 'The structure of successful ageing', in J.W. Rowe and R.L. Kahn (eds) *Successful Ageing*, New York: Dell, pp 36–52.

Rowe, J.W. and Kahn, R.L.(1997b) 'Successful ageing', *The Gerontologist*, vol 37, no 4, pp 433-40.

Rowntree, B. S. (1991) *Poverty: A study of town life*, London: Macmillan.

Saltman, R.B., Dubois, H.F.W. and Chawla, M. (2006) The impact of aging on long-term care in Europe and some potential policy responses, *International Journal of Health Services*, vol 36, no 4, pp 719-746.

Samuel, M. (2005) 'Profession becoming less focused on clients and more on paper work', *Community Care*, 15th December 2005.

Sankar, A. and Gubrium, J. (1994) 'Introduction',. in J. Gubrium and A. Sankar (eds) *Qualitative methods in ageing research*, Thousand Oaks: Sage, pp 14.

Schrijvers, A.J.P., Jedeloo, S., Jorg, F. and Hoogerduin, J.G. (2001) *Rio, the youngest child grows in Utrecht*, University medical centre: Julius centre [in Dutch].

Schulte, B. (2002) 'A European definition of poverty: the fight against poverty and social exclusion in the member states of the European Union', in P. Townsend and D. Gordon (eds) *Word poverty: New policies to defeat an old enemy*, Bristol: The Policy Press.

Scottish Executive (2006) *Changing Lives: Report of the Recommendation made by the 21st Century Social Work Review Group for the Future of Social Services in Scotland*, Edinburgh: Scottish Executive.

Secretary of State Department (1989) *Caring for people: Community care in the next decade and beyond*, London: HMSO.

Shai, M. L. (2001) 'The policy and problems of foreign carers', *Employment and Training*, vol 19, no 3, pp 8-13 [in Chinese].

Shaver, S. (1992) *Body rights, social rights and the liberal welfare state*, SPRC Discussion Paper 38, Sydney: University of New South Wales.

Shaw, A. (2001) *What works in post-qualifying education for social workers?*, London: CCETSW.

Shieh, M.E. (1993) The relevant issues around long-term care of older people, Taipei: Gui-Guan [in Chinese].

Shieh, M.E. (2000) 'Adult children as carers: Their experience', *Journal of Sociology National Politic University*, vol 30, pp 43-80. [in Chinese]

Shieh, M.E. (2001) 'Older adult carers', *Community Development*, vol 43, no 3, pp 23-34 [in Chinese].

Shin, D.M. (2000), 'Economic policy and social policy: policy-linkages in an era of globalisation', *International Journal of Social Welfare*, vol 9, pp 17-30.

Silver, H. (1994) 'Social exclusion and social solidarity: three paradigms', *International Labour Review*, vol 133, pp 531-78.

Sluijs, E. M. and Wagner, C. (2003) 'Progress in the implementation of quality control in Dutch health care: 1995-2000', *International Journal for Quality in Health Care*, vol 15, no 3, pp 223-234.

Smith, P. (1995) *Measuring outcome in the public sector*, London: Taylor and Francis.

Sohng, S.S. (1994) 'Are traditional empirical research methods inherently biased against people of colour? Yes', in W. Hudson and P. S. Nurius (eds), *Controversial issues in social work research*, Boston: Allyn and Bacon.

SSI (Social Services Inspectorate) (2002) Commission for Social Care Inspection, London: Social Services Inspectorate. (www.cisi.org.org.uk)

Stahaeli, L.A. and Brown, M. (2003) 'Where has welfare gone? Introductory remarks on the geographies of care and welfare', *Environment and Planning A*, vol 35, pp 771-777.

Stanford-Beale, G. and Macauley, E. (2001) 'Evaluation of correlation between types and level of support to PQ1 candidates and success rate', in CCETSW, *What works in post-qualifying education for social workers?*, London, CCETSW.

Strawbridge, W.J., Cohen, R.D., Shema, S.J., Kaplan, G.A. (1996) 'Successful ageing: Predictors and associated activities', *America Journal of Epidemiology*, vol 144, pp 135-141.

Strawbridge, W.J., Wallhagen, M.I. & Cohen, R.D. (2002) 'Successful aging and well-being: Self rated compared with Rowe and Kahn', *The Gerontologist*, vol 42, pp 727-733.

Swun, D.-S. (1999) 'Taiwanese ageing, family changing and the problem of older people',in S.S. Hu (ed) *Older people and policies*, Taipei: Swun Wun-Wu foundation [in Chinese].

Sykes, J. T. (1995) 'A second opinion', in D. Thursz, C, Nusberg, J. Prather, *Empowering older people: An international approach*, London: Cassell, pp 47-50.

Tagg, J. (1988) *The burden of representation: Essays on photographies and histories*, Basingstoke: Macmillan.

Taylor-Gooby, P. (1991) 'Welfare state regimes and welfare citizenship', *Journal of European Social Policy*, vol. 1, no. 2, pp 93-105.

Tester, S. (1996) *Community care for older people: A comparative perspective*, Basingstoke: Macmillan.

The Royal Commission on Long Term Care (1999) *With Respect of Old Age: Long Term Care- Rights and Responsibilities*, London: The Stationery Office.

Think, P. (ed) (2006) New horizons research programme social exclusion of older people: Future trends and policies, London: Department for Communities and Local Government.

Thursz, D. (1995) 'Introduction', in D, Thursz., C, Nusberg., J, Prather., *Empowering older people: An international approach*, London: Cassell, pp xi-xiv.

Timmermans, J.M. (ed) (2003) *Mantelzorg. Over hulp van en aan mantelzorgers*, The Hague: Social and Cultural Planning Office [in Dutch].

Tomassini C, Glaser K, Wolf D, Broese van Groenou M and Grundy E. (2004) 'Living arrangement among older people: an overview of trends in Europe and the USA', *Population Trends 115*, pp 24-34.

Tout, K. (1995) 'The aging perspective on empowerment' in D. Thursz, C. Nusberg, J. Prather, *Empowering older people: An international approach*, London: Cassell, pp 3-35.

Townsend, P. (1979), *Poverty in the United Kingdom*, London: Penguin.

Townsend, P. and Gordon, D. (2002) *World poverty: New policies to defeat an old enemy*, Bristol: The Policy Press.

Townsend, P. and Gordon, D. (eds) (2002) *World poverty: New policies to defeat an old enemy*, Bristol: Policy Press.

Trudie, K. (1994) 'Fish without bike: revision of the Dutch welfare state and its consequences for the (in)dependence of single mothers', *Social Polities: International Studies in Gender, State and Society*, vol. 1, no. 1, pp 83-105.

Twigg, J. (1997) 'Deconstructing the social bath: help with bathing at home for older and disable people', *Journal of Social Policy*, vol 26, no 2, pp 211-232.

Ungerson, C. (1995) 'Gender, cash and informal care: European perspective and dilemmas', *Journal of Social Policy*, vol 24, no 1, pp 31-52.

Ungerson, C. (1996) 'Qualitative research methods', in L. Hantrais and S. Mangen (eds) *Cross-national research methods in the social sciences*, London: Pinter, pp 63–5.

Ungerson, C. (1997) 'Social politics and commodification of care', *Social Politics*, vol 4, no 3, pp 362-81.

Ungerson, C. (2000) *Care work: Gender, labour and the welfare state*, London: Routledge.

Ungerson, C. (2004) 'Whose empowerment and independence? A cross-national perspective on "cash for care" schemes', *Ageing and Society*, vol 24, pp 189-212.

Ungerson, C. (2005) 'Care, work and feeling', *Sociological Review*, vol 53, no 2, pp 188-203.

Usher, K. and Arthur, D. (1998) 'Process consent: a model for enhancing informed consent in mental health nursing'. *Journal of Advanced Nursing*, vol 27, pp 692-697.

Van de Vijver, F. and Leung, K. (1997) *Methods and data analysis for cross-cultural research*, Thousand Oaks: Sage.

Van der Vleuten C.P.M, Norman G.R. and De Graaff, E. (1991) 'Pitfalls in the pursuit of objectivity: Issues of reliability'. *Medical Education*, vol 25, pp 110-118.

Van Euijk, H. and Kelder, T. (1999) *Netherlands institute of care and welfare*, Utrecht: NIZW International Centre.

Van Ewijk, H., Hens, H. and Lammersen, G. (2001) *Care work in Europe: Current understanding and future directions*, National report, the Netherlands, working paper 4, Surveying demand, supply and use of care, Utrecht: Netherlands Institute of Care and Welfare.

Van Leeuwen, M. (1999) 'The Costs and Benefits of Lifelong Learning: The Case of The Netherlands', Foundation for Economic Research (SEO), University of Amsterdam, the Netherlands, Paper presented at the European Conference on Educational Research, Lahti, Finland, September 22–25.

Van Raak, A.J.A., Jongerius-de Gier, G., Massop, J., Mur-Veeman. I.M. (1993) *Bridge between yesterday and tomorrow*, Evaluation of the Programme of Home Care Innovation Projects of the Ministry of Health, Universiteit Maastricht: Vakgroep BEOZ: Maastricht [in Dutch].

Victor, C.R., Scambler, S.J., Marston, L., Bond, J. and Bowling, A. (2005) 'Older people's experience of loneliness in the UK: Does gender matter?', *Social Policy & Society*, vol 5, no1, pp 27-38.

Visser-Jansen, G. and Knipscheer, C.P.M. (2004), *National background report for the Netherlands*, EUROFAMCARE (http://www.uke.uni-hamburg.de/extern/eurofamcare/documents/nabare_netherlands_rc1_a4.pdf)

von Faber, M., van der Wiel, A.B., van Exel, E., Gussekloo, J., Lagaay, A.m., van Dongen, E., Knook, D.L., vander Geest, S. and Westendorp, G.J. (2001) 'Successful ageing in the oldest old: Who can be characterized as successful aged?', *Archives of International Medicine*, no 161, pp 2694-2700.

Walker, A. (1993) 'Community care policy: from consensus to conflict', in J. Bornat, C. Pereira, D. Pilgrim and F. Williams (eds) Community care: A reader, London: Macmillan, pp 204-26.

Walker, A. and Maltby, T. (1997) *Ageing Europe*, Buckingham: Open University Press.

Walker, A. and Naegele, G. (1999) *The Politics of Old Age in Europe*, Buckingham: Open University Press.

Walker, A. and Walker, C. (1997) *Britain divided*, London: Child Poverty Action Group.

Walker, A. and Wigfield, A. (2003) The social inclusion component of social quality. Amsterdam: EFSQ, pp 1-31.

Walker, A. and Wigfield, A. (2003) *The social inclusion component of social quality*, Amsterdam: EFSQ, pp 1-31.

Walker, A. and Wong, C.K. (2005) *East Asian welfare regimes in transition: From Confucianism to globalisation*, Bristol: Policy Press.

Walters, R., Cattan, M., Speller, V. and Stuckelberger, A. (1999) *Proven strategies to improve older people.s health*, London: Eurolink Age.

Wang, C. and Tseng C.N. (2004) 'The cost impact on ageing Taiwan in health care and long term care', *Journal of Taiwanese Bank*, vol 55, no 1, pp197-225 [in Chinese].

Wang, F.T.Y. (2002) Contesting identity of Taiwanese home-care workers: Worker, daughter, and do-gooder? *Journal of Aging Studies,* vol. 16, pp 37–55.

Wang, G.C. (2001) 'Financing health care for middle-to-low income household in Taiwan', in C. J. Finer (ed) *Comparing the social policy experience of Britain and Taiwan*, Aldershot: Ashgate.

Wanless Review Team (2005) *Social care needs and outcome: A background paper for Wanless social care review*, London: King's found.

Wanless, D. (2006) *Securing good care for older people: Taking a long-term view*, London: Kings Fund.

Ward, H. and Skuse, T. (2001) 'Preferment target and stability of placement for children long looked after away from home', *Children and Society*, vol. 15, pp 1-14.

Ware, T., Matosevic, T., Hardy, B., Knapp, M., Kendall, J. and Forder, J. (2003) 'Commissioning care services for older people in England: the review from care managers, users and carers', *Ageing and Society*, vol 23, pp411-28.

Warren, L. (1990) '"We're home helps because we care": The experiences of home helps caring for elderly people', in P. Abbott and G. Payne (eds) *New directions in the sociology of health*, Falmer: Basingstoke.

Weinberg, A., Williamson, J., Challis, D. and Hughes, J. (2003) 'What do care managers do? – A study of working practice in older people's services', *British Journal of Social Work*, vol 33, pp 901-19.

Wetherly, P. (1996) 'Basic needs and social policies'. *Critical Social Policy*, vol 16, pp 45–65.

Whiteford, P. and Whitehouse, E. (2006) 'Pension challenges and pension reforms in OECD countries', *Oxford Review of Economic Policy*, vol.22, no.1, pp78-94.

Whitehouse, E. (2003) 'The value of pension entitlement: a model of nine OECD countries', OECD Social, Employment and Migration Working Papers No9, Paris: OECD (http://www.oecd.org/dataoecd/10/5/2789965.pdf).

WHO (World Health Organisation) (2000) *Health Systems: Improving Performance*, World health report, Geneva: World Health Organization.

WHO (World Health Organisation) (2002a) *Lessons for long-term care policy*, Geneva: World Health Organisation.

WHO (World Health Organisation) (2002b) *Country case studies in long-term care*, Geneva: World Health Organisation.

WHO (World Health Organisation) (2002c) *Active ageing : A policy framework*, Geneva: World Health Organisation.

WHO (World Health Organisation) (2003) *Key policy Issues in long-term care*, Geneva: World Health Organisation.

Wilensky, H.L., Luebbert, G.M., Hahn, S.R. and Jamieson, A.M. (1987) 'Comparative social policy: Theories, methods, findings', in M. Dierkes, H. Weiler and A. Antal (eds) *Comparative policy research*, London: Gower,

Williamson, V. (2001) 'The potential of project status to support partnerships', in S. Balloch and M. Taylor (eds) *Partnership working policy and practice*, Bristol: Policy Press, pp 117–41.

Wilson, A. and Charlton, K. (1997) *Making partnerships work: A practical guide for the public, private, voluntary and community sectors.* York: Joseph Rowntree Foundation.

Wilson, G. (2000) *Understanding old age: Critical and global perspectives*, London: Sage.

Wistow, G., Knapp, M., Hardy, B., Forder, J., Kendall, J. and Manning, R. (1996) *Social care markets*, Milton Keynes: Open University Press.

Wittenberg, R., Comas-Herrera, A., King, D., Malley, J., Pickard, L. and Darton, R. (2006) 'Future demand for long-term care, 2002 to 2041: Projections of demand for older people in England', RSSRU Discussion Paper 2330, Kent: Personal Social Services Research Unit (RSSRU).

Wright, F. (2003) 'Discrimination against self-funding residents in long-term residential care in England', *Aging and Society*, no 23, pp 603-624.

Wu, S.J. (2003) *Project to establish a long-term care system: evaluation report*, Taipei: Executive Yuan [in Chinese].

Wu, S.J. et al (2001) *Pilot Programme for the development of long- term care system*, Taipei: Ministry of the Interior and Department of Health [in Chinese].

Wu, S.J. et al (2002) *Pilot programme for the development of long-term care system: Second year programme plane*, Taipei: Executive Yuan [in Chinese].

Yang, H.C. and Soon, B.Y. (1998) 'The future of long-term care system for the elderly in Taiwan', *Hospital Association of the Republic of China*, vol 31, no 5, pp 23-32.

Yeates, N. (2001) *Globalisation and social policy*, London: Sage.

Zaidi, A., Makovec, M., Fuchs, M. Lipszyc, B., Lelkes, O., Rummel, M., Marin, B. and de Vos, K. (2006a) 'Poverty of elderly people in EU25', European Commission, VT/2005/034, Austria: European Centre for Social Welfare Policy and Research.

Zaidi, A., Marin, B. and Fuchs, M. (2006b) 'Pension policy in EU25 and its possible impact on elderly poverty', *European Commission* VT/2005/034, Austria: European Centre for Social Welfare Policy and Research.