

Do aboriginal adults struggle to be involved in health and social care services in Taiwan? Perspective of Paiwanese older and disabled people

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Abstract

This paper examines (a) Paiwanese traditional approaches to health and social care, (b) the ways in which current health and social care services in Taiwan impact upon them. The Paiwan is one of the 13 aboriginal tribes in Taiwan. These aborigines have been entirely governed by ‘incomers’ only for around 60-70 years and they struggle to be included in the mainstream system.

Care issues, including health and social care, have emerged for older and disabled aboriginal people, with responses to them complicated by their increased isolation as more and more younger aborigines have moved into the cities since the 1970’s.

This paper reports on evidence about the way services are working, derived from interviews of, and focus group discussions with, aboriginal people themselves and officials concerned about, or responsible for, the delivery of services. This study, for my PhD thesis, uses purposive sampling and snowball sampling to select samples. It also involves the examination of relevant documents.

In sum, Paiwanese older and disabled people are living in society where mainstream services are available but their access is limited by institutional racism which they are not fully aware.

Keywords: Taiwan; aborigines; indigenous; Paiwanese; health and social care; equality; institutional racism; older and disabled people

Taiwan is a democratic country, situated in the western Pacific between temperate Japan to the north, subtropical southern China to the west, and the tropical Philippines to the south. At the end of 2005, Taiwan had a population of 22,770,383 divided between four different ethnic groups, namely Mainlanders, Fukien, Hakka and Aborigines (Wang (F-C), 2002). The first three groups belong to the Han people and they are the majority in Taiwan. Aborigines which make up 2% of the population can be divided into thirteen tribes (Taiwanese Council of Indigenous Peoples (Taiwanese CIP), 2007): namely the Amis, Atayal, Paiwan, Bunon, Puyuma, Rukai, Tsou, Saisiyat, Yami, Truku, Thao, Kavalan and Sakizaya groups.

Where aborigines are concerned there is particular evidence of exclusion and inequality. Table 1 shows that for aborigines in the small aboriginal population: life expectancy is shorter than that of non-aborigines; they have a higher rate of unemployment and lower family income and rates of participation in National Health Insurance; aboriginal students at primary and junior school have a high dropout rate and there are only a few in higher education. These differences reflect other aboriginal social problems, such as housing, family relationships, alcohol abuse, teenage problems, and difficulties faced by disabled and older people.

Table 1 Differences between the Taiwanese population as a whole and the aboriginal population in 2000

Item		Whole population	Aboriginal population
Population		100%	2%
Life expectancy		75.58	67.24
Unemployment rate		5.02%	8.37%
Average family income/month		£1,566	£655
Over 65 years old		8.6%	5.8%
Educational attainment	Elementary school and below	24.7%	36.0%
	College and above	26.0%	6.2%
Rate of participation in National Health Insurance		97%	92%

Source: reorganised from 2002 Statistical Yearbook of Taiwan Indigenous Peoples (Taiwanese CIP, 2003).

Although aboriginal issues have become politically more significant and the Taiwanese CIP has been established, the following tables show statistical evidence of inequality experienced by aborigines in Taiwanese society. Table 2 shows that aboriginal households have a high poverty rate and that the individual poverty level is

also high, particularly for aborigines living in mountain aboriginal townships. Aboriginal life expectancy has improved, as table 3 shows, but there is a big gap between the whole population and aboriginal life expectancy and among the aborigines there is a bigger gap between male and female life expectancy than between men and women in the population as a whole. The life expectancy of the indigenous people in other countries (Canada, Australia, New Zealand and the United States) are remarkably lower than that of the non-indigenous people (see table 4) as case in Taiwan. The United Nations launched the international decade of the worlds' indigenous people in 1995 to address their problems in mainstream society. However, the report published by Health Unlimited and the London School of Hygiene and Tropical Medicine revealed that financial, geographic, and cultural barriers are still limiting indigenous people's access to basic Western health care (Tayal, 2003). In particular, those staff providing the services are insensitive, discriminatory and unfriendly.

Table 2 Poverty rate: comparison between the population as a whole and the aboriginal population in 1999

	Population as a whole	Aboriginal population	
		Mountain aboriginal townships (30)	Plain aboriginal townships (25)
Poverty rate by household	0.89%	Lowest 1.13% Highest 14.48%	Lowest 0.91% Highest 7.8%
Poverty rate by person	0.61%	Lowest 0.66% Highest 12.29%	Lowest 0.73% Highest 3.96%

Source: adapted from Wang (Y-T) (2005)

Table 3 Life expectancy variation between the population as a whole and the aboriginal population

Year	Population as a whole		Aboriginal population	
	Male	Female	Male	Female
1964	64.6	69.1	48.3	52.2
1978-1980	68.7	73.9	58.4	67.7
1984-1986	70.7	75.7	59.3	69.4
1988-1990	71.1	76.5	59.1	68.8
1991-1993	71.7	77.3	59.6	69.9
2001	72.9	78.8	62.7	72.8

Source: adapted from Ge (1998:187)

Table 4 Life expectancy at birth of indigenous and non-indigenous peoples

Country	Years	Life expectancy at birth		Indigenous as a
		Indigenous	Non-indigenous	% of non-indigenous
Canada	1995	71.9	78.3	91.8
Australia	1991-1996	60.4	77.7	77.7
New Zealand	1990-1992	70.5	76.3	92.4
United States	1992-1994	71.1	75.5	94.2

Source: adapted from Kunitz (2007:104)

There is a big difference in the standardized mortality rate between the whole population and aborigines, as shown in table 5, and this confirms the significant life expectancy gap between them. The statistics also show each cause of death for the whole population and how much rate likely aborigines are to die from each of these causes. For accidents and liver cirrhosis, for instance, there is a significant difference between the ranks and rates for the whole population (ranks 4 and 8; rates 51.3 and 23.0) and those for aborigines (ranks 2 and 5; rates 124.9 and 74.5). In general, the former is related to aboriginal transport conditions and vocation, whilst the latter is linked to aboriginal alcohol abuse.

Table 5 Causes of death for the population as a whole and the aboriginal population in 2003

Causes of death	Population as a whole		Aboriginal population	
	Rank	Observed number per 100,000 population	Rank	Observed number per 100,000 population
Cancer	1	156.0	1	174.6
Cerebrovascular diseases	2	55.0	3	94.8
Heart diseases	3	52.2	4	75.3
Accidents	4	51.3	2	124.9
Diabetes	5	44.4	6	53.8
Undefined diseases	6	41.2	7	49.7
Bronchitis, emphysema, asthma	7	23.4	8	45.9
Liver cirrhosis	8	23.0	5	74.5
Pneumonia and **influenza	9	22.6	10	31.9
Nephritis and nephrosis	10	19.1	12	21.5
Digestive system	11	16.7	9	34.6

Source: adapted from Chen (P-L) and Chen (Y-H) (2005)

In addition to aboriginal health problem, one issue that has become more problematic in recent years is the care of aboriginal older and disabled people who are a dependent population and disadvantaged within an already disadvantaged group. They were not able to join the pension system because in their youth most were only able to work in temporary jobs, for example as building workers. This was a result of their poor education, their public stereotype and the market (Lee, 1998). The government has imported foreign labourers since 1989 and this has not only influenced the national labour market but has had a great effect on aboriginal labourers (Huang & Wu, 2002). In aboriginal communities families and the tribal system have, in the past, been responsible for the care of older and disabled people. However, since 1970, more and more young aborigines have moved to urban areas to seek employment and have left behind the older and disabled people to look after themselves. Increasing numbers of aboriginal older people are now living on their own (Lee, 1998). Likewise, their traditional approach to care has been influenced by changes in their social structure brought about by the pressure of modernisation.

Shifting of their social structure is stemmed from different waves of incomers (see table 6). The invaders coveted for aboriginal lands which their original living and action areas to contribute incomers host countries. Meanwhile, aborigines had been seen as savages and they needed to be civilised. Consequently, the invaders treated aboriginal peoples as inferior people and engaged in assimilating them through breaking aboriginal social structure by religions, force power and education. The Dutch, for instance, influenced aboriginal peoples in faith, the Ching Dynasty effected them in drawing limited activity areas, the Japanese broke aboriginal social authority structure and assimilated aborigines into Japanese and the Han people/Taiwanese effected aboriginal traditional politics and abolished their traditional culture(Fujii, 2001; Rulji, 2003; Tung, 2001). Therefore, the status of aboriginal peoples always is inferior to the majority and they have to depend on majority health and social care systems as citizens regardless their ethnicity.

Table 6 The rigimes in Taiwan and their controlled areas

Ruler or Governments	Period	Controlled area
The Dutch and Spain	1642-1661	Southern Taiwan and a part of Taipei Basin
Cheng Cheng-Kung, Ming Loyalist (Chinese)	1661-1683	Southern Taiwan, fortified points in min- and northern Taiwan
Ching Dynasty (Chinese)	1683-1895	Almost all the western plains, and some of the eastern plains
The Japan	1895-1945	Western plain and most of the mountainous

		areas and eastern Taiwan
R.O.C. (Chinese)	1945-	The whole island

Source: adopted from Liou (2005:87)

In western countries, it is mostly black and ethnic minority groups who are treated in such a way, with reactions made worse by the immigration issue. However, aborigines in Taiwan are not immigrants but indigenous people who have been disadvantaged by incoming populations. The inequalities identified in Taiwan are not unique to that country but affect ethnic minorities in almost all developed countries and aboriginal people in particular. Though the historical background is therefore quite different, the outcome has been similar for minorities both in Taiwan and Britain. British National Health System, for instance, which has been indicated people received equality treatment between different ethnic groups and there is not inequality in it (Smaje & Grand, 1997). However, Gould (2004) reveals there has institutional racism and discrimination in NHS and ethnic minorities should get better treatment and this also happens in other systems (Cole, 2004; The Lancet, 1999). In addition, inequalities in NHS utilization were associated with income, ethnicity, employment status and education (Morris, Sutton, & Gravelle, 2005). Ethnic minorities/aborigines have low income, employment and education attainment which limit them to access services. Although the British case could not totally demonstrate indigenous situation, the principle could be applied in Taiwan case.

According to Dixon & Scheurell's (Dixon & Scheurell, 1995) study, the aborigines of the world have similar histories and find themselves in similar situations. Firstly, they have encountered political subjugation. Secondly, they suffered from negligence. Thirdly, governmental social policy has changed from separation, assimilation, and cultural protection to political and cultural rejuvenation. Fourthly, most of the countries have displayed social and legal discrimination toward aboriginal peoples. Fifthly, there is a tendency towards rejuvenation of ethnic culture and social participation. Finally, there are three patterns of social service provision around the world which are as follows:

- A complete absence of differentiation between services for indigenous and non-indigenous people.
- No attempt at integration but simply some specialised programmes for indigenous people.
- Dual systems, where indigenous people have rights as citizens to universal services and can also access specific social services from special

organisations in central government, for example, the Department of Indian and Northern Affairs Canada (INAC).

Health and social care services for ethnic minorities and aborigines in various countries have been particularly affected by racism and racial discrimination. Harris et al. (2006a, 2006b) have argued that racial discrimination and/or racism have contributed to inequalities in ethnic health and that government should engage in tackling racism to eliminate the health inequalities amongst the Māori. A similar situation has been identified in the United States where there is a statistically significant relationship between discrimination and poor physical and mental health (Borrell, Kiefe, Williams, Diez-Roux, & Gordon-Larsen, 2006). In the U.K., racism limits the access older people from ethnic minorities have to services, including health and social care (Blakemore, 2000). Eliminating this problem has become an important issue for developed countries.

In addition to racism and institutional racism, health disparities among ethnic minorities may be exacerbated by their unequal income and social and economic stratification (Davidson, Kitzinger, & Hunt, 2006; Ram, 2005; Rimashevskala & Kislitsyna, 2006). The poverty issue is fundamental to ethnic minority health and socio-economic disadvantages, and racial discrimination affects access to health services (Webb, 2000). Beckfield (2004) indicates that individual poverty is not associated with health disparities (Kunitz, 2007; Mellor & Milyo, 2002), but household income could explain some of the differences in health status (McLeod, Lavis, Mustard, & Stoddart, 2003). Nevertheless, there are health disparities and ethnic minorities are in a disadvantaged position when compared to the mainstream. These considerations can also bar them from access to other services such as social care. Furthermore, indigenous people do not fit well into the systems of mainstream society, which tends to ignore their group characteristics (Holder & Corntassel, 2002). Society should recognise and respect the status of the indigenous groups, rather than viewing and treating them as 'other non-indigenous people.' (Dodson, 1997; Weaver, 1998). Unsurprisingly, multiculturalism has its limitations as Brotman (2003) argues that the language and invisibility of race and racism are limits of multiculturalism in terms of provision of social service to elderly who from ethnic minorities.

Nowadays issues about ethnicity and multiculturalism are the main approaches to understanding and developing ethnic relations policies and these will be applied in this study to understand and examine the situation of the aboriginal peoples in Taiwan.

In addition to ethnicity and multiculturalism, institutional racism may be another factor which needs to be taken into consideration when looking at the aboriginal disadvantaged situation. Multicultural citizenship has also been raised which emphasises collective rights based on distinctive cultures. Figure 1 illustrates the distance between citizenship and multicultural citizenship, adapted from Webb (2000).

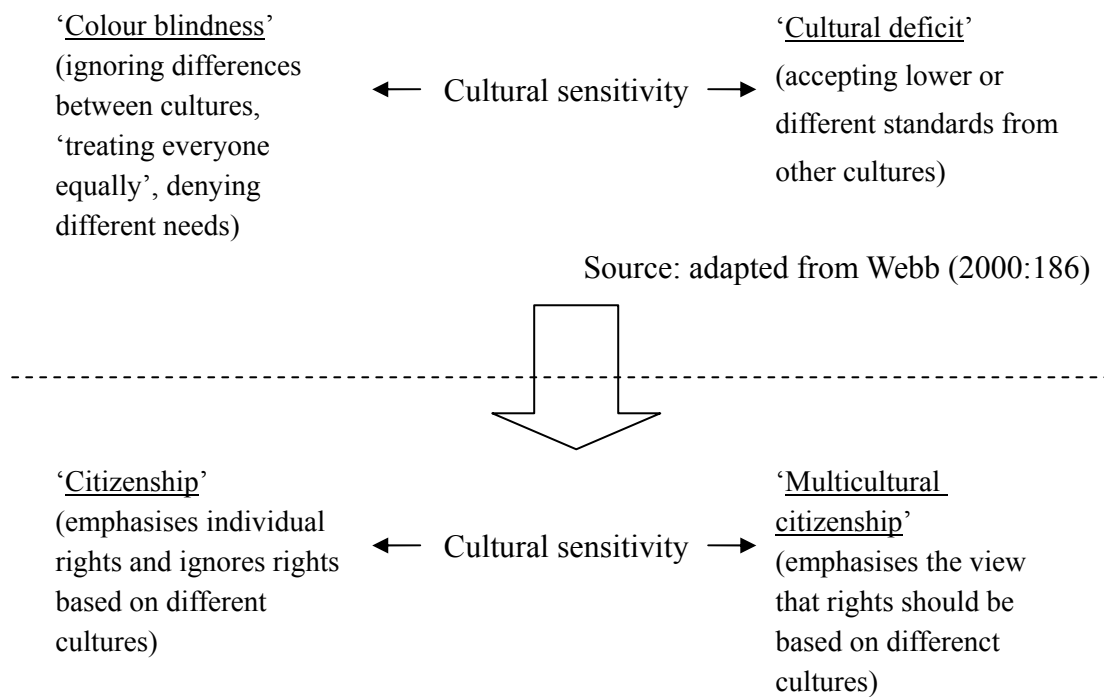


Figure 1 Distance between citizenship and multicultural citizenship

The ideas so far discussed have been included in mainstream systems and policies and, in some ways, this provides ‘insight’ in to the currently disadvantaged situation of older and disabled aboriginal people within the Taiwanese health and social care system.

METHOD

This study employs more qualitative than quantitative research. It is an exploratory piece of work and qualitative research is best used to cope with this (Hakim, 1987). As well as being qualitative, this study has employed an ethnographic approach. Ethnography is concerned with subjective understanding and is often used in

qualitative research (Byrne, 2001; Giddens, 2001). It also focuses on understanding beliefs, motivations and human behaviour, particularly where associated with people who have a distinctive culture (Byrne, 2001; Tedlock, 2000). This approach can help in the realisation of the main aim of the study, to understand Paiwanese experiences of health and social care services in different settings.

In accordance with the aims of the study and the role of the researcher, an auto-ethnographic approach has been adopted. Auto-ethnography is the name given to ethnographic research carried out by a member of the group being studied (Ellis, 2001; Hayano, 2001). It has been employed in education and nursing in which researchers have explored their own culture (Denzin & Lincoln, 2000; Holloway, 1997). Hayano (2001) indicates that the advantages of the auto-ethnographer are knowledge of the native language and feelings of empathy and emotional connection. However, auto-ethnography presents its own limitations and difficulties for the researcher as an 'insider' and raises serious issues about the researcher's objectivity (Hayano, 2001). Two further issues include the 'culture shock' experienced by the researcher and the way in which the researcher affects the environment of his fieldwork.

Participants

The number and type of participants is affected by the purpose of the study and viewpoint of the researcher. In general, these include: Paiwan adults with disabilities and older people those who lived in aboriginal townships at Pingtung County or Kaohsiung City. In all, 32 Paiwanese in-depth interviews, 29 older people (21 were females and 8 were males), and 3 disabled people (all males), were interviewed. The average ages of Paiwanese older and disabled people were 73.2 and 47, respectively.

The Author also conducted three focus groups (two Paiwanese older people and one Paiwanese disabled people). There were 67% of participants were female and the average ages of older and disabled people were 65.8 and 59.7 respectively. Most (58%, N=7) were living with their children but the majority cared for themselves (50%, N=6). The researcher did not originally plan to hold these focus groups. They developed naturally but may have provided a way to collect rich data in a short time; the Paiwanese prefer to sit and chat together than to respond to an interviewer on a one to one basis.

The researcher employed purposive and snowball sampling for selecting suitable informants and used websites and his own resources to find their contact information.

Both email and telephone were used to invite participants because some did not have personal computers. Those with an email address were invited by email, others were contacted by telephone.

Procedure

This study was concerned with how Paiwanese older and disabled people they experience current health and social care services and how they respond to those experiences. Triangulation was used in this research to enhance the credibility of the study as reflexivity (LeCompte & Goetz, 2001). The study employed focus groups, interviews which applied semi-structured in nature and relevant documentation to explore Paiwanese older and disabled people's experience, views on and attitudes to health and social care, and formal and informal care. Triangulation refers to the use of more than one method or source of data so that the findings may be cross-checked (Bryman, 2004; Holloway, 1997). The study planned to use focus groups first to collect broad viewpoints, and then to apply and explore these viewpoints in the interviews. In practice, however, focus groups and interviews had to be held depending on interviewees' and members' availability and these did not run according to plan. The research took some of the ideas and viewpoints from focus groups and interviews into either the next focus group or interview for further examination and discussion. Relevant documentation was also applied to these ideas and viewpoints and, in this way, the researcher was able to cross-check the data and fit together, as in a jigsaw puzzle, a whole picture of the subjects' views.

The researcher used computer software (NVivo 7.0 trial version) to analyse the data, but eventually resorted to analysis by hand because the licence expired on the trial version of the software. The use of NVivo may appear to have been a waste of time, but on the one hand it afforded an opportunity to re-do the open coding and to check the coding achieved by NVivo. At the beginning of data analysis, the author sought out meaningful sentences in the transcriptions and used labels to categorise them (open coding). Afterwards, the researcher connected and identified those similar concepts of categories and sub-categorised them (axial coding). Finally, the author identified and selected two categories, 'Paiwanese cultural perspective' and 'policy, service and problem of health and social care', to involve those sub-categories. These results are presented in the next two parts.

RESULTS

1. *Paiwanese traditional approaches to health and social care and the effects of incomers*

1.1 *The Paiwanese traditional approach to health and social care*

In the past, the Paiwanese used herbal medicine for their health care and were also likely to consult a ‘psychic’ for help. Psychics were usually women believed to have special powers. The people would work together to bring an injured person to the psychic from the deep mountain areas, and would also use the opportunity to find and bring back herbal medicines. Knowledge of herbal medicine is passed from generation to generation. The Paiwanese usually believed that people became sick or injured because they had broken a taboo. They would ask the psychic to find out why the person was sick or injured and what to do to bring about a recovery. At the onset of the illness, everyone would be involved, particularly the chief and the patient’s family. Then, after everything had settled down, the family would take full responsibility for the care of the sick person. This demonstrates the strength of the Paiwanese support system within a close society.

“...those who were injured were treated with herbal medicine” (ipop05; ipop08, rural older person.)

“Because there were no doctors at that time and medicine wasn’t developed, the sick person depended on herbal medicine and sometimes asked for a consultation with a psychic” (ipop06, rural older person).

“...who had been injured in a deep mountain area, everyone would go together, bring him back, and treat him with herbal medicine. Afterwards, their family would ask the psychic to drive the bad luck out of the family” (ipop10, rural older person).

“Basically, we didn’t have medicine, only herbal medicine, so we looked after each other. These medicines we learned about from older people, generation by generation” (ipop21, rural older person).

In accordance with the ‘Vusam’ system in Paiwanese society, the chief and first child of the family have to take responsibility for those who need care. Usually, family members would discuss who could stay at home to provide this, but if, for example,

they all had to work, they might also ask their relatives, friends or neighbours for help.

“It is mainly by their wife or husband, someone who is a family member. We all have to help if someone becomes injured in a deep mountain area, but those who need long term care are coped with by their family” (ipop09, rural older person).

“Here, everyone is looked after by their own family members, there is no older person without care” (ipop10, rural older person).

The chief was also a very important person, in terms of caring, because they had a responsibility to look after their tribal people. - *Why should this be the case?* The chief took charge of all resources, including land, forests, rivers and hunting fields, so could obtain crops and meat from hunters and civilians. The chief had the substance power and resources to look after those who needed care. In this way, the chief was involved and helped with the whole process.

“The chief and aristocrats looked after everyone in the tribe, and this included older people” (F04, focus group with rural older person).

“The chief and aristocrats were the main carers for tribal people. Of course, everyone respected older people. They would be invited to sit and were treated well” (F04, focus group with rural older person).

1.2 The effects of colonisation

1) Disappearance of the chief system

According to the participants' memories, the Paiwanese had a wonderful society structure. However, this has now moved towards something more mainstream. The chief care system, for instance, has already disappeared; but what are the reasons for such a change? Some of the participants indicated this was the result of intermarriage, migration, capitalism and privatisation. Within the tribe, the chief is no longer an important and powerful person, but those who have money and resources. Tribal people traditionally depended on the land and their crops for economic activity but today could not survive without money. The chief was in charge of all resources, including land, forests and rivers and s/he had power over resource allocation. During the Japanese era, however, s/he became a political tool for controlling the tribal people, and this changed the attitudes and views of ordinary people towards them. The chief no longer had substantial power over his or her tribal people. Nevertheless,

participants show they prefer Japanese system because Japanese have similar to Paiwanese chief system and Japanese adopted Paiwanese system rather than just broke it which applied by Taiwanese. The responsibility for care was assumed by the Government and, from the older person's perspective, the President is now seen as chief. People expect the President or Government to care of them as their traditional chief once did.

“The Japanese chief likes the Paiwanese; s/he will not be replaced. This is unlike the Taiwanese President who will be replaced. Japanese or Paiwanese, their children will inherit the chief's or aristocrat's place - even now it is the same. This is not like our Taiwanese chief who will be replaced by someone” (ipop01, rural older person).

2) Changing economic activities and administrative system

In Paiwanese traditional culture, tribal people revered the chief and those who hunted boar or flying squirrel, but now ‘money’ is more important than anything else. In addition, today everyone has to depend on the administrative system for Government resources; in particular Governmental welfare services. Officers, and intellectuals in the tribe, have become more important than the chief and aristocrats because they have knowledge and know how to apply it.

“now we live in a very modern society and our lives are very developed.. We have various foods to eat and everything depends on money. We are older people and we do not have money” (ipop14, rural older person).

2. response and experience of Paiwanese older and disabled people towards current health and social care services

This part is going to explore their experiences and responses with respect to health and social care services, and the relevant strategies and policies in place to deal with them. This is separated into two headings, including health care and social care.

2.1 health care

1) Participants' health options

Health status is affected not only by the individual, but also by their culture. Hence, the Paiwanese definition of health is an important ‘benchmark’. Participants believe

they are healthy as long as they can walk or go to the farm to work. This indicates that their opinions with regard to healthiness depend on their physical status and self-determination. Labouring on the farm is important to them because they believe that if they keep working they will ward off sickness.

“I am healthy if I can still go to the farm to work” (ipop22e, rural older person).

“I am healthy if I can still walk” (ipop23e, rural older person).

“You will not easily become sick if you often go to the farm to work” (ipop24e, rural older person).

2) *The views of participants on the single health care provider*

The public health centre is often the only health care provider in an aboriginal township and without this a tribal person has access to nothing without an inconvenient journey to facilities a long way away (a topic I return to below) .Thus, Paiwanese people who live in tribes have few choices of health care provider. *So where there is only a public health centre, what is the participants’ opinion of the situation?* Their comments indicate that they think the facility is there only to provide vaccinations and condoms. They do not trust the doctors (because of bad experiences) and consider the provision of health care at the centre to be poor.

“I don’t like to go there. That place is just for vaccinating” (ipop24e, rural older person).

“...that place has poor facilities and poor professionals. I went there several times but I didn’t feel better” (ipop22e, rural older person).

“...perhaps the doctors there are paid by the Government, so they are not conscientious about their patients. Besides, they open their own clinics in other places” (ipop23e, rural older person).

3) *The access issue for Paiwanese older and disabled people: the transport and distance problem*

Paiwanese have inevitable faced transport and distance problem, in particular see a doctor. Paiwanese older and disabled people in rural areas might go to the clinic or hospital by themselves, or with relatives. The township public health centre provides ‘regular outreach medicine’ and some of the participants would also visit the doctor in their village. Most of those who live in the city would take the bus because of the availability of convenient transport systems and widely available medical resources.

Hence, in terms of seeing the doctor, rural participants are more likely to be dependent than urban dwellers. This, however, should not be misinterpreted; most participants living with their tribe need someone to help them to get to hospital, but participants in the city may travel alone on the bus; perhaps this is because those in the city do not have the support of other members of the tribe (relatives and neighbours). The allocation of medical resources means that urban Paiwanese can reach health care services much more easily than rural Paiwanese.

“Basically it is my family who take me to hospital, but sometimes it is my relatives who live nearby” (ipop06, rural older person).

“Because I am an older person and my children are not here, if I need to go to hospital, I will go with my relatives. We take a taxi together” (ipop05, rural older person).

“Here, we have regular outreach medicine from the township public health centre every Tuesday and Friday. I always walk there” (ipop03; ipop10, rural older person).

“I can go to hospital by myself. There is a bus stop nearby and it is very convenient” (ikop05, urban older person).

“Because we have national health insurance now, it is easy to go to hospital if I am sick. There are lots of clinics and hospitals here” (ikop01, urban older person).

It is clear that transport and distance are rather large obstacles to seeing a doctor for Paiwanese older and disabled people. The Government and health care providers have devised different mechanisms for coping with this. First is a regular mini-bus which is provided by Pingtung Christian Hospital in Pingtung City. The hospital announces when and where the mini-bus will arrive in the village to pick up patients and advertises a route which passes through different villages and townships. The same bus also takes people back to their villages. However, this also causes tension between the hospital and the township public health centre as the hospital service diverts patients from the centre and, consequently, this may lead to its decline since the quantity of patients can influence the centre’s budget from Government. This tension can have an effect upon the cooperation and support between them in terms of health care for remote people. Secondly is the previously mentioned ‘outreach treatment’ which is provided by the township public health centre. There is only one township public health centre serving several villages which are dispersed throughout the township. This has led to the design of so called ‘outreach treatment’ in every village to provide health care for local people. The third mechanism is ‘subsidised transport’ (provided by the Council of Indigenous Peoples (CIP)) to see a doctor - the doctor of the township public health centre decides when subsidised transport is appropriate;

that is, acts as a ‘gatekeeper’. It provides a subsidy for those who need to see a doctor, the value of which is dependant on distance. The fourth approach is for doctors outside the hospital to provide outpatient services in the evenings or at weekends in aboriginal areas. The budget for this is provided by the CIP. As one participant commented, some doctors are willing to take a family holiday in the aboriginal areas and to provide outpatient services for local people at the weekend.

“There is a mini bus which will take us to hospital and it is provided by Pingtung Christian Hospital. Its route is from Taiwu township, to Laiyi township and then it goes to the hospital. The bus is free but we still have to pay to see a doctor” (ipop18, rural older person).

Having discussed current health policies and services for the aborigines, it is clear that these involve ideas on citizenship and equality. The Government and CIP have recognised the aboriginal disadvantage in the health care system and have introduced services such as ‘subsidised transport’ to see a doctor and ‘subsidy for the National Health Insurance premium’. These policies and services are designed based on ideas of equality and citizenship. However, they cope with problems which can be seen rather than with the errors in the system which are hidden behind the problems. These problems stem from the system, so can be expected to continue.

In addition to these lessons, geographic issue also should be considered in provision of health care and ethnic language, cultural and economic differences are also barriers they to access health care service (LaVela, Smith, Weaver, & Miskevics, 2004; Magilw, Congdon, Martinez, Davis, & Averill, 2000). However, geographic issue has also been examined by Tobias and Searle (2006) in New Zealand and they argue Maori disparities in life expectancy has little contributed by geographic and government should focus on policy directly linked to ethnicity.

2.2 Social care

1) *Shifting the informal care system – self, family members, relatives, neighbours and church family*

The previous part showed the extent to which the chief care system has disappeared, and the *vusam* (or family) care system has been weakened by migration and intermarriage. Increasing numbers of Paiwanese are moving to the city and intermarriage with non-aborigine people is more popular than before. These developments have affected the family care system. Some young adults have chosen

not to move away from their tribes but not to stay with their parents either, choosing instead to build another house for their own family. The older Paiwanese have accepted that this is in keeping with modern society and understand why children need to move out and to leave their parents. They also see that, to bring up their grandchildren, their own children need to make more money than before, and they appreciate why their offspring are unable to give them money or to look after them as they would previously have done.

“I have two daughters but they are both married. They moved away and stayed with their husbands’ families. My daughters are not mine any more” (ipop03, rural older person).

“I have four children, two boys and two girls. My daughters are all married and have left our family. Although my sons are not married yet, they left this family to work and have their own living” (F05, focus group with urban older persons).

“In our tribe, they leave because they have to. They have to move into city for living, family and their children” (F06, focus group with rural disabled person)

“My children do not give me money because they have children to care for” (ipop20, rural older person)

Most participants looked after themselves or were cared for by a partner. A minority were cared for by their children, regardless of whether they lived in rural or urban settings. This mirrors their situation with regard to health care. Care by neighbours or relatives is also gradually disappearing. The Paiwanese no longer visit their neighbours and relatives regularly as they used to, because all are engaged in their own business and in making money.

“In this age, you have to care for yourself, or you and your partner look after each other” (ipop08, rural older person).

“Caring for each other between neighbours is less than before” (ipop05, rural older person).

“Now everyone is always busy with their own business. In the past, if we did not see each other for a long time, people would come here to see us and to chat” (ipop02, rural older person).

The Christian and Catholic churches provide a supplementary service in terms of care. The church is a social centre for many Paiwanese older and disabled people. Regular gatherings enhance emotional support and the church provides both the place and the opportunity for this. The support and care of church friends is not as apparent

amongst tribal Paiwanese as amongst their urban counterparts. This is partially because they can find informal support within the tribe (neighbours and relatives), which they cannot find in the city. Hence, the function of church for urban Paiwanese older and disabled people is highlighted because sometimes church friends will visit and, when necessary, provide care.

“We are not afraid of being lonely if we go to church. Friends in church will come to help you if one of them knows you are in trouble. Our relatives are all living in the tribe and if we have trouble they cannot come to help us quickly. Usually friends in church will come first” (F05, focus group with urban older persons).

2) *Formal care system – home care, meal delivery and living allowance*

Care by the chief has disappeared, and the responsibility for caring has transferred to the family, Government, and people themselves. Paiwanese older and disabled people face more difficult care problems because of their own limited abilities, migration of their children and the unclear role of the Government in caring. Nevertheless, Government care services have recently been provided which are specific to aboriginal older people. As reported by the participants, the ‘senior citizens’ living allowance’ is intended to promote stable economics, and the ‘home care and meal delivery service’ is designed to improve quality of life. Allowances are delivered and managed by the township council, and home care and meal delivery have been contracted out, by the CIP, to non-profit organisations. Unsurprisingly, there is only one home care and meal delivery provider in aboriginal areas of Pingtung County.

Aboriginal and Paiwanese older and disabled people face unstable economic prospects. To alleviate this problem, there is a ‘Senior Citizens’ Welfare Living Allowance Regulation’ for all citizens aged 65 and over, and this includes the aborigines and Paiwanese. Another allowance, the ‘Provisional Regulation for Indigenous Senior Citizens’ Welfare Living Allowance’, is for aborigines aged between 55 and 64. The CIP have taken into consideration the difference in life expectancy between aborigines and non-aborigines, so most aborigines can draw a living allowance earlier than non-aborigines, and this may help to improve the stability of their income. This constitutes positive discrimination in favour of aborigine and Paiwanese older people and is also a step towards equality. However, no distinction is made between aboriginal disabled people and the non-aboriginal disabled population and this, no distinction, could be seen as inequality to aboriginal disabled people because they are already ‘located’ in disadvantaged position if

compare with others and they have been treated as others without consideration of their ethnicity.

3) *Views of the participants on formal care services*

What do Paiwanese older people think about the living allowance?

Most indicate that it is their main income and that it does not cover their bills and living expenses. Sometimes they have to give money (in a red envelope) to relatives or members of their tribe who are getting married and (in a white envelop) to those who need to pay for a funeral. All have the same wish – an increase in the size of the allowance.

“I have no other income source. Now I just depend on the Government allowance” (ikdp02, urban disabled person).

“That allowance I used for meals. Sometimes I have to give money in a white envelope to those families where someone has died and give money in a red envelope to those who are getting married” (ipop18, rural older person).

“Today is different to before, because our children have all moved into the city, and this allowance has become our funding for seeing a doctor” (ipop06, rural older person).

“Of course this is not enough. 3,000 dollars means we can only spend 100 a day. That means we can spend around 30 dollars on every meal. That’s it. We can’t buy anything, or even pay our bills” (F04, focus group with rural older person).

“I just think our allowance money could be more if possible” (ikop03, urban older person).

Although there were complaints about the size of the allowance, the participants still felt it had improved their lifestyles. Economics are important to older people and the allowance represents a stable income which should help them to organize their lives. This amount of money provides them with the ability to improve their quality of life and to choose the services they want. However, the quasi-service market does not exist in aboriginal/Paiwanese areas because there are too few health and social care providers, as previously discussed, and service competition does not exist. They can choose health care services outside those provided, but then have to pay more for transport than other citizens; this could restrict the ways in which they use the living allowance.

“After the Government gave us the senior citizens’ living allowance, our lives

improved. My husband died after he retired, so now I am entitled to more money” (ipop15, rural older person).

Most participants feel positively towards this service as living allowance. They are satisfied with the home care and meal delivery services and are not aware of any other needs. They believe the services are at least better than nothing and, at best, adequate, and hope that they will continue.

“These services are good enough, and I don’t think I have too many other needs. Now we have the elderly allowance, and we also have home care and meal delivery to older people. I expect these services can keep going” (ipop06, rural older person).

“I think these services are enough. I will be satisfied if I can get a meal every day” (ipop09, rural older person).

“What we can ask for? Now we have an allowance, so basically this is enough. We are already committed to this Government. This Government is looking after us now and we are satisfied already” (ipop11, rural older person).

“Of course I love these services, this is better than nothing. Everything is good if I am full” (ipop21, rural older person).

Some indicated that they felt the welfare system was unfair to them and did not make any difference to their lives. Some non-users felt they should be entitled to services, but were not because they were not low-income families. This conflicts with the previous discussion about the adjustments in qualification criteria for home care and meal delivery services. Aboriginal older people should be able to receive service even if they are not low-income families, but, in practice this is not true.

“Right! It depends on whether they commiserate with me, this poor older people. I was not included in the service list. They just care for a few people in our village” (ipop20, rural older person).

“No, because I am not a low-income family and I don’t have a disabled manual. I feel nothing about welfare. There are few services from outside and it is not good enough” (ipop02, rural older person).

4) Influences of formal care services

People have learned to answer questions about their living conditions in such a way that they are sure to meet the criteria which entitle them to services. *Why?* Because they are poor and the whole of mainstream society works in opposition to their

condition. They had no hope until they found they could depend on Governmental services, which helped to slightly reduce their children's care burden. They recognise that, to survive, the situation their children face is far more difficult than when they themselves were young. Institutional racism surrounds the entire mainstream system and exists everywhere. According to 'Senior Citizens' Welfare Act' and 'Physically and Mentally Disabled Citizens Protection Act', some services can not be applied, or only with difficulty, given their aborigines' physical location. These include physical examinations, health care services, home care services, half-price preferences and institutional services. Half-price preferences, for instance, might apply to bus tickets for the elderly. Most tribes do not have access to a bus route so have no opportunity to make use of the concession. Likewise, there are nearly no hospitals or institutions within tribal areas, so they cannot make use of physical examinations or institutional services. There are few organisations providing social service for aborigines, so how can a good quality service be expected? These problems originate from the system rather than from the aborigines themselves. Aborigines and Paiwanese older and disabled people find it difficult to access health and social care, and the social assistance systems. The next generation also struggles to secure employment. This all helps to reinforce the position of the aborigines and Paiwanese as relatively disadvantaged.

“Those who separated their households have done it just for welfare. Like myself, I separated my household from my children, so that I could become a poor family and older person living alone. This is just so that the Government look after us. Our children will still look after us even if we get Governmental welfare. So, this is all about Government welfare everything is just for money...I saw that other older people living alone can get wonderful welfare services, so I learned from them. Although I live alone, my children still care for me and take me to see a doctor if I am sick. Besides, I can reduce their economic and care burden after I get Governmental welfare” (ipop10, rural older person).

Service intervention, such as home care and meal delivery, can harm the relationship between users and non-users within the tribe. As discussed earlier, non-users perceive unfairness in the system, and envy those who benefit. Some of those deemed ineligible to receive services did not understand the criteria and believed their status was no different to that of other service users. They only knew they were not involved and received nothing.

“Right! It depends on whether they commiserate with me, this poor older people. I

was not included in the service list. They just care for a few people in our village” (ipop20, rural older person).

DISCUSSION AND CONCLUSION

In traditional Paiwanese society, a family member was the first line of health and social care, the second line consisted of relatives, friends and neighbours and the last line was the chief of the tribe (Rulji, 2003). As s/he no longer has the power to manage resources, the functions and role of the chief seem to have been replaced by Government, although it is doubtful that the Government can handle this in isolation. Hence, it is clear that the responsibilities for care could be shared by family members, relatives and Government. The shifting of economic activities and the concept of private property are influencing rapid changes in Paiwanese society. These changes affect the traditional care system on the one hand, and introduce new problems and challenges due to involvement with modernized social systems on the other hand. People, therefore, have to adjust and struggle to fit into mainstream society.

It is clear that the current health and social care problems are the results of rapid changes in social structure and that the Paiwanese have to face these disadvantaged conditions in mainstream society (Fujii, 2001; Tung, 2001). Institutional racism is a tool used by the dominant group to maintain their position in society. Based on the reports of the participants, institutional racism, of which they are unaware, embraces the whole of the health and social care systems because aboriginal older and disabled have been excluded in current services as discussed above. Even the Council of Indigenous People within Central Government faces racism as an obstacle within the administration system. They do not have the substance or power to implement an aboriginal health policy because their function is limited when compared to other Central Government Ministries and departments (Chan, 2001; Lee, 2000). Although the Department of Health is working towards a ‘Long-Term Care Policy’ (if it is based on current health and social care systems) for all citizens, how can aborigines and the Paiwanese expect it to help them when the present systems already leaves them at a disadvantage?

The Council is also struggling to make aborigines and Paiwanese people reach for citizenship and equality under disadvantaged conditions. Policies they have introduced to progress their status are the ‘Provisional Regulation for Indigenous Senior Citizens’ Welfare Living Allowance’ and the ‘Home care and meal delivery services for aboriginal older and disabled people’. The Council has also identified

cultural differences and conflicts and has made adjustments to allow for these, although there are still some mis-matches between Paiwanese culture and policy. Their health and social care problems (for example, transport and distance) seem continuous and endless, despite projects and regulations introduced by the Council to cope with them. *Why should this be so?* Part of the reason is that current policies and strategies engage with the symptoms of the problem - such as subsidised transport fees - rather than the causes - the need for an Aboriginal health policy or a White Paper (Tan & Tseng, 2002).

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