

**RESOURCES, RESOURCES AND RESOURCES:
LONG-TERM CARE SERVICE PROVISION OF OLDER PEOPLE IN
ENGLAND, THE NETHERLANDS and TAIWAN**

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Abstract

This paper forms a part of PhD research to examine the diversity of the service provision each country has contributed to the long-term care market pluralism of older people between the East Asia (Taiwan) and West Europe (England and the Netherlands). Consequentially, this paper has based on the views of 115 care actors in the three countries studied. The research found that the pattern in the care market pluralism, socio-economic wellbeing of older people and the service approach has impact on the quality of care provision. Both the Netherlands and Taiwan evidenced mainly not-for-profit care market were likely to stimulate market competition with more creative care services than England. Specific points for future policy and practice are signalled in the concluding notes of this paper.

Key words: service provision, long-term care, market pluralism, older people, England, the Netherlands, Taiwan

Introduction

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 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, 2006). 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.

The above research activities implied there was a growing interest in cross-national learning in the field of care for older people. In particular, attention has been drawn to the issue of resources, including service provision, to achieve quality of care in ageing long-term care, 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 for countries facing similar pressures (i.e. population ageing, funding limitation, shrinking numbers of in/formal carers), their responses were dissimilar. For example, de-institutionalisation 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. Many Northern European countries had reduced their provision of institutional care in contrast with those in Southern Europe. However, it is to be argued that most of the comparative work focused primarily on English speaking or European countries, but there was little in the way of East/West comparison.

This paper, therefore, has included England, the Netherlands and Taiwan seeking to explore the questions of what are the outcomes of the different welfare-mixes in long-term care? 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 resources to gain more understanding of the outcomes of their services? This paper focuses on examining the way each country has contributed to the long-term care of older people. It demonstrates the strengths and weakness of existing care services. Most importantly, it also considers the capacity and quality of the care services which are likely to have an effect on the quality of older people's care.

Background information

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 and different family ethics.

Welfare regimes

These three countries studied roughly represent Esping-Andersen's welfare state regimes. 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 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.

Family ethics

The availability of informal carers is partly affected by cultural attitudes and the availability of statutory support for older people.

Table 1

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 1) can be found in Taiwan. Nevertheless the proportion of older people who live alone has also gradually increased in Taiwan. 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.

An overview of long-term care services

Table 2
Share of population 65 and older received care services in 2003

Country	Care homes ¹	Home-based care	
		Home care ²	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).

Statistically, care homes and home-based care are the two main types of care service provided in all three countries. Table 2 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

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.

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).

Care service for older people and their informal carers

Table 3 shows the types of care services available in the three countries. 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. 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 staffs 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.

Table 3
Provision of care and assistance for older people

Types of care	Domiciliary care ① Personal care ② home nursing ③ Home cleaning and shopping ④ Others	Institutional care ① Residential care ② Nursing care ③ Social and recreational services ④ prevention care	Auxiliary care ① Cooked meal ② Mobility ③ Day care ④ Respite care	Housing for older people: ① Sheltered ② Pensioner ③ others	Support for informal care ① Care allowance paid to carer ② Care allowance paid to older people to cover care costs ③ Care leave ④ Employment of carer
England	Home care: ① ③	Residential home: ① Nursing home: ②	Meals-on-wheels: ① Transport: ② Day centre: ③ Care attendance and sitting services: ④	Sheltered housing: ① Granny annexes: ① Hostel and group living: ①	Invalid Care Allowance: ① Attendance Allowance: ②
The Netherlands	Home care: ① Home nursing: ② Home cleaning: ③	Residential home: ② ③ ④ Nursing home: ① ③ ④ Care hotel: ① ② ③ ④	Meals-on-wheels: ① Transport: ② Service centre: ③	Housing connected with care home: ① Extra care housing ³ :: ① Lifetime housing ⁴ :: ③	Personal care budget: ② Career break for care: ③ Short-term job absent due to family circumstances: ③
Taiwan	Home care: ① ③ ④	Residential care: ① ③ ④ Nursing care: ② ③ ④	Meals-on-wheels: ① Transport: ② Care attendance: ④	State housing: ① Older people apartments: ②	Foreign care support: ④

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.

³ Extra care housing (Woon-zorg-complexe) 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)

⁴ There were 40 of these 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)

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 3, 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.

Welfare mix in long-term care market

As mentioned 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 care 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 substantial 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; Johansson et al, 2008). 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.

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.

Methodology

This paper forms a part of PhD research conducted using the same research design and methodology in each country. For the purpose of the discussion, this paper has focus on the views of the care actors but not the older people (9 in England, 10 in the Netherlands and 9 in Taiwan) from the originate project. To maximise the coverage of each care market, a different types and sectors of long-term care services were selected. Roughly on half of service provider participants provided community care services, a quarter were providing residential care and around a quarter, residential care. Semi-structured – 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. The aim of interviews with relevant care actors was to examine the process of care provision and management quality, to find out their principle concerns.

Face to face interviews were an important way of achieving the aims of this research. Furthermore, cross-national comparison 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.

Samples

Table 4

Characteristics of the sample - service provider interviewees

Care service types	Community care						Institutional care						Total
	Home care			Extra care housing		Foreign live-in care	Residential care homes			Nursing care homes			
Sectors	LA	P	NP	LA	P	P	LA	P	NP	LA	P	NP	
England	1	3	0	1	0	0	1	2	0	0	2	0	10
Netherlands	0	1	1	0	1	0	0	1	1	0	0	2	7
Taiwan	0	0	1	0	0	3	0	1	1	0	1	1	8
Total	1	4	2	1	1	3	1	4	2	0	3	3	25

Note: 'LA' means local authority, 'P' means for-profit and 'NP' means not-for-profit

Table 4 shows the characteristics of the service providers in the three countries were interviewed (10 in England, 7 in the Netherlands and 8 in Taiwan). The interviewees came from different sectors, reflecting the mixed economy of welfare in each country. In addition this study also interviewed formal carers, informal carers, professionals, local administrators, service providers, civil servants and voluntary agency officials. As a result of total of 115 (39 in England, 33 in the Netherlands and 43 in Taiwan) participants' views are included in this paper (see Table 5).

Table 5
Number of participants

Interviewees	Number of interviews			
	England	The Netherlands	Taiwan	Total
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	39	33	43	115

Process

A pilot study was 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. As far as possible I was ensured that the language used was comparable in each country. 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. The imperial work was carried out within comparable time frame between May 2004 and January 2005.

Data bias and research limitation

The original PhD project design was to adopt an organic approach, focussing in depth on a relatively small sample of older people (28) and the relevant actors involve in their care. It was evident that the same number 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. Readers also need to note that this has been a qualitative study, the finding of which need to be verified by more quantitative research. However, 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.

Findings and analysis

Care 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 not-for-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 general care market suggests that not-for-profit organisations are more likely to provide better quality of care but that privatisation will stimulate market competition (Johnson 1987, Hutton 1995). However, in terms of care of older people, in the case of the Netherlands - 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 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, 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 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, 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, Taiwan)

Care service approach

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, 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 homes¹), to provide informal carers with a break from their caring role:

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, England)

The terms “extra care housing” or “housing complexes” were used in England and the Netherlands to describe different services. 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, 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, the Netherlands)

Studies of the Dutch extra care housing arrangements (such as Coolen and Weekers, 1998) suggested that they could substitute, in part, for care home placement, thus

reducing the rate of admission into residential and nursing homes. Coolen and Weekers' research found evidence from the cost efficient perspective, that the cost of these housing schemes was lower than care homes. From a personal perspective, 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, Taiwan)

The types of care provision in the care homes were another concern. The dividing line between nursing homes and residential homes was often not only found *between* single homes but *within* one home (Österle, 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.

As mentioned 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, the Netherlands)

In addition, private care homes in Holland where received the majority part of care cost contribute by the residents with a supplement from the state provided a wide range of care services to meet the residential, nursing and rehabilitation care needs of their clients.

Conclusion

A precise comparison of mixed care systems remains problematic. The comparison of conditions in this paper, nevertheless, has yielded some findings and conclusions concerning resource availability, choice, efficiency and quality of care. This research found the quality of the care could not be simplified as whether institutionalisation or de-institutionalisation is better, or whether for-profit section or not-for-profit is better than the other. Rather, the pattern in the care market pluralism, socio-economic wellbeing of older people and the service approach has impact on the quality of the care market. 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 in Taiwan. 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, 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.

Key points for policy and practice

This paper 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.

- 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 Dutch and Taiwanese 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, the Dutch may have institutional approaches and Taiwan might have personal tactics England can learn from.

- 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.

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Notes

ⁱ 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.