

**Full citizenship or multicultural citizenship approach for aboriginal adults' health and social care in Taiwan: a study of the Paiwan group\***

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**Abstract**

This paper reports on a study of the health and social care of aboriginal adults in Taiwan with a specific focus on the Paiwan group. This is an undeveloped area of research and the researcher is himself Paiwanese. The study aims to explain which approaches are most appropriate for the delivery of health and social care services to a minority group. The context of the study is secondary data which shows the wide range of inequalities experienced by the Paiwan and the lack of available resources. The study then uses an ethnographic approach to understand the Paiwan's experiences and perspectives. Purposive and snowball sampling were used to identify interviews in both a rural village and a major city. Forty seven people were interviewed including 11 policy makers, 4 Paiwanese cultural workers/researchers and 32 Paiwanese older and disabled people. An additional three focus groups provided data from older and disabled Paiwanese people and three more from service providers. Interviews were analysed thematically. The findings confirm that the Paiwan's traditional model of care has come under threat, not only from Japanese and Chinese invaders but also from modernization, western medicine and movement of young people to cities. It is argued that there are on the agenda two approaches to remedying this situation. One involves seeking to ensure that full citizenship rights are achieved for the community, the other the devolution of control over services to the community itself. It will be argued that an appropriate policy needs to combine both of these approaches to secure multicultural citizenship.

*Keyword: multicultural citizenship; aborigine; Paiwan; health and social care*

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## **1. Introduction**

Taiwan is not only a democratic country, but also a developing country. It has a major modern capital, Taipei, with the tallest building in the world – 101, and Kaohsiung has also been developing as a second major metropolis. In 2005, the Taiwanese GDP was USD 15,291, the unemployment rate was relatively low at 4.13% and the labour force participation rate was 57.8%. As in western countries, a high percentage of women (48.12%) were in paid employment. The illiteracy rate was only 2.67% at age 15 and above, and the National Health Insurance participation rate was nearly 99% (Taiwan Directorate-General of Budget Accounting and Statistics, 2005). While these figures support the view that Taiwan is an affluent society moving towards full and equal citizenship, other statistics indicate substantial inequalities. 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.

Aborigines have received poor health and social care because of the under-development of health services and inadequate social service provision. In the remote areas, particularly the mountainous districts, township health centres are the first and often the only available health services. However, there are problems with these centres, including they are not good emergency medical players (Yan, 1997b), centre workers' professional skills and the available equipment are often inadequate (Yan, 1997a), doctors serving in these remote areas have higher patient numbers

(1:2024) than their counterparts in other areas (1:715) (Tan and Tseng, 2002). In addition, medical resources are seriously inadequate (Shi, Wen and Hsu, 2001) and this significantly impacts on aboriginal health status (Lin et al., 2006).

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 <sup>1</sup>	£1,566	£655
Over 65 years old	8.6%	5.8%
Educational attainment	Elementary school and below	24.7%
	College and above	26.0%
Rate of participation in National Health Insurance	97%	92%

Note: 1 exchange rate was around £1 to NT 60 in 2000

Source: reorganised from 2002 Statistical Yearbook of Taiwan Indigenous Peoples (Taiwan Council of Indigenous Peoples, 2003)

Access is another factor which affects aboriginal health problems. Seeking medical services is not easy for aborigines in mountainous districts (Yao, Hsu and Hung, 1995), particularly for elderly aborigines, the disabled and children. Shi, Wen and Hsu (2001) point out that aboriginal health status is worse than that of the public in general because they are disadvantaged in terms of economic and social circumstances (Lin and Huang, 2003) and have poor personal lifestyles (Chang, 2003; Chang, 2004). They also indicate that the government does not have any plans for aboriginal health policy and this is why aboriginal health cannot be improved. Consequently, township public centres implement uniform services under central health policy rather than

design and adjust their affairs for local needs (Lan and Tsai, 1997).

Lee Ming-Cheng (1999) emphasised that current services from mainstream did not reduce the aboriginal social problems and this may be because of errors in the welfare delivery system (Qiu, 2002). Chan (2001) has found four reasons for this. Firstly, the distribution of welfare service resources is disproportionate. The city has rich resources but cannot meet aboriginal needs, whilst resources are insufficient for aborigines in mountainous regions. Secondly, the operation of welfare delivery relies upon network interaction. The third reason is inadequate transverse contact between local organisations or groups. And, finally, the function of aboriginal administrative organisation at different levels of government is indistinct. The role of the Council of Indigenous Peoples (CIP), as Chan (2001) argues, is ‘not leading but co-ordination’ and ‘not execution but planning’ in relation to aboriginal affairs.

There has been very limited research into health and social care issues affecting aboriginal older and disabled people. This study provides an opportunity to explore which approaches, full citizenship and multicultural citizenship, are most appropriate for the delivery of health and social care services to a minority group and to contribute to knowledge in this field. The author, an aborigine of the Paiwan group, lived with his tribe until he graduated from senior high school. His relatives face health and social care problems every day and he recognises the extent to which, for his tribe, this is still an under-represented area of research. For these reasons, and because he is concerned about the inequality aborigines face, he is committed to this investigation.

## **2. Concepts and lessons from other countries**

Currently, 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.

Conflicts between different groups with their own distinct cultures and, in particular, languages, have a long world history. In the past few decades, minorities and majorities within countries and societies have clashed over such issues as language rights, religion, political representation and education (Kymlicka, 1995). These conflicts arise between different groups and the term 'race' has often been used to describe the differences between them. 'Race', as a concept in the English language, emerged around the 16<sup>th</sup> century as a result of imperialism and empire expansion and referred to different types of people with the same ancestors and culture. In the early 18<sup>th</sup> century, it came simply to refer to the human species and the divisions thereof in accordance with their physical characteristics (Law, 1996).

However, race is too simple a way to define groups not just because it has no real biological basis but because it disregards culture. Following the Second World War, there was a shift away from the concept of race towards the recognition of cultural differences (ethnicity). After 1945, migration became an important issue for the UK and European countries, and this led to a new form of racism, not focused on racial hierarchy but on assumed cultural differences between ethnic groups (Alcock, Erskine and May, 2002). The defining features of an ethnic group are cultural rather than

physical, creating a kind of sub-set within a nation-state. Ethnicity has also become a powerful factor for mobilization and movement. This is because members of ethnic groups are usually concerned with similar problems and situations, such as their jobs, education, legal status and welfare (Fenton, 2003) and these usually refer to their primary rights in society.

Citizenship is usually referred to as a social exclusion issue. It has, in other words, been seen as a way to highlight those who are excluded. Therefore, every individual/group has a right and obligation to be a full member of the community or normally the nation-state (Kofman, 1995). The situation of ethnic minorities within a mainstream society can be seen as an indicator of citizenship. However, denial of their full citizenship, particularly in terms of social rights, leaves them disadvantaged and in a weak starting position from which to pass on to the next generation (Hill, 1996, p. 276). At the core of multicultural citizenship are minority rights (Kymlicka, 1995). These involve two important features, as highlighted by Kymlicka and Norman (2000), who argue that: ‘they go beyond the familiar set of common civil and political rights of individual citizenship which are protected in all liberal democracies’; and ‘they are adopted with the intention of recognising and accommodating the distinctive identities and needs of ethnocultural groups.’ Therefore, multicultural citizenship emphasises collective/group rights which have their own distinctive ethnic culture (Hooker, 2005; Russell, 2005; Soutphommasane, 2005).

Multiculturalism implies that the majority group is willing to accept and respect cultural differences (Marden and Mercer, 1998). It emerged in response to the needs of immigrants in the 1970s, because previous policies had failed, and involves four types of rights - civil, political, social and cultural (Castles, 2000). However,

multiculturalism recently has been viewed as a gentle process of assimilation and incorporation (Forrest, Poulsen and Johnston, 2006), although Beckett and Macey (Beckett and Macey, 2001) argue that it has failed because it does not address the limitations of cultural diversity in a liberal democratic society. Lack of public support, and inadequacies and failures of multiculturalist policies with respect to the socio-economic dimension have led to its retreat (Joppke, 2004). Opposition to multiculturalism is also focused on the argument that it may “freeze identity on the basis of difference, rather than focusing upon working for equality on the basis of shared humanity” (Malik quoted in Mayo, 2000, p. 76). What this points out is that multiculturalism may actually encourage the unequal treatment of indigenous peoples by focusing on the diversity within a country. This discussion about ‘positive discrimination’ is complex and continues to be important for many groups, such as women, disabled people, older people and others, as well as for aborigines.

Nowadays issues of ethnicity and multiculturalism are the main approaches to understanding and developing ethnic relations policies (positive discrimination). Multicultural citizenship has also been raised which emphasises collective rights based on distinctive cultures. Figure 1 illustrates the differences between citizenship and multicultural citizenship, adapted and modified from Webb (2000, p. 186).

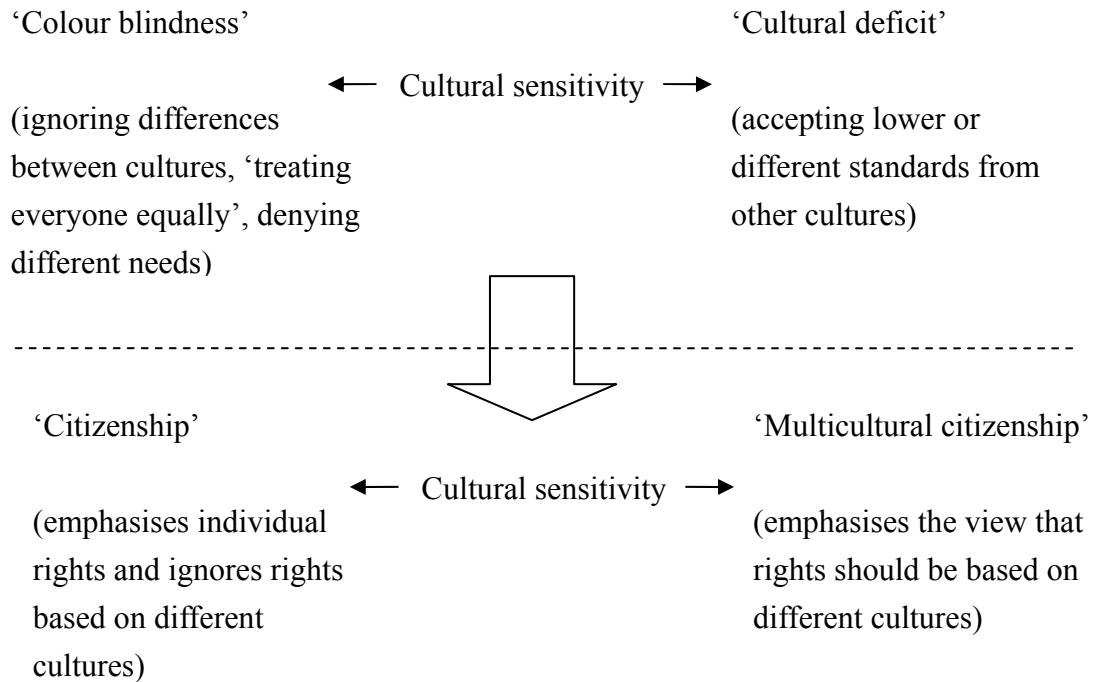


Figure 1 Differences between citizenship and multicultural citizenship

Canada, Australia, New Zealand and the United States have been facing ethnic relations issues for a long time, particularly because indigenous people originally inhabited these countries. In fact, these countries, with the exception of New Zealand, all have a similar, federal regime and very similar systems in terms of social and health care services for aborigines. Aborigines have access to the same services, including social and health care, as citizens in mainstream society. In addition to service provision, these countries have also established specific organisations, such as Indian and Northern Affairs Canada (Canadian INAC), in central government for improving or promoting aboriginal life and reducing their economic, unemployment and education related social problems. They have also established central health organisations within the relevant health departments for promoting aboriginal health. These special organisations are expected to make efforts to cope with aboriginal special needs and problems. Moreover, the New Zealand Te Puni Kōkiri (New

Zealand TPK) is working together with other state sectors to ensure that Māori people have access to adequate services, in line with their entitlement.

In addition to special systems for aborigines, these countries have recently been concerned about aboriginal participation; they have either contracted-out services and delivery to local organisations or have employed aboriginal staff to work within their systems. In New Zealand, Māori people participate in health care services in accordance with the health care reforms of 1991, and traditional indigenous healers have become involved in health care provision (Laing and Pomare, 1994). The involvement of indigenous people in service delivery has been seen as a path to improving the status of aboriginal health (Ellison-Loschmann and Pearce, 2006; Simpson, Hall and Leggett, 2007). In addition, involving culturally and linguistically competent staff in health care delivery can improve ethnic minorities' health outcomes (Magilvy, Congdon, Martinez, Davis and Averill, 2000; Yoku, 2002).

Despite this, aborigines still do not fit in because the tendency is for health and social care systems to be focused on the individual rather than on the group problems which stem from their distinctive collective culture (Holder and Corntassel, 2002). As Bentley (2003) argues, 'cultural factors were found to influence coping in health and illness, and in legitimising access to primary health care'. To combat inequalities 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). Moreover, health disparities among ethnic minorities are exacerbated by their unequal income and social and economic stratification (Ram, 2005; Davidson, Kitzinger and Hunt, 2006; Rimashevskala and Kislitsyna, 2006) and have been particularly affected by racism and racial discrimination (Borrell, Kiefe, Williams,

Diez-Roux and Gordon-Larsen, 2006; Harris et al., 2006b, 2006a).

Clearly, a multicultural citizenship approach might be appropriate where indigenous peoples are also an ethnic minority, because it would be more concerned with collective rights than with those of the individual. Canada, America, New Zealand and Australia have realised that aboriginal problems are based on ethnic discrimination in mainstream society, so have designed specific systems and programmes for positive discrimination for their aborigines as a multicultural citizenship approach. However, the achievement of special systems depends on the extent to which mainstream systems are prepared to cede power to them.

### **3. Method**

The study aims to explain which approaches are most appropriate for the delivery of health and social care services to a minority group. The study then uses an ethnographic approach to understand the Paiwan's experiences and perspectives. Although a qualitative approach is useful for exploring views on and experiences of a subject, it may also be criticised on the grounds of being too subjective, difficult to replicate, subject to problems of generalization and lacking transparency (Bryman, 2004). To deal with these objections it is important for the researcher to make his own processes and reflections as clear as possible and to use a range of research tools to 'triangulate' the methodology and check on the quality and validity of the evidence obtained (LeCompte and Goetz, 2001). The study employed focus groups, interviews and relevant documentation to explore Paiwanese older and disabled people's experience, views on and attitudes to health and social care. Triangulation refers to the use of more than one method or source of data so that the findings may be

cross-checked (Holloway, 1997; Bryman, 2004).

Purposive and snowball sampling were used to identify interviews in both a rural village and a major city. Forty seven people were interviewed including 11 policy makers, 4 Paiwanese cultural workers/researchers and 32 Paiwanese older and disabled people (65.6% (N=21) were female and the average ages of Paiwanese older and disabled people were 73.2 and 47, respectively). An additional three focus groups provided data from older and disabled Paiwanese people and three more from service providers. Interviews were analysed thematically.

The researcher was very aware of the translation problem with this study, because the interviews took place with Paiwanese groups and most of the interviewees were Paiwanese. Some interviewees, particularly older people, might speak in Paiwanese, but the interviews have been written up in Mandarin. The researcher sought help in making accurate translations into Chinese/Mandarin. All data was transcribed and analysed in Chinese/Mandarin first and then recorded in English. Data analysis was based on a thematic analysis approach. The researcher realised that training in the use of NVivo was essential to use it effectively, particularly in Mandarin, but, without this, he still felt confident that his thematic analysis reflected the richness and significance of the interviews.

#### **4. Findings and discussion**

The Paiwanese are one of thirteen aboriginal tribes in Taiwan with their own traditional care approach, including health and social care, based around their chief, psychic and the '*vusam*' system. Like other indigenous peoples in Taiwan, the

Paiwanese experienced different waves of invaders and, since the Japanese colonial period, have lost their autonomy completely. The evidence of aboriginal nomenclature history reflected the way aborigines were seen as savages (inferior people) who needed to be educated/civilised. Their traditional society, including their authority structure and approach to care, was affected and changed by the dominant society, gradually damaging their original life and culture and driving them into a disadvantaged status. These included loss of the land, new authority structures (political/administrative system), religion, economic activities, migration and intermarriage. Nowadays, care services for Paiwanese older and disabled people are not only dependent on the Paiwanese themselves or their family members, but also on government services which are seen as replacements for the chief and psychic systems.

*“The incomers were bad guys. They occupied our lands in mountain areas and they would not give it back to us” (ipop21, rural older people)*

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

*“This is why I mentioned earlier about political transfer. The essence of the chief within the tribe has been replaced by a selected representative system... In other words, the representative system is just another face of the essence of the traditional chief” (icg02, policy maker)*

*“Western religions such as Christianity influenced our Paiwanese culture deeply. They affected our faith and beliefs and replaced the position of the psychics on the one hand; they blamed and criticised our chiefs and aristocracy as bad people on the other hand” (icr03, cultural worker/researcher).*

*“...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).*

*“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).*

Equality policies are often 'colour blind' treating everyone equally without considering that groups such as aborigines have their special needs and problems. The introduction of multiculturalism as an alternative approach to coping with the issues of indigenous peoples and immigrants (black and ethnic minorities) in Western countries acts as a balance to the idea of full citizenship but it is not clear how best to translate this principle into action (Butt, 2007, p. 149). As discussed with reference to health and social services for indigenous peoples in developed countries and in Taiwan, the establishment of special systems for aborigines and introduction of special laws/regulations for aborigines/ethnic minorities can be seen as multiculturalism in practice (Wieviorka, 1998, p. 884), but countries which have introduced multiculturalism are still struggling to improve aboriginal status.

In Taiwan, aborigines as citizens can receive health and social care services from the mainstream system and from the special organisation (see table 5). However, the Taiwan CIP has struggled to improve aboriginal status, partly because it was set up for 'political purposes' rather than just to solve aboriginal problems (Chan, Yang and Huang, 2001; Lin, 2004). According to table 6, with respect to health and social care services for aborigines, there was £6,972,857 (7.30% of total CIP budget) for health care services and £12,731,429 (13.33% of total CIP budget) for social care services (Taiwan Council of Indigenous Peoples, 2007). However, the budget for subsidy the National Health Insurance premium used 95.61% of the health care services budget. This situation also happened in social care services, with 83.99% of the social care services budget spent on allowances for indigenous older people aged between 55 and 64. Consequently, the rest of the budget in terms of health and social care services for aborigines was too small to make much difference to the aboriginal current health and social care situation. Premiums and allowances should be provided by the general

systems, because the need for these arises from the aboriginal disadvantaged status. Ideally, the Taiwan CIP should do more to improve the status of aboriginal health and social care, rather than make up for the weaknesses in the system for aborigines.

Table 5 The health and social care systems for aborigines in Taiwan

Identification	Health care system	Social care system
As general citizens	Services available through the Department of Health e.g. National Health Insurance	Services available through the Ministry of the Interior e.g. Senior citizens' living allowance
As aborigines	Special programmes available through the CIP e.g. Subsidy for National Health Insurance premium	Special programmes available through the CIP e.g. Provisional indigenous senior citizens' living allowance

Table 6 CIP budget for health and social care services for aborigines in 2006

	Department of Health and Welfare services	Percentage of the CIP budget <sup>1</sup>	Main service within the available services and its cost
Health care services	439,289,991	7.30%	Subsidy for National Health Insurance premium. It cost 420,000,021 and accounted for 95.61% of the budget for aboriginal health care services
Social care services	802,080,027	13.33%	Provisional Regulation for Indigenous Senior Citizens' Welfare Living Allowance. It cost 673,657,992 and accounted for 83.99% of the budget for aboriginal social care services

Notes: 1 Total CIP budget was £95,517,746. One hundred and sixty-six people worked at the CIP in 2006. Staff costs were £2,743,540, nearly 3% of the CIP budget.

Source: adapted from the Council of Indigenous Peoples (2007)

The interviewees showed that, in their opinion, the Taiwan CIP is weak as currently constituted and has very limited authority within mainstream systems. In other words, the majority is not willing to give up its dominant position and treat aboriginal problems seriously. The extent to which greater efficiency can be achieved by mainstream services for aborigines on the one hand, and improvements in aboriginal status can be achieved by the special system on the other hand, will depend very much on the mainstream system's willingness to cede power to the special system and develop a real partnership between them, as is the case with the TPK in New Zealand.

*"I wished this allowance act could have an attachment article for aboriginal older people that adjusted the qualifying age of aboriginal older people to 55 years, to reflect their low life expectancy. But this suggestion was rejected by them...Consequently, the CIP made our own special living allowance for aboriginal senior citizens who are aged between 55 and 64 because of the failure to co-ordinate" (icg04, policy maker).*

*"The common consensus between ministries and departments is that there is no maturity and not a good enough understanding of one another. Hence, there is a gap in implementation; even our people do not feel the effect of the services." (icg05, policy maker)*

Aboriginal dual identity is a reflection of the two sets of systems available to aboriginal people in Taiwan and this would appear to be the perfect approach in terms of health and social care services. However, discussions about the CIP throughout this study have shown that there is an unclear division of responsibilities between the mainstream system and the special agencies. In other words, aboriginal affairs have been put in an 'ambiguous' position and neither the mainstream nor special system totally takes charge of aboriginal issues because each is responsible for only one side of the dual identity. An appropriate way to deal with this might be for the special

system to take complete responsibility for aboriginal issues and for the mainstream system to completely support and co-operate with the special system.

*“Because we are not self-governed yet, there are a lot of resources controlled by mainstream systems, rather than by us” (icg05, policy maker)*

Full citizenship is the main approach adopted in developed countries with respect to aboriginal issues, on the basis that each individual has equal value and should receive a standard level of service wherever possible. Taking account of minority rights, multicultural citizenship has emerged as a possible alternative to this, because aboriginal peoples have their own distinctive culture that differs from the majority and this should be recognised as part of the policy planning process. The interview data summarised in figure 2 shows the respondents’ perspectives on citizenship and multicultural citizenship in terms of health and social care services. Developments in health care services for aborigines, for instance, have focused on ways to improve national health services (National Health Insurance). Policy makers’ efforts are rooted in the concept of citizenship and the belief that aborigines should receive the same levels of service wherever they live. Health care providers, however, recognise that the Paiwanese people are a discrete group which shares the same culture and health problems. They would like to be given the authority and resources to provide appropriate health care services to meet local people’s health needs. Therefore, there is a mixed position in terms of health care services. This is what particularly makes it important to combine a full citizenship approach with greater efforts by NHI to ensure the services are not affected by institutional racism and deliver services with cultural sensitivity.

*“If one day we have aboriginal self-government, then we could make our own plans based on local people’s needs and problems. We should go this way if we are in a*

*self-government system one day” (iph01, health care provider).*

Interestingly, while the general perspective of respondents in terms of health care favours full citizenship, with respect to social care, multicultural citizenship is the preferred option. Though Paiwanese older and disabled people focussed on their individual rights in terms of both health and social care services, health and social care service providers, given their experience of current systems, were in favour of multicultural citizenship because current services are inappropriate for the Paiwanese culture and do not address Paiwanese special needs and problems.

*“It depends on whether they take pity on me - a poor old person. I was not included in the service list. They just care for a few people in our village” (ipop20, rural older person)*

*“...We had our own standards for who should be cared for and what kinds of care they should receive. These would all be determined by the tribe” (icg03, policy maker)*

*The council could just play a negotiation role at central government in the near future. Of course it will be different if the government introduces self-government for aboriginal people” (icg05, policy maker)*

As the below figure indicates, in terms of health care the interviewees tended towards the concept of full citizenship because National Health Insurance is well established for all citizens, but with respect to social care, their preference was for multicultural citizenship as the aboriginal people would like to manage and deliver it themselves, based on their cultural perspectives. It is possible, therefore, that both concepts of full citizenship and multicultural citizenship could be applied in health and social care, rather than employing only one of them to cover all aboriginal issues.

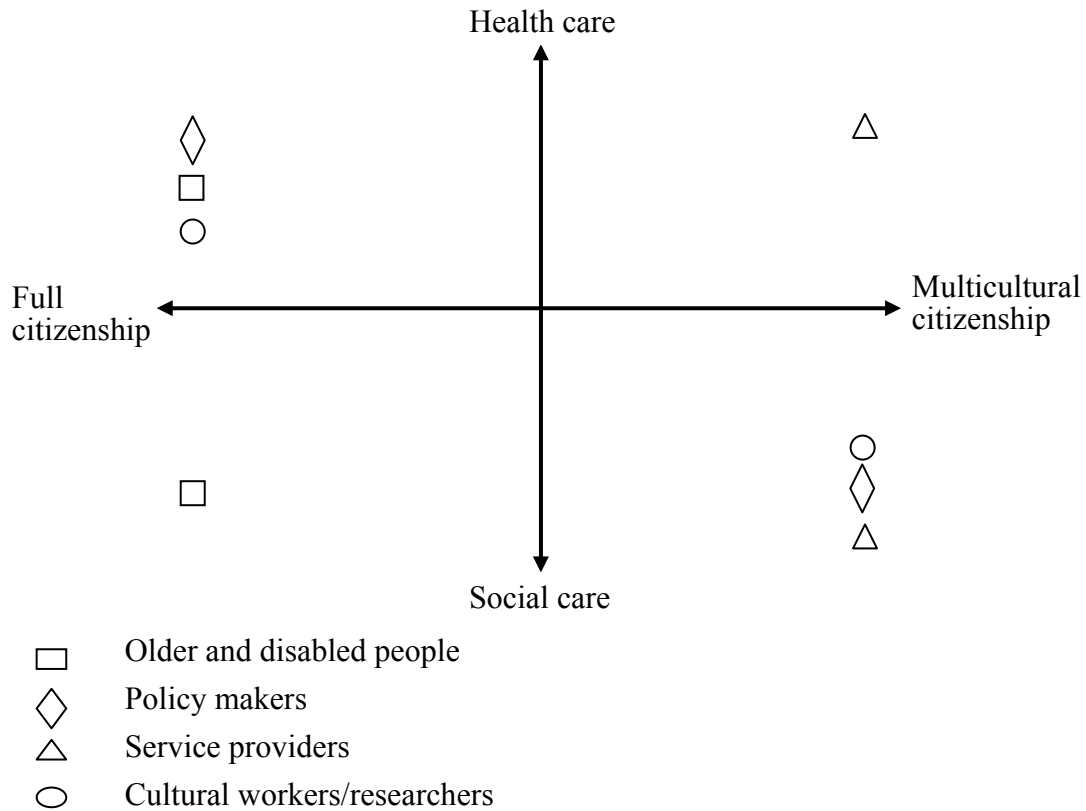


Figure 2 The perspective of respondents on citizenship and multicultural citizenship in terms of health and social care services

This idea of self-government provides aborigines with ‘space’ to make appropriate health and social policy and to deliver services for their people. It might be viewed as an extreme application of multicultural citizenship. As the interviewees in this study suggested, this is an alternative approach which might improve the health and social care status of aboriginal older and disabled people. However, the self-government/self-determination approach has a long way to go and the population of aboriginal peoples in Taiwan is too small to have substantial political influence. In Canada, several issues have still to be resolved. The relationship between aboriginal governments and the other governments (including local governments) of Canada, for instance, is less precise, in particular the extent of sovereignties between them (Isaac, 1994). Moreover, Belanger and Newhouse (2004) suggest that self-government is still

looking for appropriate support from both federal government and people in the community. In Australia, aboriginal self-determination has recently been abolished and its structure dismantled (Anderson, 2007). Therefore, the self-management approach could be a 'lower key' approach, if compared with self-government/self-determination, to manage health and social care resources and for aboriginal people to deliver appropriate services to themselves. Here, the aboriginal community, rather than the individual, is the base for running a self-management approach. Taking the current administrative system into account, the township office would be the self-management base and would manage the resources for local people from either the mainstream or special agencies. They would set appropriate criteria for service entitlement and its content based on cultural perspectives. However, the participation of local people would be the key issue for success in this approach (Ratima et al., 1999). Hence, a committee within the township office, composed of local people of different classes, should represent the opinions of the people. This thinking does, however, require further research to determine whether it is appropriate in a Taiwanese setting as it is currently under-developed.

## **5. conclusion**

The fact that aborigines hold two different identities, as full citizens and also as members of a special ethnic group implies that there are alternative solutions to their problems: strengthening their claims as citizens or providing separate services that are directly orientated to their needs. Hence, the argument for strengthening citizenship implies that the NHI should not only put more effort into a fairer allocation of health care resources, but also take into account the significant geographic and economic

issues.

Even with a fairer allocation of resources, however, the universalist approach of National Health Insurance scheme does not address institutional racism. This partially explains why Paiwanese health care providers have stated their preference for self-government (as in a multicultural citizenship approach) to manage and deliver health care services for rural aborigines. What is important is that this should be achieved without damaging the basic principle of entitlement based on citizenship. Turning to social care services however, the need for services to be personalised supports the belief that self-government can 'exclude' the influences of institutional racism and provide appropriate services for aboriginal people. However, self-government is a long term goal and difficult to achieve in practice. In the medium term one strategy might be to focus on training more aboriginal staff and encouraging them financially to remain working in the mountain areas. Therefore, making appropriate policy for aboriginal health and social care services needs to combine both of these approaches to secure multicultural citizenship.

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