

Social Welfare Transformation and Community Governance Model for the Aging Generation: Rural Community Care in Chiayi County as a Case Study*

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Over the past two decades, Taiwan's welfare policies for the elderly have prepared for the arrival of an aged society with the aim of facilitating aging in place (AIP). The Long-Term Care Services Act passed by the Legislative Yuan in 2015 set regulations for long-term care personnel, thereby improving the welfare system for the elderly. The government's AIP policies focus on providing welfare institutions or service units and do not sufficiently explore key factors such as the relationship between care services and community governance models. Since the basic focus of elderly welfare policies is AIP, it is important to actively empower grassroots community organizations and consider the elderly as important subjects of community participation. AIP policies emphasize providing long-term care and nurturing the elderly until death; such policies will be more proactive and innovative if coproduction is incorporated. This study briefly discusses theories related to coproduction using the case study of Chiayi County's Dingcaiyian Community Development Association, which links six communities in remote rural villages and establishes a community care network based on the coproduction concept. Follow-up issues related to community care are considered and potential practices and ideas to guide social welfare transformation and community governance in the future are discussed.

Keywords: aging in place, coproduction, social welfare, community governance, community care

Foreword

As the aging of a country accelerates, various social issues inevitably emerge. These include the reduction of the labor force, an increasing burden to provide support, changing family structures and care, long-term care, and social insurance. The issue of care provision for the elderly is especially pertinent and cannot be ignored. Aging is a multi-faceted process; it does not only involve health and social welfare issues. On the one hand, there must be a rapid response to urgent needs for long-term care; on the other hand, it is necessary to consider ways to develop a stable and friendly community care environment in the future.

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In 2002, the United Nations (UN) made a call for all countries to prioritize aging policies in their respective action plans and compiled details on the aging process from around the world (UN, 2002). The aims were to develop perspectives from broader life processes and examine the aging issue from a wider social perspective. At the same time, it aimed to carefully review related policies on aging to ensure that the elderly in all regions can enjoy their later years securely and with dignity, continue to participate in society, and enjoy the rights to which all citizens are entitled. Considering these aims, the UN proposed three priorities: (i) development for an aging world; (ii) advancing health and well-being into old age; and (iii) ensuring enabling and supportive environments. These directions serve to guide policies on successful adaptation to elderly life to make aging a positive experience and allow the elderly to live long lives with opportunities to maintain their health, participate in society, and be secure.

The World Health Organization (WHO) proposed the concept of active aging in 2002, which involves optimizing processes related to the health, participation, and security of the elderly, thus improving the quality of their lives (WHO, 2002). This immediately became an important concept for all countries to consider when formulating their elderly health policies for the future. The WHO also defined the meaning of health, which refers to a healthy state that balances three aspects of life: physical, mental, and social life. In terms of the length and quality of a person's life, positive and negative aspects are mostly related to the dimension of living as part of a community.

Considering that the issues associated with the social trends of aging and declining birth rates are complicated, this study adopted a different approach from related past research by attempting to further discuss the concept of community co-aging through a case study: a community care and mutual help living area (CMLA) that was jointly formed and promoted by six communities in remote rural villages of Chiayi County. The intention was to use the case study to highlight the current predicament associated with community care in Taiwan's rural villages and to consider potential practices and ideas to guide social welfare transformation and community governance through the coproduction concept.

History and Evolution of Community Care

The need for long-term care to cater to an aging demographic structure becomes more pressing day by day. Observations of the trends and developments of policy reform on long-term care in various developed countries over the past two decades have revealed a shift towards deinstitutionalization in long-term care services. In other words, the pure institutional placement model is being replaced by the community care model.

Origins of Elderly Daycare

The concept of elderly daycare has always been strongly related to day hospitals for the elderly. In 1958, the United Kingdom (UK) established elderly daycare centers focusing on nursing and occupational therapy. These day hospitals were positioned as an extension of the emergency healthcare system with the aim of shortening the length of patients' hospital stays. These subsequently evolved into adult daycare, which refers specifically to a social service system based on community care. Daycare was still a relatively innovative and rare service in the early 1970s. It was a generic term at that time, without clear distinctions between the health and social service dimensions. It was only in 1976-1986 that there was bifurcation into the health versus social developmental directions, with the respective directions becoming the initial foci of program design.

In the United States (US), the term adult daycare encompasses both the healthcare and social models under the health and social administrations, respectively. Although the elderly daycare system in Taiwan is not

exactly similar to that of other countries, it is generally more aligned with the usage and significance in the US.

Development of Long-Term Care Institutions

Many elderly veterans (also known as “honored citizens”) lived in the vicinity of Taipei City’s Shilin and Beitou Districts in the 1980s. For the elderly of this group who were single or whose family members were unable to provide personal care, patient attendants (i.e., nurses) from the Taipei Veterans General Hospital, Cheng Hsin General Hospital, and other hospitals would bring them home to take care of them. The nurses opened up their own homes to accommodate these elderly who were unable to take care of themselves or needed to be taken care of. Over time, this naturally became a pseudo long-term care institution.

Later on, due to the surge in the elderly population and an increase in women’s participation in the labor force, the family care function became increasingly ineffective. In response, many private elderly care institutions have emerged in the past decade or so. The government passed the Amendments to the Senior Citizens Welfare Act in 1997, which mandated that elderly care institutions were to be operated as foundations. This led to strong opposition from the operators because the criterion was too demanding. This prompted the government to allow the operation of small-scale private institutions (SPIs) for elderly care on the premise that they comply with the “three no’s” principle (no external fundraising, no tax reliefs, and no subsidies) when registering to enter the services market. This led to the rapid growth in the number of SPIs, which established their stake in the market.

The development of daycare in Taiwan basically took a top-down approach. It was based on the ideology of three generations of a family living in the same house, with family members being encouraged to take care of their elderly relatives. The Council for Economic Planning and Development (CEPD) of the Executive Yuan budgeted for the comprehensive promotion of home visitation and home care services for the elderly and elderly daycare under the Six-Year National Development Plan. The target was to increase the number of service subjects by 10% per year. However, there was a lack of personnel at the local level to implement the plans. In most instances, existing communal services and activities organized by the Evergreen Academy (EA) were repackaged with lunch and transportation added to create a Taiwan-style elderly daycare model.

In other countries, the focus of daycare services is the disabled elderly who are isolated from the community or are not taken care of in the daytime. In contrast, the development of Taiwan-style elderly daycare within the social system has always been mixed with different types of communal and EA activities. This caused a duplication in the allocation of resources to the same group of the elderly population, specifically those who are healthy, highly educated, and with active external participation. The dimension of community care services was only given perfunctory recognition.

In reality, the government had considered the experiences of developed countries when it initially planned the long-term care system. It set the principle that home-based community care services would be predominant (70%) and supplemented by institutional care (30%). The large-scale development and use of home and community resources were encouraged and subsidies were given to encourage people to prioritize the use of these services. Long-term care institutions are generally divided into public institutions, build-operate-transfer, foundations, and SPIs.

The SPIs refer to residential institutions that provide 24-hour services and accommodate a maximum of 49 beds. The care subjects are the elderly at 65 years or older who lack mobility or are partially or completely unable to take care of themselves. These institutions are mostly located in the community, which makes family

visits convenient. Their fees are also generally lower than those of foundations that receive government subsidies or social resources. Thus, SPIs can better meet basic care needs.

Despite foundations' repeated emphasis on their advanced equipment and the high quality of care they provide, SPIs are also well-equipped in terms of equipment and professional staffing (including nurses, nursing aides, social workers, chefs, nutritionists, pharmacists, physiotherapists, and occupational therapists). In addition, most of the foundations are located further away from residential areas, which make the elderly feel isolated and abandoned. In contrast, SPIs are distributed across the country and are thus better able to meet the elderly's expectations for aging in place (AIP). This is one of the reasons that many family members and elderly are willing to choose SPIs for care. After all, their greatest wish is to live in an institution that feels like home rather than one that is hospital-like.

Diversification of Community Care

In response to the rapid increase in disability and dementia cases in Taiwan, the government has actively developed long-term community care resources by injecting funds into administrative resources, cultivating long-term human resources, and integrating counseling teams. To promote diversified, accessible, and balanced development of daycare services, as well as to maintain a universal service network, the government has also expanded the capacity of community care, providing elderly day care services to revitalize medical and nursing institutions and leading the transformation of social welfare facilities. Moreover, it has cooperated with daycare centers to pilot small-scale multi-function services, providing daycare, homecare, and respite accommodation services. Hence, the following three aspects of family relations, government policies, and research findings illustrate the importance and necessity of community care diversification.

Family relations. In Taiwan, the family has historically been the most important social support system for the disabled elderly and has been the main focus of efforts to promote elderly care. The Taiwan Association of Family Caregivers (2007) found that of the approximately 370,000 disabled elderly in the country in 2014, 80% were still living in the community or with their families, while only 20% were admitted into long-term care institutions. Related research pointed out that 53.1% of Taiwan's elderly still lived with their family members (Department of Statistics [DOS] of the Ministry of the Interior [MOHW], 2018; Chiu, 2004; Tseng, 2005). In addition, 90% of the disabled elderly who suffered from diseases or physical dysfunction were cared for by their families. For the remaining 20%, the family care relationship did not end even after they were institutionalized.

Chen (2005), Hsung (1999), and Sharkey (2000) assert that social support networks (SSNs) strengthen bonding relationships. The more involved one is in SSNs, the more likely is one to develop strong feelings of intimate dependence and mutual understanding. Geographical proximity also facilitates the provision of care and assistance. Network mating is especially important when caring for the frail elderly. SSNs often change with the conditions of the elderly, including their age, health, and social situation. Therefore, different and appropriate interventions and enhancements must be introduced to the care strategy as the SSNs change. Sharkey (2000) proposed that frequent connections and interactions enable members to clearly identify their own roles and tasks in different networks. This allows care recipients and givers to perform at their own maximum efficacy through mutual support.

When faced with tremendous pressure, SSNs allow individuals to provide various kinds of assistance through family, friends, and others. The establishment of SSNs thus plays a key role for individuals who are

dealing with stress and socio-psychological impacts. SSNs have the function of cushioning and buffering the psychological stress borne by individuals (Cassel, 1976). Social support generated through connections, exchanges, and interactions with others can meet individuals' basic social needs. Interpersonal interactions with family members, relatives, and others are especially important as these engender a sense of respect, care, intimacy, and security. When the SSNs are permanent, sustained, and tight-knit, the relationships developed will better help one to properly handle the various problems and predicaments encountered in life.

Government policies. Welfare states actively promote community care for the sole purpose of deinstitutionalization or transinstitutionalization. Doing so helps the government to save on fiscal expenditures while allowing the elderly to continue living in the community and maintain a living situation that gives them a sense of humanity and flexibility. In the past, residual social welfare provided by the government led to the issue of care becoming dependent on the law of the jungle and survival of the fittest during resource allocation. This resulted in excessive duplication or uneven and insufficient distribution of resources.

When the sociopolitical system is responsible for the elderly through community care, the foci of service items and contents tends to be the provision of support and economic assistance for their daily needs. Governments have always used residual social welfare as the last line of defense in social security, with the main community care policies being family-centered. In terms of Taiwan's policies on long-term care, there has been a transition from families providing full care and support, to participation by social organizations being permitted, to governmental involvement and the establishment of related laws and regulations, and finally, a comprehensive long-term care network has been jointly forged by the public and private sectors. This has been a gradual process of revisions and developments.

The Taiwanese government has adopted AIP as the highest guiding principle of aging policies and the basic concept behind its elderly welfare policies. This was in response to global trends and to meet the expectations for elderly life, while considering that services provided by in-place resources are more accessible and can better meet the needs for care by those who are AIP. The main target and function of the Community Care Bases (CCBs) Establishment Project, promoted from the perspective of social welfare, are to care for the elderly in the community. The support services provided under this project include care visitations, telephone greetings, counseling and referral services, homecare services, food delivery services, education and training, and support groups.

The 10-year long-term care service launched in 1998 was in line with the welfare communitarian flagship plan implemented under the Six Star Project of the National Development Plan. The intentions were to strengthen the public's active participation in public affairs and to expand the scope of grassroots participation through the establishment of a bottom-up proposal mechanism. Despite being the main content of the elderly welfare policy, its effectiveness was limited due to care services systems being overly disparate.

In 2015, the Executive Yuan passed the upgraded long-term care plan that spanned three years and cost 30 billion Taiwanese dollars. The aim was to moderately allow industries to participate in the provision of long-term care services and to encourage enterprises to prioritize funding for five major areas: home-based services, community-based services, transportation, assistive equipment, and elderly housing. The doubling of funds was meant to accelerate growth of the long-term care system to achieve the goals of increasing the number of service subjects, enhancing service delivery efficiency, enriching human resources, and connecting long-term care insurance. Home-based services include meal delivery and bathing assistance, while community-based services include the provision of daycare, family care, and temporary housing at specific

venues and facilities located in the community.

The majority of the budget for the upgraded plan was intended to compensate for the lack in long-term care capacity and personnel faced by the elderly living in rural villages and outlying islands. The government encouraged corporate participation in the five major areas because it felt that there was an urgent need for those services in the present society, but the supply remained insufficient. It hoped that the enterprises and market would provide the resources to address the shortfall. Unexpectedly, industry-based long-term care efforts did not enhance related services in terms of quantity and quality. There was also failure to achieve the goals of cultivating sufficient care personnel and providing diverse choices.

Research findings. Hwang, Yang, and Chen (2013) found that social care in present Taiwan was based on community care as the main service target. The next three service dimensions, in descending priority, were home-based, community-based, and institutional services. The latest report on the survey of the elderly by the Ministry of the Interior (2009) also found that in terms of family composition, the highest proportion of the elderly lived in three-generation households (37.86%), followed by two-generation households (29.83%). Those who lived with only their spouses (cohabitants) accounted for 18.76% of the total. Obviously, most Taiwanese elderly preferred to spend their later years at home. Family care had also always been the most common and important component of the long-term care system.

Hu, Kuo, and Wang (1996) pointed out that Taiwanese generally believe that living with elderly parents at home is a demonstration of filial piety on the part of their children. In contrast, when parents are sent to live in nursing homes, they may feel that their children and family members have abandoned them. Such cultural labels have profoundly affected the choices and needs that the elderly have for long-term care. Wu and Chang (1997) found that approximately 80% or more of Taiwan's elderly suffer from a chronic illness and 50% live with two or more chronic illnesses; 13% have mobility issues in their daily lives, 5-10% suffer from dementia, and 25-30% have depressive tendencies.

The global economic costs associated with the prevalence and incidence of dementia and dementia-related mortality have been repeatedly confirmed. Globally, dementia is currently the leading cause of disability and dependence among the elderly. The rapid rise in dementia and disability is a major concern of aging societies. A study by the US National Institute on Aging revealed that depression could significantly increase the physical disability index among the elderly due to reductions in physical activities and the lack of social contact (Penninx, Leveille, Ferrucci, van Eijk, & Guralnik, 1996).

When Chou, Chang, Fuh, and Wang (2001) examined the economic costs associated with dementia in Taiwan's elderly, they found that the economic cost of caring for the elderly with dementia was mainly indirect care costs rather than direct cash expenditure on medical care. Direct medical costs incurred per person with mild and moderate/severe dementia amounted to 40,000 and 50,000 Taiwanese dollars per year, respectively; indirect costs per person for the various stages of dementia were in the range of 160,000-420,000 Taiwanese dollars per year. In other words, the indirect costs of providing care grew fourfold as the disease deteriorated.

The DOS of the MOI (2015) estimated that there were approximately 460,000 disabled elderly people in the country, and 2.34 million who were in good or suboptimal health. The risk of dementia among the elderly in rural villages may be reduced if prevention and care are provided in a timely manner. If more measures are taken to promote independence, morale in later life may be lifted and the occurrence of depression may be alleviated, thereby enhancing the quality of life for elderly people. Therefore, in addition to providing adequate resources and related medical services for elderly long-term care in the future, the relevant government

departments should pay more attention to the actual daily needs of the majority of the elderly, specifically in the areas of health promotion and disease prevention.

The WHO launched a global campaign to strengthen primary health care in 2002. The main aim was to improve the health of the elderly through continuous and attainable care. Concurrently, this concept of care would expand the developmental dimensions of elderly care: in addition to the original medical care and long-term care, preventive health care and health promotion would also be included.

Issues With and Demand for Elderly Care in Rural Areas: Discussion Based on Chiayi County's Rural Communities Origins

Reality of Demand-Supply Imbalance for Elderly Living in Rural Villages

Presently, many residents of rural communities in Taiwan suffer from severe aging and dementia, and an increasing number live with disabilities. Yet, there is an obvious demand-supply imbalance in the allocation of urban-rural regional resources and a general lack of long-term care resources in these communities. Elderly in rural villages generally do not expect their later years to be carefree or dignified. Elderly care is a complex social welfare service that combines the multi-faceted needs of physiology, psychology, and society. A sustained and diversified care concept must be developed in order for all elderly people to enjoy their later years while continuing to live lives filled with humanity and dignity.

The subjective feelings of the elderly are often critical to the success or failure of community care programs. When the elderly enjoy autonomy in life, their satisfaction with community care services increases. From the government's standpoint, related policies must proactively guide the market to respond to and satisfy the various daily living needs of the elderly. After the Long-Term Care Services Act has been fully implemented in the future, the government can also encourage civil participation by permitting more individuals and corporations to operate home- or community-based services. This will address the lack in supply of care personnel in the country, as well as meet various needs in transportation, assistive equipment, and elderly housing.

Reflections on the Provision of Residual Welfare Services

Arising from the demand for long-term elderly care in the early 1980s, the concept of a community care service delivery model emerged rapidly in the UK. The financial crisis faced by the welfare state further prompted the popularization of the New Right's welfare ideology. The social welfare ideology of pursuing social justice asserts that the government is responsible for guaranteeing that every citizen enjoys a basic living standard. State intervention is seen as an important means of addressing social injustices. Therefore, Taiwan's elderly welfare policies in the early days were mostly based on residual services, with welfare protection for the elderly's daily living provided to targeted and specific subjects only. The market mechanism was adopted for the general public, who could freely choose to purchase the services that they wanted. Non-profit organizations (NPOs), public welfare organizations, and volunteers were tasked with providing services and financial assistance to the economically disadvantaged and destitute (Wu, 2011). Regardless of professional social work or amateur volunteer services, the traditional view of services habitually limited options for the majority of elderly people. The roles and responsibilities of both parties were unidirectional in terms of the provision or reception of assistance and care. Consequently, the important fact that helping others involved reciprocity and two-way relationships was overlooked, to the extent of negating the case subjects' abilities to be productive and professional.

Thinking Ahead About Participation and Empowerment

The government's approach towards the physical and mental health of elderly citizens is mostly aimed at meeting their daily needs. The elderly can only accept assistance passively, which causes them to have the negative feeling of being labeled. Since they are unable to actively integrate into the community or participate in community activities, it is difficult for them to identify with the community or cultivate a sense of belonging. When the healthcare situation is a true reflection of local daily living needs, the members of a community should take greater responsibility for their own health. This is because ensuring the quality of the elderly's lives goes beyond providing material satisfaction; the entire society must also be motivated and willing to share and work together.

Gregson and Court (2010) argued that empowerment provides many opportunities for care recipients to respond to improvements in health services and performance. With their involvement, the risks of non-use, abuse, and misuse of services can be avoided. Empowerment causes the people to: (i) gain additional resources and knowledge; (ii) participate more actively after gaining a sense of identity; (iii) have more opportunities for social participation; (iv) be more willing to take collective action; and (v) acknowledge the changes brought about by their participation. Therefore, if the processes of engagement and empowerment are combined, members of a community will be encouraged to increase their participation. This will foster a spirit of self-reliance and self-help among locals, which in turn leads to services that expand community interests.

Background of the Case Study

The case study discussed in this paper was located in Chiayi County, located in Taiwan's Chiayi-Tainan Plain. The proportions of elderly population and low-income households in this county are significantly higher than the national average, and its rate of aging ranks the highest in the country. The county's demographic data in 2018 are shown in Figure 1. The elderly population is approximately 90,600 and comprises 18.93% of the county's total population. The aging situation of Liujiao Township is the most serious (25.70%), while the proportion of elderly in another eight townships/towns exceeds 20%: Lucao (25.55%), Yijhu (25.19%), Sikou (23.57%), Dongshi (22.67%), Meishan (22.43%), Dalin (21.11%), Budai (20.48%), and Singang (20.30%). These data indicate that the county has entered the stage of a superaged society, meaning that one out of every 4-5 resident is an elderly person.

A survey conducted by the MHW (2013) in 2011-2013 found the prevalence of dementia in Taiwan to be 4.97%, meaning that one out of every 20 elderly suffers from dementia. The number of elderly aged 65 years or older suffering from dementia was estimated to be nearing 130,000. In addition, the number of sufferers increased significantly with age. The prevalence in rural areas was approximately 14%, which was almost twice that (or more) of the rate in urban areas. Going by an estimate of 6%, possibly 5,220 elderly in Chiayi County aged 65 years or older were suffering from dementia in 2015, and approximately 8,968 were disabled (Cheng, Chen, & Leu 2014).

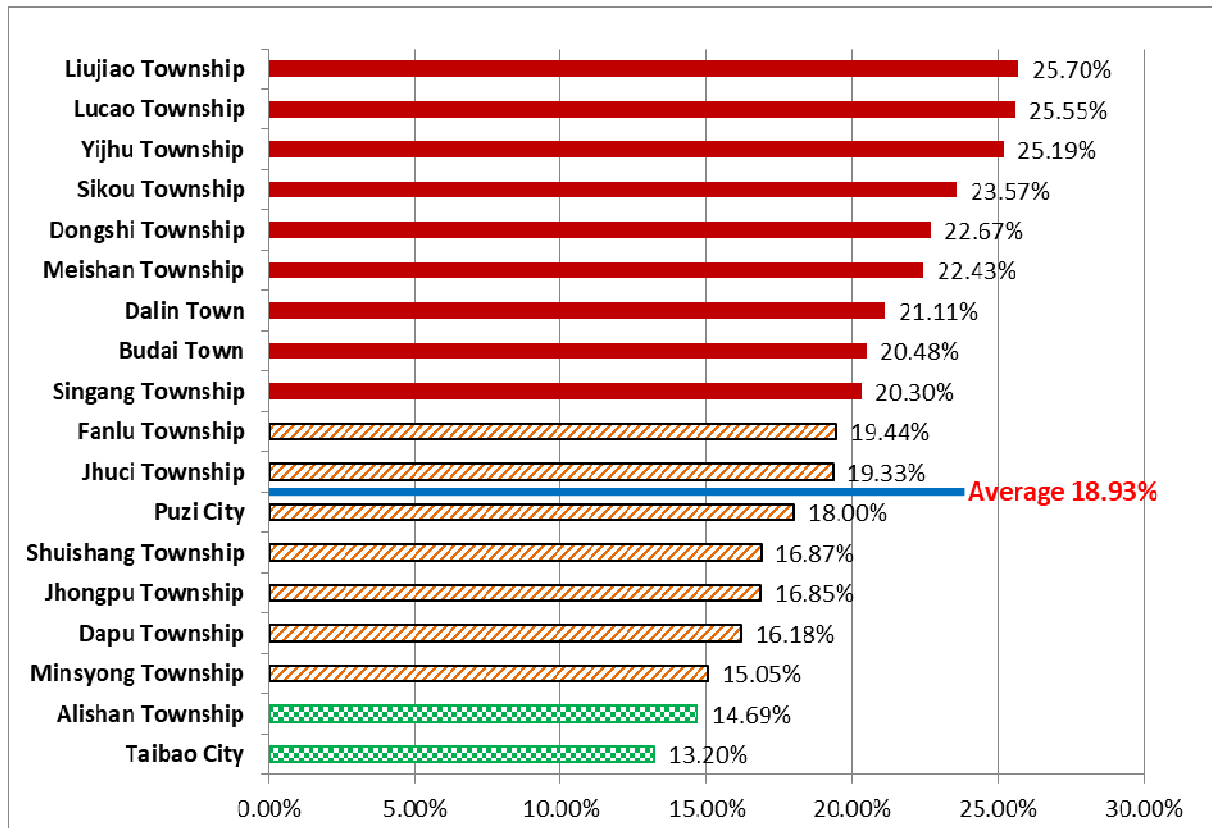


Figure 1. Proportion of elderly population in Chiayi County's 18 townships/towns. Source: Compiled from the demographic data from Chiayi County's various township household registration offices, October 2018.

In another survey, Yang, Lung, Yen, Wen, and Li (2002) found that 16%-58% of Taiwan's elderly have depressive tendencies, and that the prevalence of depression was 1.3%-13%. The study also found that the prevalence of depression was higher when elderly presented symptoms of cognitive impairment, poor ability to execute daily functions, and multiple chronic conditions. The prevalence also increased with age, and was higher among females, those in the lower social classes, or those who were widowed. Furthermore, elderly depression was also significantly related to the quality of family functions and social support, as well as participation in community activities. Therefore, in addition to providing medical treatment for elderly depression, social participation and support are also indispensable.

The issue of mental health is a major challenge that all aging societies must face. Statistics show that currently, only approximately 10% of the elderly regularly participated in community activities, although the frequency of activities was still too low. On the flip side, as much as 65% of them were not particularly interested in any activities or hobbies. If the goal of community care is to provide a care management mechanism that is holistic and continuous, then it is necessary to provide a range of supportive programs that promote diversified participation, resource linkages, and needs assessment.

All empowerment efforts—whether they aim to enhance the quality of service personnel or change society's existing attitudes towards and perceptions of the elderly—must start from the elderly's needs for health and social care. The ultimate goal of community care is to mobilize the entire community to work together to care for and meet the diverse needs of those in the community who are relatively vulnerable. From the perspective of an aging rural community, the accumulation and presentation of culture is both a social value

and a lifestyle. For communities that are old, poor, and lack community care resources (such as those in Chiayi County), the cultural dimension can be a starting point to inspire more people to provide care and assistance with resources.

The supply situation of community elderly care in Chiayi County is shown in Table 1 and Figure 2. Presently, CCBs have been set up in almost every township. The main supply type is community-based care bases (provided by community development associations), numbering 49 out of a total of 97 bases. The Chiayi County Government has adopted the service principle of locals caring for locals, with volunteers taking the initiative to provide social welfare services such as visitations, telephone greetings, and referrals for consultations to the elderly in the community who are 65 years or older and have limited mobility. They also organize weekly health promotion activities to increase the elderly's social participation and keep their physical and mental functions active, thereby achieving the goal of the government's long-term care program to promote primary prevention.

Table 1

Types of CCBs in Chiayi County

Township/town	Community bases	Non-profit bases			Total
		Foundations	Associations	Others	
Minsyong Township	13	2	0	0	15
Singang Township	5	4	1	2	12
Dalin Town	6	3	0	0	9
Jhongpu Township	3	4	1	1	9
Taibao City	0	3	0	2	5
Puzi City	2	1	1	1	5
Liujiiao Township	3	1	0	1	5
Lucao Township	3	2	0	0	5
Shuishang Township	1	2	0	2	5
Jhuci Township	4	1	0	0	5
Sikou Township	2	2	0	0	4
Dongshi Township	2	1	0	1	4
Yijhu Township	3	0	0	1	4
Budai Town	1	1	0	0	2
Meishan Township	1	1	0	0	2
Fanlu Township	0	2	0	0	2
Dapu Township	0	2	0	0	2
Alishan Township	0	2	0	0	2
Total	49	34	3	11	97

Note. Source: Compiled from statistical data by the Chiayi County Bureau of Social Affairs (as of September 2018).

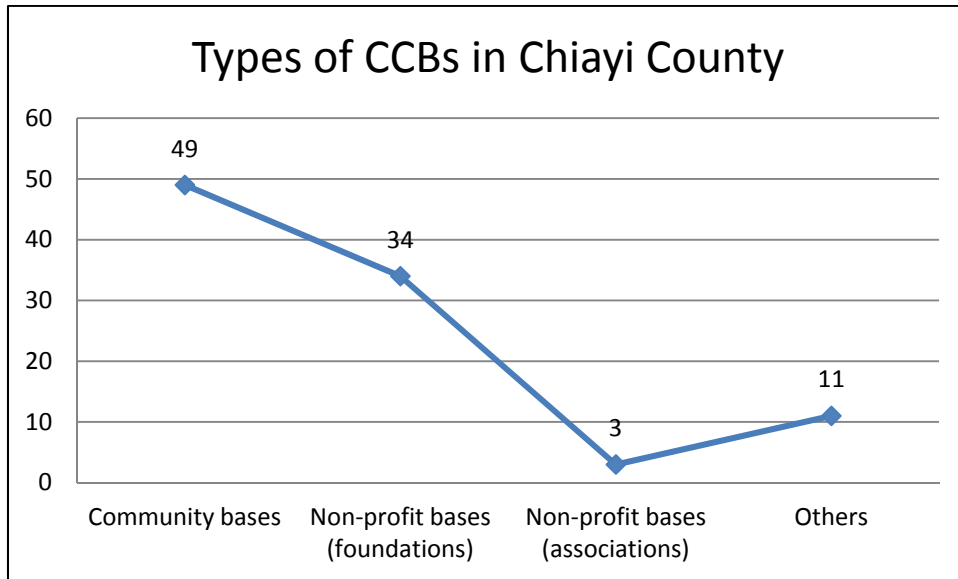


Figure 2. Types of CCBs in Chiayi County.

Further analysis was conducted of the number of CCBs in Chiayi County’s various townships/towns (Figure 3). The data show that the Minsyong Township had the highest number of CCBs (15). Of the 18 townships/towns, Minsyong was one of the rare cases in which the proportion of the elderly population was still below average (at only 15.05%). For townships/towns in which the proportion of the elderly population was higher than 20%, Singang and Dalin had 12 and 9 CCBs, respectively. The others—Lucao, Yijhu, Sikou, Dongshi, Yijhu, and Budai—had only 2-5 CCBs each. The provisions were evidently insufficient.

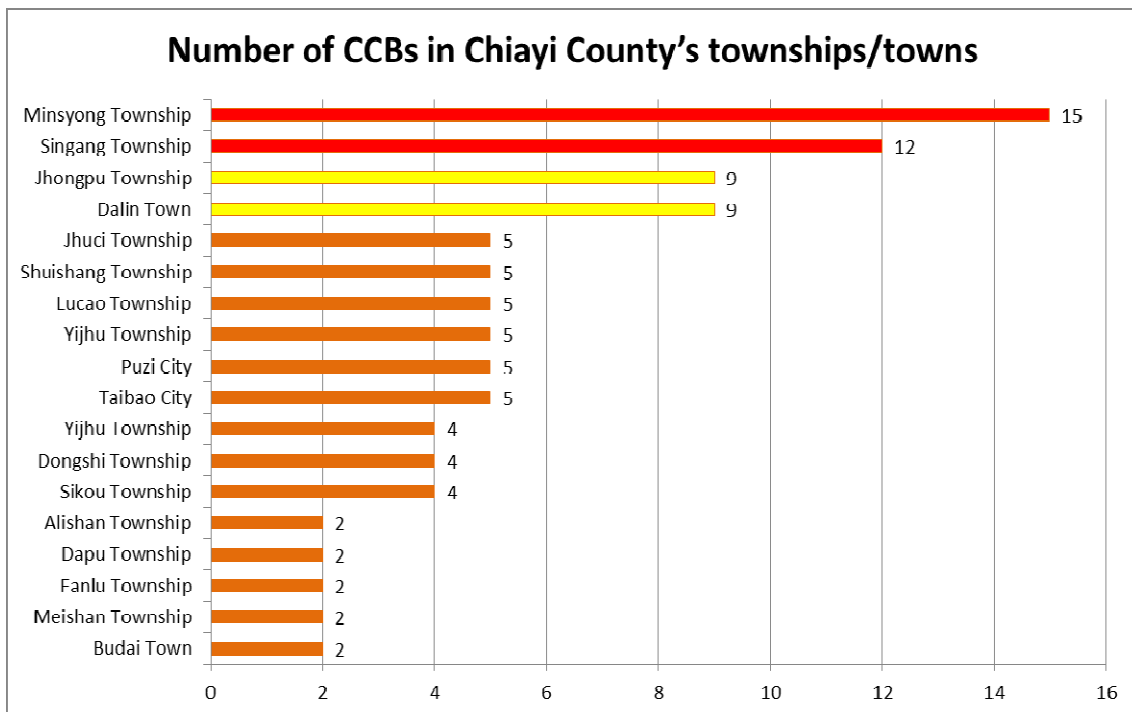


Figure 3. Number of CCBs in Chiayi County's townships/towns.

Considerations and Actions Related to Chiayi County's Community Care Model

Trends in Welfare Services: From Economic to Care Orientations

With the aging demographic structure and maturation of the social security system, the prior economic orientation of assisting the poor had evidently declined, while the care orientation had become more prominent (Wu & Kang, 2008). Chen (2005) stated that existing formal or informal resources for community care must be properly managed in order to achieve the principle of 5As: geographic accessibility, acceptability, availability, accountability, and adequacy. Doing so will ensure the most effective use of resources while concurrently providing the elderly with official or informal health and support services. Only then can the ideal service model of maximizing the independence of individuals be actualized.

Sherreden, Morrow-Howell, Hinterlong, and Rozari (2001) argued that older people must create various roles and opportunities through the social system in order to engage in productive activities. Faced with the challenges of an aging society and knowing that some time is still needed for system reform and optimization, the most urgent task at the moment is to actively create a friendly living environment in which "the elderly are given rest, friends show sincerity, and the young are treated tenderly", rather than passively waiting for "all the elderly to have a place to live and be taken care of". The community should be the basis to review and integrate relevant resources so that welfare services are provided more effectively.

Based on ideas from Western societies and the assistance they provide to vulnerable populations, the historical development trend has moved from poverty alleviation to modern institutionalization and from charity to justice. Giving to the vulnerable (such as the elderly, sick, disabled, and poor) is no longer regarded as a matter of charity but rather comes from a sense of justice (Trattner, 1998, pp. 1-5). Traditional charities are mostly voluntary and involve individual actions and behaviors. The starting point is one's own clan and township, with differentiation based on closeness in blood relations or even physical distance.

With developments in social welfare and in response to the universal value of social care, operations of related welfare service delivery systems are being closely scrutinized and criticized. Considering risk societies, Ku (2010, pp. 14-15) questioned, "Who really are the 'vulnerable' that Taiwan's social welfare (system) wants to assist?" He argued that "everyone can become 'vulnerable' since the focus is not on class, gender, and age, but the degree, orientation, and frequency of risk". Redefining social welfare should not only be a philanthropic act aimed at the minority vulnerable groups; it should be an indispensable part of everyone's life in modern risk societies. This is because "social care is no longer an act of charity but an entire social atmosphere. Helping others is equivalent to helping oneself because one never knows when one may also need assistance from others" (Ku, 2010, p. 15).

Re-creation of Cultural and Social Assets

Fukuyama (1998) proposed that human beings are born with the ability to solve collective problems. To solve problems, individuals promote self-organization and establish a system of norms and cooperation. Under this premise, they also create a wide variety of social organizations. Social welfare does not replace the original social function of the family. Therefore, everyone has the right to social welfare and should treat it as an obligation and responsibility. Social welfare cannot impede the operation of the free market. Instead, it is a way for the triumvirate of families, corporations, and governments to work together. Here, community governance emphasizes the close interactions between individuals and the neighborhood. Emphasis is placed on establishing social networks and accumulating the social capital of both parties while simultaneously meeting

each other's social needs and improving the living conditions and strengthening the public security of the entire community. In doing so, overall social well-being is promoted and advanced, the level of social trust is enhanced, and individuals experience genuine feelings of happiness.

From the perspective of power sharing, using community empowerment as the foundation continuously increases the people's interest in joint management to the extent that they want to further obtain specific related information, make their own plans, take necessary actions, and break through the inherent limitations of decision making in top-down public management (Liu & Wu, 2015). According to Gregson and Court (2010), community empowerment is the means to break away from traditional information sharing and negotiation. It enables people to change power relations through public hearings, filling out questionnaires and forms, and providing service feedback. At the same time, the people gain more self-esteem and the ability to control and be responsible for their own health.

The aims of empowerment are participation in decision making and capacity building. These include learning new knowledge and skills and changing organizational cultures and connection processes. During the coproduction process in which there is mutual contribution of one's possessions and abilities, both service providers and recipients are able to develop mutual trust and respect. Outside of monetary economics, this process is not entirely concerned with labor but more with the creation of cultural and social assets (Cahn, 2009). When members of the community begin participating, their aim is usually to help solve community problems through effective uses of social resources and at the same time make improvements to the community in which they live. The various health promotions and activities that link the CCBs of the various townships/towns aim to promote interactions between the elderly and their neighborhoods, as well as expand the residents' networks. When they improve their physical and mental health, they also gain a sense of belonging to and identity with the community.

Participation provides the opportunity for the public to identify with the community through a transparent and open decision-making process. Modern citizenship awareness is consolidated, a sense of community is established, and the differing views between professionals and members of the community are examined from the perspective of different stakeholders. In the end, members of the community will be provided with the ability to construct and manage their own environment and resources. Local expertise and traditions will also be effectively developed through the residents' active participation. With increased participation comes the promotion of shared results and awareness, such that the initiative to participate is returned to the community. This process is then gradually integrated into community life through localization and indigenization.

Community Empowerment Actions

In enabling the elderly to lead energetic, dignified, and autonomous lives, it is not sufficient to provide them with the guarantee of a basic livelihood. Efforts must be made to create a friendly environment that is supportive and enabling. An organized, systematic, and well-planned network of comprehensive community care resources and an innovative community governance model must be synchronized so that actual local welfare needs are met. Therefore, the steps of community empowerment (Figure 4) should start with awakening the community's awareness before moving up to the use of demand surveys to understand the life issues about which that members of the community care. After a consensus has been formed, locals will participate on their own accord and work together with professional counseling teams (comprising representatives of public departments, local organizations, and academic units), thereby becoming empowered in the process.

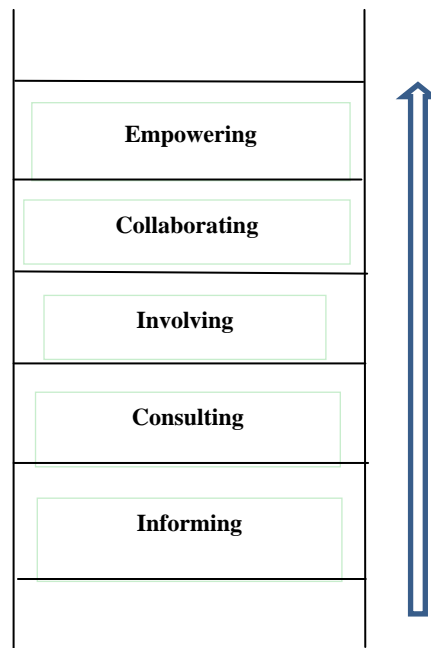


Figure 4. Empowerment ladder: Community empowerment process. Source: Modified from Simpson et al. (2008). *Every Voice Counts Resource Pack*.

Chiayi County's Dingcaiyan Community Development Association implemented plans to connect the nearby Southern Branch of the National Palace Museum with six communities spanning the Singang and Liujiao Townships, namely Dalun, Lunyang, Liutouwei, Koumei, Hsuanghan, and Bantou, to jointly develop plans for a CMLA. The first step was to integrate relevant courses conducted by CCU's Department of Social Welfare, which allowed students to enter the community and conduct on-site investigations. Community tools such as SWOT analysis and fishbone diagrams were then used by the community research team to draft a questionnaire on the community residents' welfare needs. The questionnaire would be the basis for planning and promoting community welfare programs and future community development. With residents' participation as the main focus, the team began linking community mutual help networks based on the residents' real needs in order to develop a series of service systems focusing on "giving concern in-place and providing care nearby". Various activities including environmental maintenance, landscape preservation, industrial revitalization, and cultural conservation were conducted to revitalize the community and motivate community changes, so that the community could naturally form the conditions for self-sufficiency and sustainable development.

Community awareness is subjective and personal. The residents' participation in various community activities or organizations is the actual manifestation of their attitudes towards the community. Such awareness is naturally weaker in rural communities given the relatively shorter development time. In general, the residents tended to adopt a wait-and-see attitude. Even when they did participate, there was a relative lack of professional abilities. Hence, a long time is needed for proper communication and consensus building, together with assistance by professionals. The purpose of participation is to improve service quality and enhance health outcomes; that of empowerment is to promote mutual respect and the level of accountability. The overall focus should be on improving social health and well-being (Gregson & Court, 2010).

Coproductions jointly carried out by the givers and recipients of assistance regard the elderly as assets rather than burdens and find innovative ways to enhance the image of the elderly and highlight their opportunities and potential. In community care, in addition to meeting the elderly's needs for health and medical care, support should be given to those who are healthy to lead independent lives and even enable them to demonstrate their vitality and possibilities. A consensus was reached after many rounds of consultations, negotiations, and discussions by the community executive team, and the collaborative community decided to adopt the coproduction concept and strategy to design the CMLA. The three-phase rotating operational model (consisting of empowering volunteers, reengineering the organization, and providing caring services) was used to develop and sustain community actions (Figure 5).

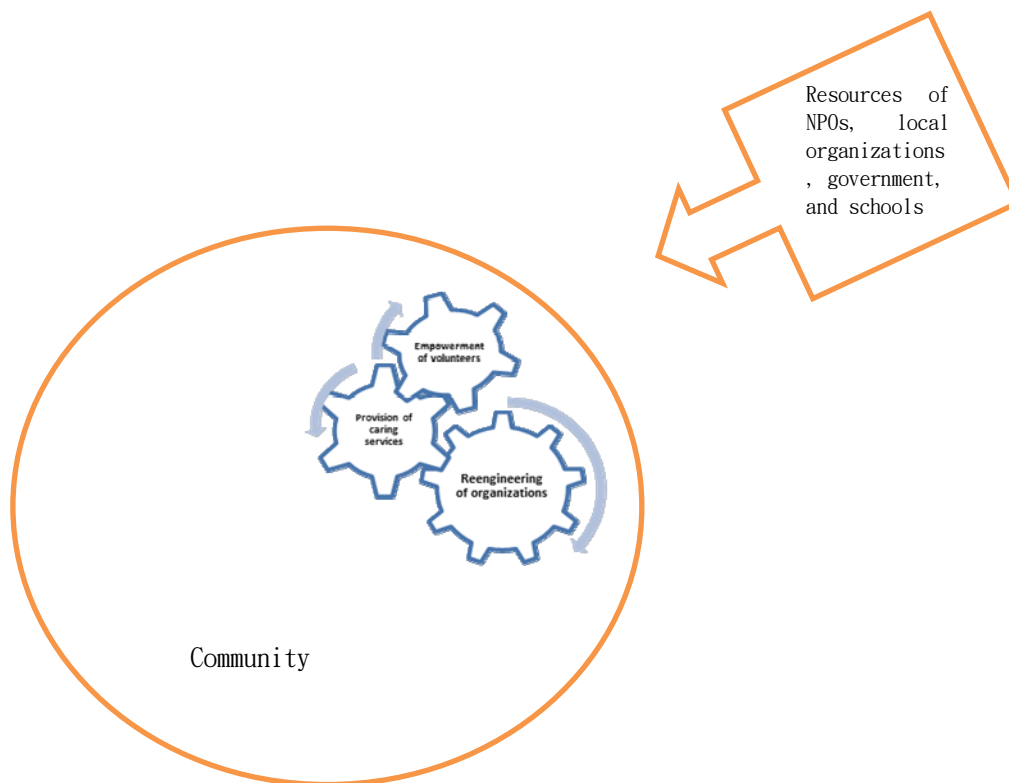


Figure 5. Rotating community action model.

Under past management methods, the government and professionals would manage public affairs on behalf of the people, while the latter could only participate indirectly. In the current approach, in contrast, empowerment was gained through interactive planning and workshops, which established and deepened public subjectivity. The people were permitted to participate directly and specific actions were consolidated, which broke the limitations of top-down decision-making used in traditional public management and even led to the raising of more diversified governance issues. Inter-generational integration and cooperation were facilitated through the promotion of community participation, activation of the public's collective strength, and a fresh view of the role of the family, neighborhood, and community. With a balance struck between professionals and recipients of assistance, social welfare services and operational effectiveness were enhanced on the whole (Boyle, 2011).

The specific action plans were as follows:

- i. Recruit volunteers through various internal and external resources/channels and cultivate local talented volunteers through various training and planned activities, so that their professional knowledge and skills are enhanced, and they are equipped to implement the planned goals of community care.
- ii. Link the resources of the community with those of the public sector and coordinate interpersonal networks among the community's locals before organizing and mobilizing those networks, so that welfare resources can be delivered with the highest efficiency.
- iii. Consolidate community consensus through the community autonomous meeting mechanism so that the community's strengths are aligned. Stimulate awareness of community autonomy, consolidate consensus, and communicate and negotiate continuously to complete community development tasks.
- iv. Build a community caring and sharing platform through self-help and mutual assistance, expand the contents of community services, and provide elderly welfare services for the neighboring communities.
- v. Increase community residents' participation rates through the implementation of diversified activities related to care services, thereby strengthening the community's centripetal force.

Conclusion and Suggestions

Conclusion

Daycare services, whether provided under the medical or social administration model, face three issues: shortages in manpower, funding, and organizational resources. An elderly person's social welfare needs are closely related to their health status. The community must be the main implementation body in order to change the service structure of existing long-term care, with AIP at the core of policies. A diversified and continuous service system must be planned based on the elderly's health status, before different modes of care are given to those who are in good health, suboptimal health, and disabled. Policy coordination with and funding subsidies by the government are indeed needed when community governance is initiated. Subsequently, the community can gradually reduce its dependence on government resources through the empowerment process. The strategic goals of localization, decentralization, and participation are to return power to the community. In addition to feeling enabled, care recipients can also engage in mutual empowerment with carers, thereby obtaining humanized social welfare services.

When developing rural communities, the leadership skills of the community's residents can be enhanced through empowerment by professional teams. This will cultivate more talented people to become community leaders. Over time, the community will be able to depend on their own strengths to organize the various resources networks, develop local industries, establish local cultural characteristics, and eventually, solve their own community problems. In one's later years, family, friends, and the community one is familiar with are the best resources to rely upon. These are also the foundation of the real spirit of AIP. After having lived in one place for a long time, the elderly naturally develop a sense of attachment to the place. The many life experiences that a place holds provide one with precious memories and recollections. When the strength of the community is used to support elderly with declining health, they are able to continue living independently at home. Doing so also helps to delay the onset of dementia and disability.

The community should be the basic unit for integrating and using existing resources (such as medical care, social education, leisure, health care, and various public facilities), which will enhance the provision of elderly daycare services. During the process of policy implementation, grassroots community organizations must be

actively empowered to become the centers of network governance, so that the vast gap between policy planning and implementation is narrowed. Under the condition of limited resources, these organizations can use the concept of coproduction to spread the cultural heritage of mutual assistance, sharing, and reciprocity. On the one hand, the social support system of family caregivers is strengthened; on the other hand, the enthusiasm and care that the community's residents have for their village are rekindled by the integrated care services model developed through inter-community coordination and cooperation. These conditions in turn facilitate the sustainable development of the community, giving it renewed vitality.

Suggestions

To respond to the service transformation and community governance of social welfare in the future, community care should be approached from three aspects: the individual, government, and community.

At the individual level:

- i. Strengthen the elderly's basic life knowledge and abilities.
- ii. Provide the elderly with relevant medical care services such as disease prevention and health education.
- iii. Encourage the elderly to actively participate in community affairs and activities so that they have more interpersonal and emotional connections, which in turn consolidates the community's centripetal force.

At the governmental level:

- i. Develop resources for home-based support services, build a community-based care environment, and implement an AIP policy.
- ii. Integrate community resources and encourage NPOs to participate in and promote efforts related to elderly AIP.
- iii. Promote the concept of coproduction and avoid excessive dependency on welfare.
- iv. Provide empowerment and counseling mechanisms and build community service networks and care management systems.

At the community level:

- i. Use the concept of coproduction to help the vulnerable to reorganize their life energy, provide feedback, and jointly care for the community's elderly so that an interdependent relationship is developed before establishing a family-like mutual help group.
- ii. Build a vision of the future together through common local cultural traditions and characteristics.

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