**The Experiences and Challenges of Long-Term Care in Taiwan**

**- A case of an indigenous community**

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**Abstract**

Taiwan has become an aged society with the population over 65 years old breaking 14.5%, and the indigenous population is aging faster than majority, with people over 55 years old getting 21% in 2018. In order to respond to the rapidly aging society and multiple ethnic groups in Taiwan, the Ministry of Health and Welfare incorporates the concept of cultural safety care into Long-Term Care Service Act (LCSA) with the goal of aging in place. However, how to deliver the government’s resources and services of long-term care (LTC) to the remote and deprived indigenous communities is still a challenging task. This study applied the participatory action research to explore the difficulties when the first-line local LTC providers were trying to deliver LTC service to indigenous elders among six villages belonging to the Bunun tribe from 2012 to 2017. The main findings of this study are demonstrated through the lenses from the supply side and demand side. On the demand side, the first and the most important task is to identify and approach the indigenous elders who are in the invisible corners and indeed need LTC. On the supply side, firstly mobile-service offices and vehicles are inevitable resources to reach the remote area and to provide in-time service. Secondly, due to different cultural backgrounds, local people should be empowered to enhance their competence of care-taking and further to establish the stable local workforce with sustainability. Lastly, constructing an integrated community-based network is critical to ensure the sustainability of the LTC. Hospitals, as outsiders to the indigenous communities, have to cooperate with the local public and private sectors to make the most efficient and effective use of all available resources.

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**Introduction**

Based on the definition of World Health Organization (WHO), the proportion of a society's population that is comprised of persons aged 65 or older is called the “aging rate."  If a society's aging rate exceeds 7%, it is an “aging society”. If the rate surpasses 14%, it is an “aged society”; if over 21%, it is a “super-aged society”. Taiwan has become an aged society with the population over 65 years old breaking 14.5% (Lu 2017[[3]](#footnote-3)), and the indigenous population is aging faster than majority, with people over 55 years old getting 21% in 2018[[4]](#footnote-4). Moreover, Taiwan’s birth rate of 1.13 is the third-lowest in the world in 2017[[5]](#footnote-5).

In order to respond to the rapidly aging society and multiple ethnic groups in Taiwan, the Ministry of Health and Welfare incorporates the concept of cultural safety care into Long-Term Care Service Act with the goal of aging in place. However, how to deliver the government’s resources and services of long-term care (LTC) to the remote and deprived indigenous communities is still a challenging task.

This study applied the method of participatory action research to explore the difficulties when the first-line local LTC providers were trying to deliver new LTC model, ABC tiers service, to indigenous elders among six villages belonging to the Bunun tribe in the east of Taiwan from 2012 to 2017.

**Long-Term Care model in Taiwan**

Currently Taiwan is in the second stage of two-decade program of Long-Term Care (LTC). The deputy minister of Ministry of Health and Welfare, Pau-Ching Lu, explained how Taiwan government has been responding to an aging society3. She provided the brief history and basic contents of LTC policy from 1.0 to 2.0 to the public as below.

The first stage, from 2007 to 2016 – referred to as Long-Term Care (LTC) 1.0 – established state-subsidized care for the elderly and disabled.

The LTC 1.0 service items include (1) Care services (2) Transportation services (3) Nutrition meals for the elderly (4) Assistive device purchases/Rental and handicap-friendly improvements to residences (instances) (5) Home nursing (6) Home/community rehabilitation (7) Respite care services (8) LTC institutions. The service target people of LTC 1.0 are older people with functional limitations of ADLs (aged 65 and over), mountain indigenous people with functional limitations of ADL (aged 55 to 64), people with disability (aged 50 and over), older people living alone with only limitations of IADLs (aged 65 and over).

During initial planning for LTC 2.0, government recognized a major barrier to implement LTC effectively was due to separate operations and lack of coordination of health and social welfare systems (Glavin 2017[[6]](#footnote-6)). The second stage, from 2017 to 2026 – refer to as LTC 2.0, adds a number of community-based services, including preventive care, dementia care, and family caregiver services. Under the new policy, LTC 2.0 expanded to include people with Dementia (aged 50 and over), plain-land indigenous people with functional limitations (aged 55 and over), people with disability (aged 49 and under) older people with frailty (aged 65 and over) (Lu 20173; Wu 2017[[7]](#footnote-7)).

Constructing the comprehensive community care service system is the most important work of LTC 2.0. The goal of the comprehensive community care service system is to create a comprehensive care system that integrates medical care, LTC services, housing, prevention, and social assistance to allow people with disability to receive the care they need within a 30-minute drive. Lu (2017) showed the care system can be divided to three tiers:

1. Tier A – Community integrated service center, which coordinate and link care service resources according to the care plan designated by the care managers, establish localized service delivery system that integrates and connects to B-tier and C-tier resources, and pick up and transport service connecting A-B-C service through community transport and care transport personnel
2. Tier B– Combined service center, which elevate community capacity to provide LTC services, and increase diverse services for the public.
3. Tier C – LTC stations around the blocks, which provide respite service in the neighborhood and implement primary prevention programs (Huang& Chang 2019[[8]](#footnote-8); Lu 20173).

To summarize, the A-B-C Community Caring Network is the basic delivery unit. The Tier A centers will serve as the first contact windows for applicants, arranging their specific needs, providing comprehensive LTC services, while the Tier B and C centers will be in charge of delivering services such as day care, meal delivery, rehabilitation, nutrition counseling, and transportation.

**Long-term care model for indigenous communities**

The integration of health care models in indigenous and mainstream communities involves transitional issues and conflict pertaining to cultural and historical context. Specifically, the caregiver and care receiver relationship has changed from mutual care and daily relationship to a care model that is "top-down" and "supervision of local people by outside professionals" (Wang & Yang 20174). Therefore, indigenous anthropologist in Taiwan emphasize the importance of cultural care in the long-term care for indigenous people (Ru 20155), and appeal to policy makers to regard the special needs of indigenous people such as geographical location and cultural differences.

Social work studies on Taiwan’s long-term care policies found that the needs assessment and assessment tools for indigenous elders fail to address the unique culture of indigenous people, making it difficult to meet their service needs. An obstacle is their inability to co-pay for the services. In terms of service delivery, indigenous people are unable to pay for the high cost of institutional care. Yet due to factors such as vast territory and inconvenient transportation, providing community-based care in indigenous communities is problematic. On the other hand, while home-based care is relatively feasible, limited transportation and human resource in indigenous communities make home services challenging (Hou & Guo 20176).

Huang and Zhan (2000) pointed out that compared to the mainstream population, indigenous communities have a higher rate of dependency, unemployment and alcohol abuse; lower educational level, income and life expectancy; and less welfare resources, medical resources and employment opportunities (Huang & Zhan, 20007; Zhan, 20108). As with other indigenous regions in Taiwan, Zhuoxi Township in Hualien County is typical mirror of the above description.

Zhuoxi Township is a [mountain indigenous township](https://en.wikipedia.org/wiki/Township_(Taiwan)) in [Hualien County](https://en.wikipedia.org/wiki/Hualien_County). The population is 6,210 inhabitants and the total area is 1021. 313 sq km[[9]](#footnote-9). Zhuoxi Township is the second largest town in Hualien County and the fifth largest town in Taiwan. It covers an area almost equal to Changhua County, a non-indigenous county in western Taiwan. However, its population is only about 6,000, far less than the 1.28 million in Changhua County. Its sparse population is scattered around livable areas in a territory that is more than 95% mountains. Moreover, with severe population outflow, real estate development is difficult. Given the lack of resources and the difficulty of service delivery, overall community care in Zhuoxi Township is an arduous challenge.

The innovative and integrated services of LTC 2.0 include Community Integrated Services in Indigenous Region. Tiers A, B and C long-term care service stations are incorporated into the community-based care model. Seeing the need for local care, the Hualien Mennonite Christian Hospital (MCH)10, which has always been deeply involved in medical services for indigenous communities, began undertaking LTC 1.0 and LTC 2.0 programs in 2012. The hospital set up a base in Zhuoxi Township to penetrate low-lying indigenous areas to provide long-term care services for the elderly. This study examined LTC 2.0 within overall community care in indigenous communities that have relatively scarce resources and unique geographical location and culture.

After the new LTC 2.0 was launched in 2016, Hualien MCH was selected as the first pilot organization for the overall community care model. The Hospital established the Tier B Yuli- Zhuoxi Community Integrated Service Center in Zhuoxi Township while Taipei Veterans General Hospital Yuli Branch, Yuli Township public health center, Zhuoxi Township public health center and Zhuoxi Community Development Association each set up neighborhood stations (Tier C) . Hence through this 1B4C model, long-term care resources are delivered to Yuli Zhuoxi Township.

With the efforts of the MCH, long-term coverage in Zhuoxi Township has significantly increased from 10% in 2012 to 80% in 2018. Originally the lowest coverage in Hualien County, Zhuoxi Township has become a town where long-term care services have become prevalent. Since the beginning of this year, Tier A requirements have relaxed. As a result, the MCH Yuli- Zhuoxi Tier B case management and resource integration services have been upgraded into a community-integrated service center. It now integrates overall community care in Yuli and Zhuoxi areas under the name Yuli-Zhuoxi Tier A Unit.

**Priorities and content of long-term care delivery model in indigenous areas**

Through the indigenous community work experience from 2012 to 2017, the main findings of this study are demonstrated through the lenses from the supply side and demand side. In addition, this paper also emphasizes the key priorities and content of long-term care delivery model for the elderly in indigenous areas.

1. Supply side:

(1) Determining current elderly situation through population inventory

The database for the locations of service targets must first be established. Information about local population flow is needed to understand the daily life of local residents, and subsequently determine the demand for long-term care services.

When the MCH went into Zhuoxi Township, its biggest immediate problem was not even knowing where the service targets were. The next house number could mean a 10-minute drive away, and sometimes even the local township offices had no knowledge of current household situations. Therefore after establishing the base in remote Zhuoxi in 2012, the first task of the MCH was a comprehensive population survey. In collaboration with the Zhuoxi Township Office and Zhuoxi Township public health center, every community was visited to survey all the households in the entire township. The survey, which took 3 years to complete, included not only indigenous people aged 55 years or older, or dementia patients aged 50 years or older in the scope of the Long-term Care Act. All community residents aged 0-100 years old were included. The survey provided clear information on the daily whereabouts and conditions of the elderly to better determine their current situation. Knowing the flow of the local population is necessary for understanding their daily life, and subsequently their long-term care service needs.

From the overall perspective of community and long-term care resources in Zhuoxi Township, availability of current long-term care resources for LTC 1.0 and LTC 2.0 in indigenous community-based and institutional long-serving services remain difficult and limited. However, over recent years, Zhuoxi Township has gradually established four neighborhood stations, two tribal cultural health stations, two community care stations and one station for dementia care. One of the three tribal kitchens provides LTC 2.0 meal delivery service. Such a service network effectively enhances long-term care services in indigenous communities, and the services provide by each station can be flexibly adjusted according to the disability situation in each village. Therefore, the promotion of community-based long-term care service model is overall beneficial to indigenous communities. However, these benefits are built upon a bottom-up communication platform. As such, the MCH has formed an executive team with local community organizations to improve many top-down implementation issues through local committee initiatives. Currently, 21 local caregivers and professionals are involved in constructing long-term care resource delivery. Case management has reached 200 cases at Tier A stations and 225 cases at long-term care sub-stations, and 2 units have almost completed an inventory of all elderly in Zhuoxi Township who can use long-term care services. The endeavor cannot be achieved overnight, but accomplished through the accumulation of past efforts and cultivation. If long-term care programs cannot be sustained, existing service model will suffer varying degrees of impact.

(2) From a fixed remote service base to a mobile and accessible service model

After collaborating with the most basic local medical units to establish a "mobile office" and determining the location and status of the service targets, the next problem to address is the difficulty of service delivery. The MCH collaborated with the Zhuoxi Township Office to establish a Mobile Office. Using mobile vehicles, teams comprising case managers, long-term care professionals, social workers and staff from the township office and public health center visit each community to provide local residents with medical care, health promotion, counseling and assessment, and even employment counseling and other community care services. These services to communities in remote corners allow residents to receive care services without having to travel long distance to fixed-point service locations.

1. Demand side:

(1) Through local training, provide overall culturally safe care services for indigenous communities

Zhuoxi Township is an area with indigenous communities, and localizing LTC 2.0 can be quite challenging. For example, in homecare service contracts, house cleaning services is limited to inside the home. However, in indigenous communities, the concept of home may extend to outside the house. During a visit to a community, an elderly resident made the following request to the authors, "It doesn't matter if the inside of my house is not cleaned, but can you get your home service provider to clean my little front yard because whenever I open the door and see the fallen leaves, it's as if my life is withering. And I'm unable to clean it up myself. " This highlights the importance of cross-cultural care. The Han culture definition of home space in the mainstream long-term care policy differs from the indigenous concept of home space, and therefore should be adjusted as necessary.

Zhuoxi Township comprises 6 administrative villages and 15 indigenous tribes[[10]](#footnote-10). The Bunun tribe accounts for 90% of the total population, followed by few other indigenous tribes such as the Sediq, Taroko and Amis people, thereby resulting in 4 different kinds of languages, culture, diet and lifestyle in the local area. Although both authors of this study are indigenous people as well[[11]](#footnote-11), we have problems when we first visited Zhuoxi Township. We could not speak the Bunun language, and hence felt a certain barrier when first initiating the relationship[[12]](#footnote-12). Therefore, a strategy must be actively adopted to recruit youths back to their hometown to serve their people.

The Bunun people has a very strong sense of community and family cohesion. They hope that care providers or homecare service providers for their elderly would be youths from their own tribe. Therefore, through local tribal meetings, the MCH conveyed the following message to the Bunun people, "If your children or grandchildren work in the hospital, let us know and we will invite them to work in their hometown. "

After recruiting people back home, the next step is training. For Tier A unit case managers (hereinafter referred to as case managers), training in long-term care policy implementation, roles of Tier A units, understanding of various resources, familiarity with local service delivery, and inter-disciplinary cooperation and operations can be well provided by the Mennonite Christian Hospital Yuli-Zhuoxi Tier A-level unit. In addition, the Yuli-Zhuoxi Tier A case managers are confronted with diverse ethnicity, and must therefore respond to differences in the elderly community and adjust their service delivery system. Thus in addition to professional courses, learning cross-cultural knowledge and sensitivity are required. For care providers, the MCH has a training center for certification and on-the-job training. It not only equips youths to provide professional long-term care services to their elderly upon returning to their hometown, but also creates local job opportunities. The MCH Yuli-Zhuoxi Tier A unit has connected 21 local staff, such as caregivers, case managers, social workers, business supervisors and drivers. Including the existing 26 middle-aged or older home service providers before the MCH was stationed, there are 47 local Bunun people involved in overall community-based care. The local people best understand the needs, habits and taboos of the local people. Hence at this time, attracting, training and providing a health care market for local indigenous youths is an important task.

(2) Integrating and partnering with local organizations

Local official and non-official organizations are the cornerstone of sustainable local development. As an "outsider", the hospital needs to cooperate with local organizations to promote elderly care that is sustainable. When an outside organization enters an indigenous territory to provide services, it must first be clear about its role and positioning, and become a working partner with local organizations.

The authors believe that the hospital should not only connect with Tiers B and C units in the community, but also with other organizations such as local township offices, public health centers, community development associations and churches. As such, regardless of the Mobile Office jointly created with the Zhuoxi Township Office or the tribal kitchens jointly run by private organizations, they are the product of joint thinking and partnership.

In the case of the tribal kitchens, the MCH collaborates with community development associations, churches and corporate fundraising to enable the sustainable development of tribal kitchens. For healthy and sub-healthy elderly, the tribal kitchens provide community dining for the elderly to eat, socialize and enhance their emotional support after participating in health promoting activities or disability prevention activities. For disabled or seriously ill elderly, the tribal kitchens provide meal delivery services, which not only ensure their nutritional care but also their home safety. For example, workers for the meal delivery service undertaken by the Gufeng Village Community Development Association are women in the community, and the scale of service is increasing. When a service base can develop steadily, new local industries will become possible.

In addition, the Yuli-Zhuoxi Tier A unit convenes regular joint meetings and promotion committee meetings. Local organizations are invited to participate to jointly promote overall community care. Joint meetings is a level one meeting, and encompasses a larger scope. All organizations related to overall community care are a part of the meeting to jointly determine the forms of long-term care in tribal communities. If a problem cannot be resolved at the joint meeting, it will be discussed at the level two promotion committee meeting. In addition to the MCH, participants include the town mayor, village chiefs and members of the town council.

Partnering with local administrative bodies on promotion is more efficient than striving alone. For example, the public health center not only assisted with establishing 3 neighborhood long-term care stations, it also approved residential long-term care institutions to provide localized home services. Moreover, it also established the town's first dementia service station, thereby furthering the fulfillment of LTC 2.0 goals.

Through the integration of inter-disciplinary teams in the community, overall local community care can be developed. When everyone understands the importance of long-term care in indigenous communities and jointly participates in decision-making and implementation, they can advance the goal of community co-prosperity.

**Difficulties and challenges of long-term care in indigenous areas**

Although the hospital-based promotion of overall elderly care in indigenous communities has achieved certain results, many difficulties are yet to be resolved. including:

1. Limited transportation.

Given the vast and sparsely populated environment of indigenous areas, transportation is already difficult. The resource service system of the program only subsidizes one vehicle for Zhuoxi Township. Hence effective shuttle service is not feasible, and service delivery continues to be problematic. Currently, long-term care shuttle service requires reservation, which in fact renders it unable to meet the actual needs of the elderly. Indigenous communities are incapable of maintaining an economic-scale transportation system, drivers are scarce and transportation problem remains unresolved.

Moreover, policy grants for case managers are reduced each year although the operations in indigenous communities are very different from cities. These differences include geographical and transportation limitations, case complexity and difficulty, and yearly population declines such that case load levels off and stop increasing after a certain volume. For example, current coverage in Zhuoxi is 90% and the case load is approaching a plateau. However, the annual decline in personnel funding makes it difficult to pay for personnel costs and retain professionals.

Eventually professional resources in remote towns will be lost in the rolling plan of the policy. The service benefits offered to indigenous community is not guaranteed, and hence it is recommended that policies for promoting the program should be adapted to local conditions.

1. Serious shortage in medical professionals and difficulty in promoting timely in-home medical treatment.

Demand for medical services remains high in indigenous areas. However, there is still a lack of certain professionals such as doctors, nurses, nutritionists, physical therapists and occupational therapists. Therefore, timely in-home medical treatment is still limited and inaccessible.

1. Lack of integration between social and health administration units, resulting in

uncoordinated multiple directives and increased administrative burden for Tier A units.

To date, with the rolling plan adopted by the TLC 2.0 and the lack of integration between social and administrative units, the Yuli-Zhuoxi Tier A unit is faced with uncoordinated multiple directives, which increases its administrative process. The role of county and city government long-term care centers and Tier A units are unclear, community organizations lack human resource, and no supervision mechanism is in place for managing contingency. Furthermore, the marketization of LTC 2.0 will inevitably lead to market competition and create caseload pressure on Tier A units.

After the Tiers ABC system was launched, the Yuli-Zhuoxi Tier A unit was able to implement active case management and local training. While discovering the needs of the elderly, it was also able to cultivate Tiers B and C units and integrate long-term care community resources to construct a localized network of overall community care.

Nevertheless, despite the numerous problems with LTC 2.0, its overall benefits exceed its disadvantages. Before the community Tiers ABC system, the government long-term care centers were overwhelmed with cases, making active case management difficult. Moreover, most elderly in the community were unaware of available services.

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9. Website of Zhuoxi Township.

   https://www.zhuo-xi.gov.tw/content\_edit.php?menu=2598&typeid=2598 [↑](#footnote-ref-9)
10. The contemporary Taiwan indigenous people call their villages as tribes (Pu-Lo, 部落). [↑](#footnote-ref-10)
11. The first author is from Paiwan tribe, and the second author is from Atayal tribe. [↑](#footnote-ref-11)
12. The island of Taiwan is narrow and densely populated, but the languages of the indigenous peoples are highly diverse. The government of Taiwan has officially recognized 16 indigenous groups, which has independent languages that are not inter-communicable. Therefore language barrier is a great challenge in localized care. [↑](#footnote-ref-12)