



Welfare and long-term care in the East and West

Cross-national inequalities

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inequalities

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Abstract

Purpose – This paper aims to provide an overview of the inequalities between three countries – England, The Netherlands and Taiwan – in relation to the welfare and long-term care of older people. It compares the positive and negative distinctions between the respective countries and their systems.

Design/methodology/approach – This paper discusses and analyses data from public sources and literature and measures the similarities and differences between demographic and social issues, the cultural and political differences shaping policy objectives, economic constraints and long-term care services.

Findings – All three countries face similar pressure in long-term care provision of ageing populations, funding limitations and shrinking numbers of carers. None of the countries studied completely conforms to Esping-Andersen's ideal types; instead they seem to constitute hybrids. The care system in the Dutch social democratic-conservative welfare regime seems to provide wider support for older people who need care, the English liberal-social democratic welfare regime comes second and Taiwanese conservative-liberal welfare regime comes third. Overall, some converse trends of the long-term care systems indicate a narrowing of the gap in responsibility between state, family and individuals in the East and the West.

Practical implications – The paper contributes suggestions to further research in the area of elements and structures of care systems support and the failure to provide ongoing quality of long-term care and reflects on the implications for the global market of care-workers and the extensive use of migrant workers in the field.

Originality/value – The paper provides a detailed consideration of the wide-ranging issues that impact on older people's care provision in England, The Netherlands and Taiwan.

Keywords Long-term care, Elderly people, England, The Netherlands, Taiwan

Paper type Research paper

Introduction

It is clear that populations are ageing across the world, and subsequently, care for older people has been compared intensively since the 1990s. Most of this research looks at cost and care provision, with some studies focusing more specifically on informal care (e.g. Glendinning and McLaughlin, 1993; Le Bris, 1993; Glendinning *et al.*, 2004; Ungerson, 2004). Furthermore, some comparative studies have begun to take the East into account when addressing macrowelfare system issues (e.g. Gould, 1993; Aspalter, 2002; Walker and Wong, 2005). Many of these studies include detailed perspectives on the economics, politics and cultural dynamics of national care systems. From these studies we learn that for countries facing similar pressures (i.e. population ageing, funding limitation, shrinking numbers of in/formal carers), policy responses were dissimilar. Nonetheless, little cross-national research aims to look at *inequalities* in care for ageing generations as an object of investigation. It can be argued that good long-term care provision is not common between countries, as it is common to see that both



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between and within most nation-states, inequalities in eligibility for care and expenditure on long-term care are profound.

Building on the above studies, this paper focuses on the gap in state policies of welfare and long-term care for older people by seeking to investigate the overall strengths and weaknesses of each system. The countries which form the focus for this study are England, The Netherlands and Taiwan. They are selected for the following reasons:

- All of these countries are industrialised and face similar pressures in meeting the care needs of older people.
- Although the three countries differ in population and size, the differences are not as great as those countries compared in other studies (such as USA, Canada, UK and Sweden in Matcha (2003)).
- The Asian-European dimension has been a largely neglected aspect of comparative study.
- In essence, each country represents one of the different types of welfare regime as classified by Esping-Andersen (1990)[1] – England as liberal, which encourages a strong *market*-oriented welfare system for the middle and upper class, has minimal de-commodification and provides a residual safety net for the poor; The Netherlands as social-democratic, which provides universal *state* welfare provision, as well as having a strong de-commodification and redistribution element.

Taiwan is similar to Japan (Jones, 1993) in that it has a conservative/corporatist type of familialism welfare regime, which supports the idea of class and status differentials and minimal redistribution. The benefit and welfare provision in this system is status-differentiated.

However, this study also differs from Esping-Andersen's original social security focused work as this research applies his typology to the long-term care of older people and adopts a dynamic perspective, focusing on the three countries' demography and social issues which have an impact on economic constraints and the scale of welfare provision. This is followed by a discussion of the policy and care responses to the long-term care of older people in the three countries. It will argue that while the three countries have different traditions, interests and ideas about care, there have been some cross-national inequalities and challenges in meeting the demand of long-term care of older people as regards individuals, families, market and state.

The article is a discussion and analysis of data from public sources and literatures that pull together data around the key themes of sociodemography, social spending and long-term care provision. The statistical data for this paper have been collected from supra-national institutions (i.e. WHO, OECD, Eurostat) and national governments (i.e. England: Office for National Statistics, The Netherlands: Statistic Netherlands, Taiwan: Executive Yuan/Department). The difficulties in comparing national and even international databases are well known as they are not always strictly comparable (Lindner and Comolet, 2007). For example, the data from each country are not always from the same year, and definitions, such as what is meant by health, social or long-term care, can vary from country to country. Data are also collected from different sources in different ways and are often difficult to compare. Therefore, in examining the tables and figures which set out data collected in the three countries explored in this paper, the reader needs to take into account the problems of cross-national comparisons; therefore, I have indicated specific anomalies where they occur. While

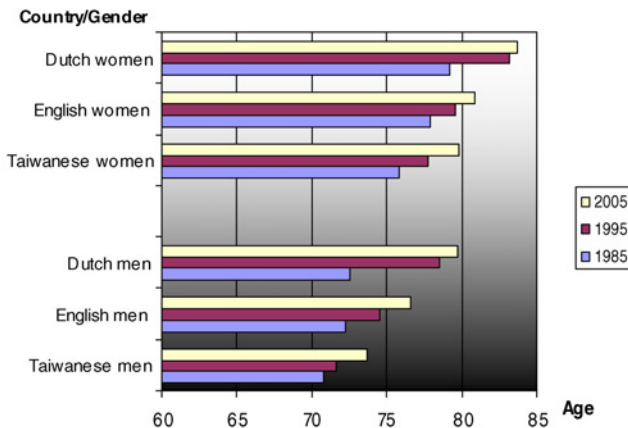
such indicators need to be treated with care, nevertheless they supply us with a basic understanding of social, political and economic circumstances.

Demography and social issues

There are a number of demographic and social transformations that can influence long-term care distribution of older people. For example, changes in demography and the female labour force in past decades could have a strong impact on family structure, living arrangements, the demand for long-term care and the availability of informal care and support.

The demand for care has increased as life expectancy for both men and women has increased in all three countries (Figure 1). This is most apparent in The Netherlands where average life expectancy has improved more than 6 per cent for both men and women between 1985 and 2005. Women tend to live longer in all three countries, so that the ageing population of each country becomes increasingly “feminised”. From Figure 2, we see that the number of people aged 65 and over has also grown rapidly in all three countries, especially in Taiwan since 1995. The indications are that unless fertility (or immigration) rates rise, future gains in longevity will continue to increase the old-age dependency ratio and all three countries are likely to face substantial demand in meeting the care needs of older people over the next 20 years. The outlook is not entirely negative, after 2040, England and The Netherlands will face a somewhat slower increase in their ageing population. In contrast, because of the continuing sharp increase of the population aged over 65 in Taiwan, it is almost certain that the pressure of care demand in Taiwan will be far greater in the next four decades.

A common feature of all three countries studied here, especially Taiwan, is that most care for disabled older people living at home is provided by informal carers. There are two great demographic transformations that can influence informal care distributions. First, if the rise in equality of familialising caring capacity reflects factors of family structures and living arrangements, the large proportion for older people living alone in England and The Netherlands may mean there is less accessibility to daily family support than Taiwan which offers an extremely high rate of multi-generational



Source: England: Office for National Statistics; The Netherlands: OECD Factbook 2006 and Eurostat; Taiwan: Department of Statistic, Ministry of Interior

Figure 1. Life expectancy of men and women from 1985 to 2005

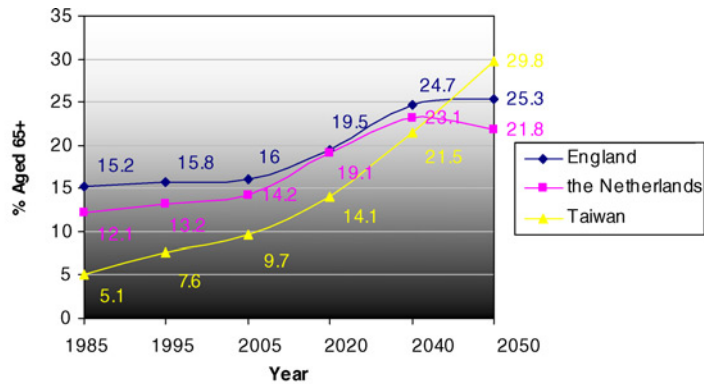


Figure 2.
Population aged 65+

Note: Figures for England cover the whole of the United Kingdom
Sources: England and The Netherlands: OECD Factbook 2007; Taiwan: Department of Household Registration Affairs, Ministry of Interior

households (see Table I). Cross-cultural and social expectations are especially relevant in explaining the differences in living arrangements between the East and the West. The Taiwanese pattern of co-residence follows from how older people used to be – and to an extent remain – looked after by the family who adopted the “Asian way” based upon the idea of filial piety (Phillips, 2000) with large familialising welfare responsibilities. This cultural belief partly explains the reasoning behind family obligation towards older people as legally stated in the *Family Obligation Act*. It also partly explains that state spending on families was modest in Taiwan because it was assumed that families were self-reliant. This is evident in the statistic which shows that over 80 per cent of disabled Taiwanese are cared for by their own families without any formal support (Bartlett and Wu, 2000). There is a darker side to this fraternal arrangement as it is reported that 5,000 older people have been abused or abandoned by family since 1995 (Liu, 2004). This has raised the demand for state support to carers and to frail older people when the family is not available. In the West, older people are either expected to continue to lead an active life on their own or at least not to interfere with the ongoing lives of their family. Socioeconomic factors such as greater financial independence and possible improvements in health may explain the increase in independent living for older people in England and Holland. This issue has brought to prominence concerns about the shortage of suitable housing in the two countries.

Second, since women have traditionally correlated with informal care provision, female employment is likely to alter the future care resources that older people will

Table I.
Percentage distribution of living arrangements of the elderly 65 and over in 2000

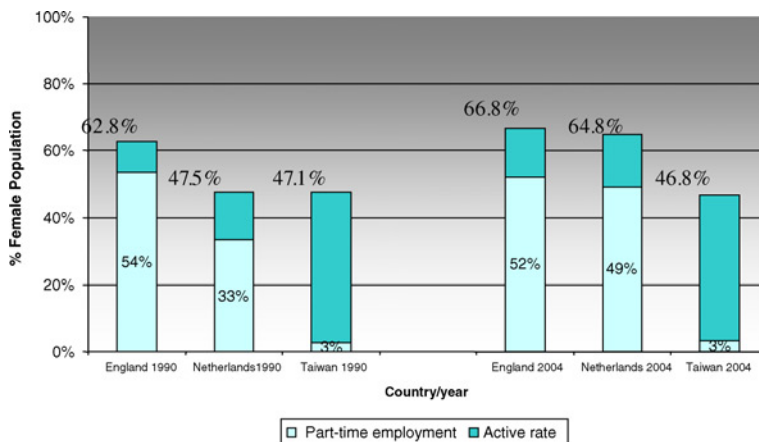
	Living alone	Living with spouse	Living with adult children (and spouse)	Others
England	35	50	8	7
The Netherlands	33	57.7	7.4	1.9
Taiwan	6.5	13.8	70.1	9.6

Sources: England: GHS 2001; The Netherlands: CBS Stateline, Person in independent household by age and sex 2000; Taiwan: Executive Yuan (2000)

receive. Figure 3 shows that the two European countries have a much higher percentage of female labour force activity than Taiwan. The difference is largely associated with English and Dutch women who were much (17 times) more likely than Taiwanese women to work part-time in order to maintain the balance of work and care.

The high employment participation of women in England and The Netherlands might be associated with the flexible working hours in labour market regulation and the relatively good public support for children and older people. This is in contrast to Taiwan where women have traditionally been expected to take the entire care for their family members at home. As a consequence many of them stop working when they have children and nearly all of the Taiwanese women who work also provide the main care for their families at home. This reflects the different norms and culture surrounding family obligations in general and women in particular. If we are genuinely concerned with equality there are good reason why we may want to reduce the social asymmetries connected with carerhood and work.

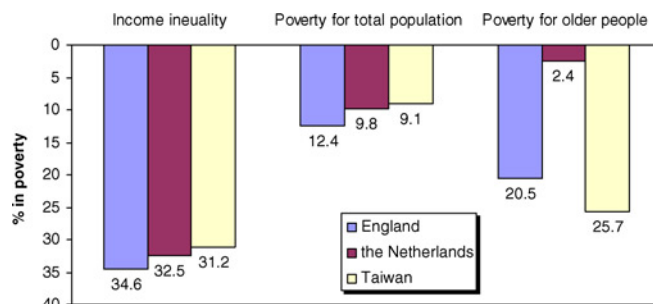
From the individual's perspective, financial security is central to well-being in old age and is another major resource that older people may command. This is problematic because, as life expectancy is longer, retirement without adequate income may cause hardship for many older people in the form of social exclusion, poverty and may increase public expenditure. Of the three countries covered in this study, the old-age poverty rate is greater than the rate of poverty for the general population in England and Taiwan, but the Dutch welfare state has succeeded in stemming the tide (Figure 4). Nonetheless, European research has shown that old-age poverty is biased against females, due to the high proportion of widows in this age group who are less likely to be entitled to pensions related to their own earnings (Zaidi *et al.*, 2006). Considering the trend of longevity, especially as women are expected to live longer than men, we would anticipate Dutch and English women will subsequently face high risk of old-age poverty which compromises their affordability of long-term care in the years to come. This is likely to be the case for those who currently work part-time or are unemployed. In contrast, older males have a higher poverty risk in Taiwan due to the main income resource deriving from kinship since most Taiwanese children are more generous to



Note: England figure from United Kingdom.

Sources: England and The Netherlands: OECD Factbook 2007; Taiwan: Executive Yuan 2006

Figure 3.
The activity rate of women and their share in part-time employment 1990-2004



Sources: Income inequality: WIDER world income inequality data base; Poverty: LIS Key Figure, 2006; Statistics Netherlands, Department of Household Registration Affairs, Ministry of Interior, Taiwan

Figure 4.
Income inequality,
poverty for total
population and older
people in 2000

their mother (Shieh, 2000). However, the problem is increasing in Taiwan as even though nearly 50 per cent of older people currently receive financial and care support from their children, the ratio has dropped drastically in past years, with the decrease in the number of children each older person can depend upon (Chiu, 2004).

Jehoel-Gijsbers (2004) argued that older people who are in a vulnerable situation can be protected by well-established social rights. This then is an added reason why we should lessen our reliance on social insurance by creating basic first-tier, redistributive components that is revenue-financed backed by a future pension guarantee (such as public pensions). It constitutes an effective measure against old-age poverty. Both England and The Netherlands have the universal state pension, but are moving away from an almost exclusive reliance on public pensions towards mixed models of retirement income provision (Whitehouse, 2003; Barr, 2006). The policy reasons for this trend are risk diversification and a wish to contain the level of compulsory contributions to public systems (Pearson and Martin, 2005). In contrast, Taiwanese pension provision has moved away from the historical reliance on privileged welfare and segmented social insurance (Chiu, 2004) to public pensions in 2007, along with family support to fund the incomes of older people. The good news about such international changes in pension systems is that the ageing financial inequality may become moderate. However it also bodes poorly as more individualised and unequal methods of provision may be found within the countries.

Economic constraints and the scale of welfare provision

The general sociodemographic trends discussed above cast doubt on the ability of publicly funded welfare systems in many industrial countries, especially in the areas of long-term care. The implementation of care and support can never be separated from a nation's economic performance, politics and public policies. Ensuring adequate welfare production today has become a question of how to co-ordinate the state, family, private and voluntary sectors.

From a macroeconomic perspective of these three countries, England was the first industrial nation, The Netherlands' industrial revolution was relatively late, followed by Taiwan recent industrialisation in the 1960s. Economically, England and The Netherlands have a similarly strong per capita income and Taiwan lags behind, but is closer to average Western economic wealth (see Table II). Table III shows that the Dutch

social-democratic regime clearly outperformed the other two countries in its public and social expenditure during the 1980s and 1990s. Nonetheless, the Dutch have also experienced significant political and economic pressure on state welfare provision and have moved toward a combination of public and private social benefit. As a result, their social expenditure had fallen to the level of England by 2000. In contrast, Taiwanese public social expenditure has increased since the 1980s; nonetheless, it remains much lower, around two-thirds of the two Western nations. Part of the explanation for Taiwan being a state welfare “laggard” can be found in its political development that has only recently moved away from what was in effect one-party rule to representative democracy.

The social expenditure of older people in combination with health and social care helps account for state expenditure in long-term care of older people. As statistics profiling the health cost of long-term care among older people cannot be found, the data of government health expenditure in the past 15 years can be used to make estimates of what constitutes health care inequality between the countries studied. Table IV suggests that the Dutch devote a higher percentage of gross domestic product (GDP) to health care expenditure, England comes second and Taiwan third. Such international variation relates to England’s (and Britain’s) National Health Service (NHS) which is tax funded and free at point of delivery (part of Esping-Andersen’s social-democratic element), whereas The Netherlands and Taiwan have health

	1990	1995	2000	2005
England	14,300	16,900	21,800	30,900
The Netherlands	13,900	17,200	23,100	30,600
Taiwan	–	10,600	16,100	26,700

Source: The World Factbook

Table II.
Real GDP per capita,
US \$

	England			The Netherlands			Taiwan		
	1980	1990	2000	1980	1990	2000	1980	1990	2000
Public expenditure	45.7	42.2	37	55.3	54.8	45.3	14.2	21.4	32.9
Social expenditure	17.9	19.5	21.7	26.9	27.6	21.8	3.8	6.8	13.1

Sources: England and The Netherlands: BNP Paribas and OECD (2004); Taiwan: Executive Yuan, Statistic Yearbook (2003)

Table III.
Public and social
expenditure as a
percentage of GDP

	1990	2000	2005
England	6.5	7.3	8.3
The Netherlands	8.2	8.3	9.8
Taiwan	4.6	5.7	6.2

Sources: England and The Netherlands: OECD Health Data (2005); Taiwan: Department of Health (2007)

Table IV.
Government health
expenditure as a
percentage of GDP

insurance systems. The difference in health insurance systems is significant as in The Netherlands the public sector continues to be the main source (62 per cent) of health financing based on a two-tier health insurance system (combining private insurance for some and social insurance for the whole population). A later scheme, the *General Act on Exceptional Medical Expenses*, also covers long-term care needs. In Taiwan, 70 per cent of the health care issuance made by individuals and their families in employment.

Whether long-term care is regarded as a social risk or a welfare issue shows major differences in the public cost of social care for older people between the two chosen EU countries and Taiwan – varying from 0.27 per cent of GDP in Taiwan to nearly 2.5 per cent in The Netherlands and approximately 1.7 per cent in England – based on means testing (part of Esping-Andersen's selective liberal type) (Lee, 2002; OECD, 2005). If we adjust the Taiwanese percentage for its comparatively low proportion of over-65s (see Figure 2) by a multiplier of 3, it would still be much less than the figures for The Netherlands and England. The figures imply that The Netherlands has made extensive public investment in long-term care support, followed closely by England and finally Taiwan. However, the cheapness of labour in Taiwan is a factor, which should be considered and may shrink the gap somewhat. There is also variation in the role of public and private spending, with over 90 per cent of Taiwanese older people relying on self-funding with considerable family support, an estimated 30 per cent of older people are self-funded in England and only 9 per cent in The Netherlands (Lee, 2002; OECD, 2005). This reflects each country's public financing arrangements and their welfare regime characteristics. Nonetheless, even the Dutch social democratic regime has found it difficult to uphold state responsibilities and the *Social Support Act 2006 (WMO)* has enforced the care cost retrenchment and de-centralisation in care responsibilities. There is evidence in England that in spite of the amount spent on care, under-funding in care services seems to be a problem. One in eight care providers stated they have been under-funded and 11 per cent were considering organisation closure (Knapp *et al.*, 2001). In contrast, the state in Taiwan has been increasing its funding in long-term care, focusing on universal home care support since 2003[2] as well as providing a universal old-age allowance. Additionally, a social-insurance type of long-term care system is expected to be announced in 2010. The above evidence shows that in terms of financing long-term care for older people, England, and especially The Netherlands, has moved from universalism towards selectivity, whereas Taiwan has moved from selectivity towards universalism. This may give some indication of further improvements in equality of long-term care public financing between the three countries studied.

So far, we have seen how England and The Netherlands, which have a tradition of strong state social protection, have provided more public financial support in long-term care in comparison with Taiwan. However, it is difficult to estimate the size of other welfare sectors apart from the state, family-oriented tradition. In order to explore the appropriateness and value of one care system over the other, a key empirical question, therefore, is how spending is allocated and how the cultural, political and demographic environments interact with the service responses to the benefit of older people.

Long-term care provision of older people

Table V summarises the major issues that are taken into account in determining eligibility for accessing state funding support in the three countries. All three countries have similar needs assessment criteria, but the service eligibility thresholds are

dissimilar due to economic conditions, public resources and social values. Because of near-universal enrolment in care, the Dutch represent the broadest range of factors to be considered for public support in care for older people. As mentioned earlier the Dutch have less older people in poverty than the other two countries. The Dutch case affirms the assertion that older people tend to be financially further disadvantaged because of the cost of care and can be protected by well-established social rights based on an ideology of solidarity between the strong and the weak (Ex *et al.*, 2004). In England, despite most long-term care being focused on personal care and safety (Wanless Review Team, 2005), there are issues regarding the quality of care that older people received: the means-test social care support requires that older people contribute most of their income and/or capital to the cost of long-term care and this negatively impact upon dignity and contribute to old-age poverty in care. This is manifested in the inadequate allowance – 2.5-3 GBP a day – for older people in care homes (Guardian, 2002); the “top ups”[3] payment for care homes (Bebbington, 1998); and the selling of older people’s homes to pay for their care in care homes. Nevertheless, in England, Taiwan and to some degree The Netherlands, the allocation of state funding support is influenced more by household composition than by the characteristics of older people themselves (Grundy, 2006). It can be argued that one consequence of policies that favour those living alone may be to disadvantage family carers and reduce incentives for older people to live with others.

Statistically, care homes and home-based care are the two main types of care service provided in the care markets. Table VI provides a general view of the percentages of older people who have received the two most commonly available care services. The Netherlands has the highest ratio of formal institutional care and home-based care for older people as a whole, England comes second and Taiwan a distant third. If we take live-in care (the preferred option in Taiwan) into account, Taiwan can be considered to have reached a similar level of care support to England. Taiwan is the only country of the three to have introduced self-funded 24-hour live-in home help to older people in their own home by migrant care-workers from South-Asia. As highlighted above most of the Taiwanese family carers face difficulties in undertaking substantial caring responsibility but also increasingly rely on the private market. The alternatives are

Criteria	England	The Netherlands	Taiwan
Age	All age groups	All age groups	65+
Health and functional status	ADL/IADL	Physical and psychological functioning	ADL/IADL
Availability of informal care	Considered	Considered	Considered and living alone
Income test	Means tested	Universal	Means tested
Additional eligibility criteria	None	The state of living environment; formal care support network	Living alone

Notes: 1. Activities of daily living (ADL) has been used in clinical assessments of older people, such as bathing, dressing, transferring from bed or chair, walking, eating, toilet use and grooming
2. Instrumental activities of daily living (IADL) has been used to assess functional capabilities of older persons. There are seven criteria: use of the telephone, use transportation, shopping, meal preparation, housework, medication use and management of money

Table V.
The eligibility criteria for access to long-term care support in the three countries

Country	Care homes	Home-based care	
		Home care	Live-in care
England	5	4	0
The Netherlands	8.8	12.5-13.0	0
Taiwan	1.3	0.7	5.3

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Table VI.
Share of population
65 and older received
care services in 2003
(per cent)

Notes: The estimates of share of population aged 65 and over in institutions may vary according to the definition of institutions. For example, the Netherlands includes those in shelter housing; proportion of older persons receiving formal help at home, including district nursing and help with Activities of Daily Living

Sources: England: Wanless Review Team (2005), The Netherlands: Adapted from Gibson *et al.* (2003), Taiwan: adopted from Department of Social Affairs (2006), Council of Labour Affairs, Executive Yuan ROC (2006)

necessarily found locally leading to the rise of the “global commodification of caretaking” (Parreñas, 2005) and the creation of “global care chains”. The *Live-in Caregivers Programme* regulates the migrant care worker to provide low-skill and low-cost care tasks in order to gain rapid entry into the workforce. Such a care option might be desirable for Taiwanese service users and family carers who pay a minimal wage to carers to provide 24-hours support, as it is more affordable than employing Taiwanese carers or live in care homes.

Although the ratio of care home admission in The Netherlands is relatively high, both The Netherlands and England have been actively de-institutionalised because of the cost, and in England – the poor quality of care (OECD, 1999). In some parts of the two countries, traditional homes for older people have gone through a transformation into care-intensive homes or extra care housing (European Commission, 1999). For example, Dutch extra care housing emphasis on connecting care, nursing, adapted housing, housekeeping assistance, a linen service, provision of meals, a shopping services and educational as well as social-recreational activities (Arcares, 2002). Research has suggested that such services could substitute, in part, for care home placement, thus reducing the rate of admission into residential and nursing homes (Coolen and Weekers, 1998). At the level of the individual, this could mean that an older person would be most unlikely to require to move when their care needs increased, thus their sense of security would be upheld. On the other hand, as mentioned earlier, Taiwan currently has youngest population in the countries studied and there is evidence of expanding its care homes alongside community care services in meeting the new demand of old-age long-term care (DH, 1997; Yang and Soon, 1998).

The crux of the welfare system structure lies in political and governmental intervention and family ethics in the market (Esping-Andersen, 1990). English welfare mix and privatisation policies, such as the NHS and Community Act 1990 has forced care services for older people into the private for-profit sector (Mur-Veeman *et al.*, 2003). Some commentators have noted that for-profit providers were often motivated purely by profit maximisation (Langarm, 1994; Knapp *et al.*, 2001). However, in the case of The Netherlands, Coolen and Weekers (1998) highlighted the problem that not-for-profit sector dominance has resulted in a lack of competition and a failure to stimulate quality improvement. The most severe problem which occurs in the Taiwanese newly developed care market is the existence of unlicensed care homes, which can take liberty with safety of older people.

Arguably, quality of care is crucial if older people's quality of life is to be maintained. One way to improve the quality of care is to ensure older people are empowered, especially to those who are excluded and overlooked because they are too frail physically to exercise rights and views. Cowger (1994 cited in Thursz, 1995) defined service-user empowerment as being characterised by two dynamics: personal empowerment and social empowerment. The former aspect is particularly relevant to state and multi-agency support. The latter is related to for example, "collective empowerment" whereby people with common goals and interests are grouped together for collective action. The greatest factor in achieving the empowerment of people who are disempowered for both action – personal and social empowerment – is to construct modes of action in a way that maximise the involvement of service users, while maintaining their autonomy and participation in decision making. In England, the quality of providers is monitored by local authorities through a system of contracting. Furthermore, at the national level, the Care Quality Commission provides quality control of health and adult social care in England, including monitoring the quality of residential care, nursing care and home care services across all sectors. At the individual level, service users are entitled to raise their views through the Complaints Procedure. In Taiwan, care services have been monitored and regulated by the Department of Health at national and local levels since 1995. Although many homes which existed before 1995 are in the process of becoming registered because of the penalties for non-compliance, many uncertified homes are associated with poor quality provision (Bartlett and Wu, 2000). Some problems, however, have occurred within this new system. For example, inspections have tended to emphasise the structural aspects of care (i.e. staffing ratios, size and residents per rooms), rather than processes and quality of life (Bartlett and Wu, 2000). Furthermore, a shortfall in quality monitoring staff at the local level has restricted the amount of quality control, resulting in greater inequality of care performance in general (Huang *et al.*, 2003). Therefore, the quality of care service still relies on strong family involvement and a care market that reflected the conservative-liberal welfare regime. In contrast, the Dutch social democrats raise a valid point when they conceptualise equality and welfare as a question of resource-command, capabilities and autonomy. To realise oneself through empowerment, one needs to first command sufficient social resources. The Dutch consumer councils (known as client boards) are organised within care agencies by law. Councils offer power to service users, their families and independent legal advisers by addressing their views and acting as watchdogs over services (Chen, 2007). Additionally, structured instruments for inspection and regulation are underway to increase regulation by setting price and quality standards (Huijbers and Martin, 1998). This suggests that the Dutch quality control mechanism is more active and better established and Dutch older people are better empowered than the other two countries.

Conclusion

This article provides a context for understanding the gaps in long-term care for older people between countries with different welfare regime traditions. Although cross-national comparison can be problematic as data and definitions vary from country to country, some important issues have emerged. The population is ageing, more women are participating in the labour force and all three countries are moving towards mixed welfare provision. Even The Netherlands has found it difficult to sustain increases in state provision due to the over-riding economic impact. The Dutch and English achieved advanced industrial status long before Taiwan and have developed welfare

systems over a long period of time as part of their systems of representative democracy. Taiwan's economic wealth has only recently caught up with the European standard and has started to invest more on the state support of care for older people. In spite of recent developments, Taiwan remains a welfare laggard in terms of public and social spending. It is however, difficult to estimate the size and significance of other welfare sectors apart from the state. It could be said that private and familial welfare goes some way towards narrowing the gap between Taiwan and the other two countries studied. The culture and tradition of England and The Netherlands are not dissimilar but Taiwanese traditions represent a considerable contrast.

Esping-Andersen's analysis has contributed significantly to our understanding of different between welfare states. This paper demonstrates that not one of the countries studied has completely conformed to Esping-Andersen's ideal types; instead, they seem constitute hybrids. England has elements of both the universal *social democratic* and the selective *liberal* type element in long-term care. The NHS is universal, but social care is means tested and private for-profit providers are becoming increasingly prevalent in England. The Netherlands has a strong *social democratic* element under the remit of state leadership by ways of payment of social insurance (*conservative* elements); accompanying voluntary associations are particularly strong in The Netherlands. Taiwan offers a *conservative* regime with a strong role for non-government organisations, as well as privileged welfare and segmented social insurance but with strong market/private or *liberal* element. All of the above factors impact on the equality of long-term care provision among the three countries. The Netherlands seems to provide wider support for older people who need care, England comes second and Taiwan comes third. Greater generosity and support were found in the Dutch social democratic-conservative welfare regime, based on their belief in solidarity and more tolerant care eligibility criteria with strong non-profit sector care provision. Furthermore, The Netherlands continues to modernise its long-term care services. It is becoming more comprehensive in meeting people's changing needs and has greater service-user empowerment through consumer councils. The care system in English liberal-social democratic welfare regime provided well-established quality control mechanisms and care services; however, the high threshold to attaining services and the basic level of care provision may have a significant impact on care quality. Insufficient public supply to meet demand for care is one element where Taiwan's quality of care fares poorly in comparative terms, especially where there is little or no family support. This is associated with cultural expectations and political agendas that force the care of older people to be seen as a family – and particularly feminine – concern and that is reflected as the conservative-liberal welfare regime. Nevertheless, there is clear evidence of increasing state support for the long-term care of older people in Taiwan. What this paper has clearly shown is that the gap in responsibility between the state, individual and family is closing between the three countries studied, as older people's rights become more clearly understood. It means that the potential and the requirement for cross-national learning become greater. Before this can be achieved more attention will need to be given to the complex relationship between policy, practice and a whole range of supplementary background factors.

The fragmented nature of the literature and data means it is difficult to claim that this is an exhaustive study. However, if the present study forms a platform for criticism and further work then one of its key objectives will have been achieved. It is hoped this paper will inform and encourage further effort in order to gain a better understanding

of cross-cultural long-term care of older people. This would include further investigation of the finding that the Dutch system is superior to the other two countries; what elements and structures of care systems support or fail to support the quality of later life; and the global market for care-workers and the extensive use of migrant workers in the field. The latter point is particularly important since there is a tendency in The Netherlands and England for service users to be expected to take more responsibility for their care through the English *Individual Budget* scheme and the Dutch *Personal Care Budget*.

Notes

1. The UK was given a liberal decommodification score of 23.4; The Netherlands, a social-democratic score of 32.4 and Japan – the only Eastern country to be included – a conservative score of 27.1.
2. Based on two scales: a maximum of 20 h per week for low-dependency clients and a maximum of 36 h per week for high-dependency service users.
3. ‘Top up’ payments is a term used to refer to contributions towards care home fees paid by the third party. It is estimated that more than 14 per cent of supported residents had to “top up”, and the number is likely to continue to increase (Bebbington, 1998).

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