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Possibility and Problems of a cross- country Comparative Analysis of Long- term Care Needs and Systems: Germany and Taiwan in Comparison

Dissertation zur Erlangung des akademischen Grades Doktor der Philosophie (Dr. phil.) vorgelegt von
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Chapter 1.
Issues Related to Long- term Care Needs

Rapid demographic change and the urgent need for the social rights to sound long- term care systems have taken place both in Germany and Taiwan. As a driving force, the two above-mentioned elements have influenced the establishment of care system and the traditional pattern of care. Regarding the social and politic aspects, both countries have some variations. Before addressing the main contents of this thesis, the context regarding both Germany and Taiwan will initially introduced. As a push force of the main pressure compelling reforms, demographic and social changes are two of the main issues faced in both countries. There is a wide spectrum of representation on demographic and social changes. Nevertheless, both these elements that drive the pattern of long- term care have become more difficult and there is a need for fundamental reforms to the respective systems. In order to compare the two systems, first it is necessary, to understand the general situation. The following sections will introduce the issues, which influence the long- term care needs in both Germany and Taiwan. In order to ensure the integrity of the statistical data used here, the period of collected statistic data in the dissertation will be selected from between 2007 to 2016.

Furthermore, the medium- variant projection is selected to describe all the data and all the collected data are from international or official organizations ad departments. These include the United Nations (UN), the World Health Organization (WHO), the Organization for Economic Co- operation and Development (OECD), the International Monetary Fund (IMF) and authoritative statistics departments e.g. the Federal statistical office (German: Statistisches Bundesamt) in Germany and the Directorate- General of Budget, Accounting and Statistics in

Taiwan.

1.1 The General Situation in Germany and Taiwan

Ageing has been a major focus for the demographic phenomenon in both Germany and Taiwan, and is the driver of a revolution in demographic changes in Europe and Asia. Germany's circumstance of experiencing an ageing population has lasted for at least three decades, and it is now one of the oldest countries in the world with a low total fertility rate, extended life expectancy, and growing numbers of immigrants. Under the same measures, Taiwan also faced the fastest rise in the age of population- in 25 years from 7 per cent to 14 per cent. The speed of population ageing in Taiwan was the second fastest in the world (Tsai, 2008). The proportion of the ageing population will rise from 7 per cent in 1997 to 14 per cent by 2017. Unlike the other countries around the world, Taiwan takes only twenty- four years to reach the aged society. For instance, in comparison the same rate of ageing takes 114 years in France, 82 years in Sweden, 56 years in Germany and 52 years in the Netherlands (Chung, 2004). Twenty- four years does not simply mean the speed at which the population is ageing, however, but also implies that Taiwan does not have much time to react to the phenomenon of rapid population ageing. Furthermore, having the lowest total fertility rate and continuing extension of life expectancy will cause an increase in the proportion of the ageing population. With the lowest total fertility rate in the world, and extended life expectancy, the demographic changes exist indexed meaning in Asia. Despite the growth rate slowing down when the last cohort of baby- boomers enter old age, however, the increase in the ageing population will cause the challenge to begin.

People live longer and this means that the need for long- term care will be greater than currently. Germany has experienced this and found ways to lessen the effect. Taiwan also has not much time to react to the issues. Besides, for Taiwan, the lowest fertility rate is the main problem it faces. With an unsupportive social environment, for instance, regarding governmental support, labor rights and the whole economic status of the country, the fertility rate in Taiwan is now the third lowest around the world and higher only than Macau and Hong Kong, with 1.12 births/ per woman (CIA Factbook, 2013). Despite this phenomenon occurring in all developed countries, the situation in Taiwan will be more serious than other countries because of the fast growth of the ageing population, i.e. the whole society does not have much time to respond to it and the reliable functioning of the traditional family setup will be threatened.

At the end of 2012, the total population in Germany was 80,996,685 (July 2014), of which, 39.4 million inhabitants were male and 41.5 million inhabitants were female. To analyze the compositions of each age group, people who were aged 65 occupied almost twenty per cent of total population. Based on the definition used by the United Nations (UN), when the proportion of the ageing population is over 20 per cent, it is deemed a “super- aged society”.

By comparison, at the end of 2013, Taiwan had a population of 23,359,928 inhabitants (11.6 million male and 11.6 million female). The percentage of ageing population was over 14 per cent, which means that Taiwan has already become an aged society. In 2008, the ageing population especially at age 80 and over, was about 4 million which accounted for 5 per cent of the population and for 25 per cent of the ageing population i.e. age 65 and over in Germany. Besides, in Taiwan, those aged 80 and over accounts for 2.8 per cent with 0.6 million people, while by 2012, those aged 80 and over accounts for 25.6 per cent of the ageing population. According to the estimation made by the Federal statistical office in Germany and the

Directorate- General of Budget, Accounting and Statistics in Taiwan, by 2020, the percentage of those aged 80 and over will account for 7 per cent of the population in Germany and 3.7 per cent in Taiwan respectively.

Table 1.1 shows the age groups as a proportion of the total population in Germany and Taiwan. In Germany currently, those who are aged 0- 20 occupy 19 per cent of the total population (15.6 million), while for those aged 20- 65 account for 61 per cent (49.7 million), and those aged 65 to under 80 are at 21 per cent (16.9 million). In Taiwan, 17.0 per cent are aged 0- 14 (3.9 million), while those aged 15-64 accounts for 72.6 per cent (16.7 million), and those aged 65 and over occupy 10.4 per cent (2.3 million). However, according to population projections by both countries, by 2060, the percentage of those aged 0- 14 will reach approximately 9.8 per cent in Taiwan, and 11 per cent in German. The proportion of those aged 15 to under 65 in Taiwan will reach 50.7 per cent, and 52 per cent in Germany. In addition, those aged 65 to under 80 will accounts for 21 per cent in Taiwan and 19 per cent in Germany respectively. Moreover, those age 80 and over will occupy 17.4 per cent of the total population in Taiwan, comparable to 13 per cent in Germany. The population pyramid in both Germany and Taiwan are shown in *Figure 1.1*.

Table 1.1 Age Groups as a Proportion of Total Population in Germany and Taiwan in 2008, 2020 and 2060 (in million (in per cent))

Age Group	2008	2020	2060
		Taiwan	
0 to under 14	3.9 (16.9%)	2.9 (12.5%)	1.8 (9.8%)
15 to under 65	16.7 (72.6%)	16.8 (71.4%)	9.5 (50.7%)
65 to under 80	1.8 (8.1%)	3.2 (12.7%)	4.3 (21.0%)

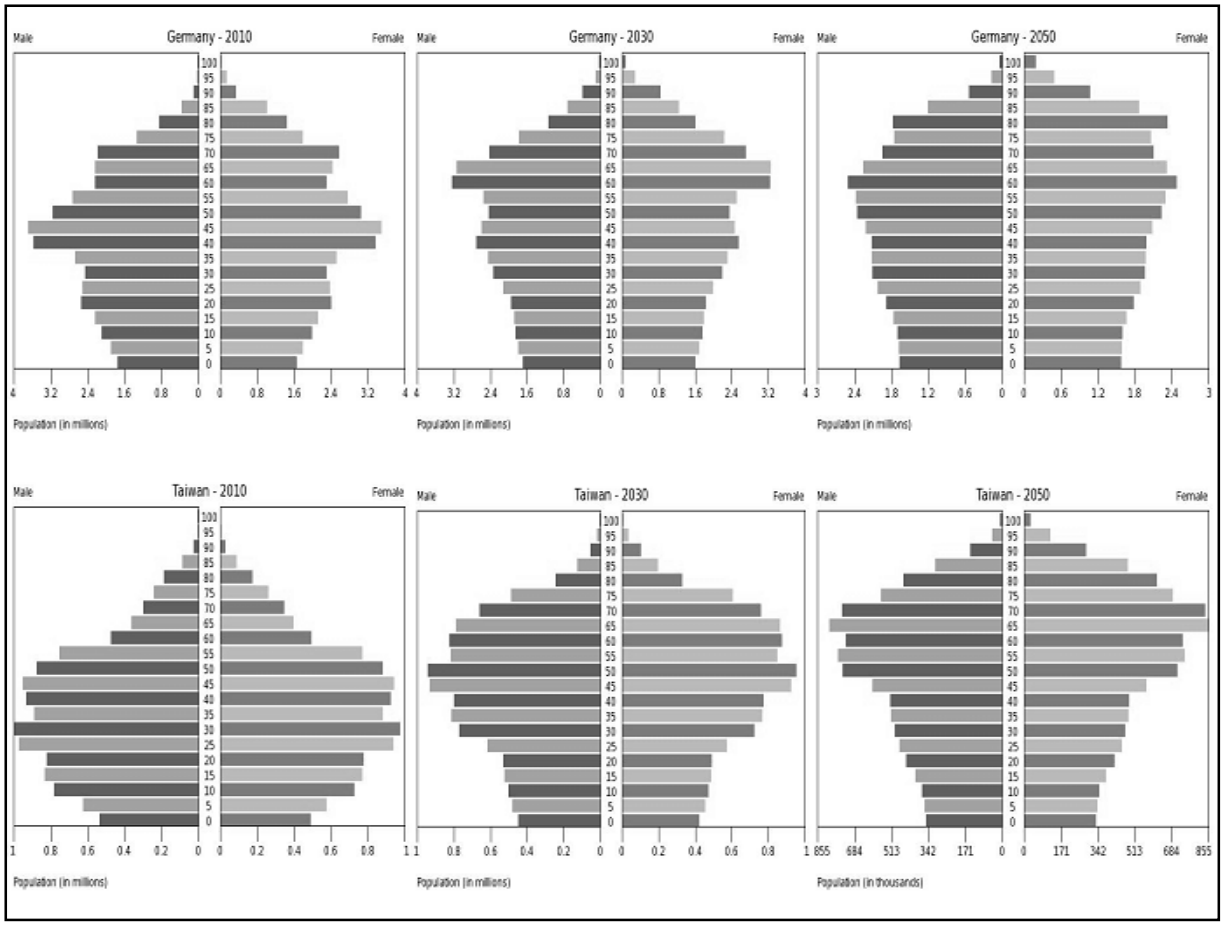
80 and older	0.5 (2.3%)	0.8 (3.7%)	3.0 (17.4%)
All ages	23.0(100%)	23.0 (100%)	18.6 (100%)

Germany			
0 to under 20	15.6 (19%)	13.7(17%)	11.0 (16%)
20 to under 65	49.7 (61%)	48.1 (60%)	36.2 (52%)
65 to under 80	12.7 (15%)	12.7 (16%)	13.7 (19%)
80 and older	4.1 (5%)	6.0 (7%)	9.2 (13%)
All ages	82.0 (100%)	80.4 (100%)	70.1 (100%)

Source: Germany: Federal Statistic Office (2009). 12th Coordinated Population Forecast;

Taiwan: Council for economic planning and development, Executive Yuan (2012).

Note: 1. All the data in 2020 and 2060 are calculated and estimated at a level of the median.



Source: U.S. Census Bureau; International Data Base, from
< http://www.census.gov/ipc/www/idb/informationGateway.php >

Figure 1.1 Population Pyramid Data in Germany and Taiwan, 2010, 2030 and 2050

Based on the official projection report, the proportion of the ageing population who are over 65 years old will not be significantly different. By 2060, both Germany and Taiwan have a similar old- age figure: 38.4 per cent in Taiwan and 32 per cent in Germany. With the rapidly growing number of ageing population, the trend reveals that this ageing population takes up the most resources in the social security nets. Furthermore, on the other hand, according to the research by the World Health Organization (WHO) in 1999 and the United States Department of Health and Human Service (U.S.DHH) in 2009 respectively, the demand for long- term care for the ageing population will increase gradually.

1.1.1 The Extended Life Expectancy (at Birth)

Related to the issue of demographic change is that, extended life expectancy will lead to a situation of demographic ageing (or: population ageing). Life expectancy (at birth) reflects the overall mortality level of a population. It summarizes the mortality pattern that prevails across all age groups of children and adolescents, adults and the elderly (WHO, 2008). Life expectancy uses a mathematical tool called a life table to predict the health of a population at a specific point in time. It summarizes the death rates from the population and applies a hypothetical cohort to them. The life table is then able to provide probabilities concerning the likelihood of someone in this hypothetical population dying or surviving before their next

birthday.

Technically, it constitutes the average number of years of life that a person has remaining at a specified age, assuming current age- specific mortality rates continue during the person's lifetime. Demographically, extended life expectancy at birth and a low fertility rate will contribute to the growth of ageing population.

Medical advances and economic development have caused the decrease of mortality and low infant mortality and extended life expectancy (at birth). However, smoking, high blood pressure, high blood sugar, and obesity have cut years off human lives, dropping life expectancy by about four years for women and five years for men. These four risk factors contribute to cardiovascular disease, cancer, and diabetes (Ezzati & Murray, 2006). Life expectancy is also used in public policy planning, especially as an indicator of future population ageing in developed nations.

The trend of medium life expectancy (at birth) in Germany and Taiwan reveals it to be increasing. *Table 1.2* shows very clearly that life expectancy (at birth) in German and Taiwan means that the elderly will grow older. Moreover, female life expectancy (at birth) exceeds that for men- by 5.2 years in Germany and 6.7 years in Taiwan. Although men's life expectancy is expected to improve, so too will women's. In 2060, the difference is still projected to be around 5- 6 years in both Germany and Taiwan. In this case, ageing issues are increasing pressure on politician to modify social policy to lighten the conflict caused by existing social circumstances.

Table 1.2 Medium Life Expectancy (at birth) in Germany and Taiwan, 2010 and 2060 (years old)

Year	Germany		Taiwan	
	Women	**Men**	**Women**	**Men**
2010	82.7	77.4	82.3	75.6
2060	89.2	85.0	89.0	82.2

Source: Germany: Federal Statistic Office (2009). 12th Coordinated Population Forecast; Taiwan: Council for economic planning and development, Executive Yuan (2008).

Life expectancy (LE) is treated as a concrete index to react to the development of the medical environment. However, with the increase in chronic diseases, people who live longer do not always live healthily. In order to measure the life expectancy by health level, the World Health Organization (WHO) collected data from 191 member countries and created a new index called Healthy Life Expectancy (HALE) in 1999 (Mathers, Murray, and Salomaon, 2003). Unlike the traditional one, the HALE index refers to an average number of years that a person can expect to live in full health by taking into account years lived in less than full health due to disease and/or injury, and so rates the quality of life.

In 2012, the health life expectancy of both genders in Germany was 71 years, and 70 years in 2003 in Taiwan. Comparing life expectancy and healthy life expectancy in both Germany and Taiwan shows that, people will suffer an unhealthy status for some period during their lifetime (7 years in Germany and 9 years in Taiwan). Among them, it can be seen that the life expectancy in both Germany and Taiwan share the same status as extended life expectancy. (see *Table 1.3*)

Table 1.3 Healthy Life Expectancy (HALE) at Birth in Germany and Taiwan in 2012 (years old)

Country	Female	Male	Both Genders
Germany	73	70	71
Taiwan	69.6	65.8	67.7

Source: Germany: World Health Organization (2012). Global Health Observatory Data Repository, from <http://apps.who.int/gho/data/node.main.688>;
Taiwan: Directorate- General of Budget, Accounting and Statistics, Executive Yuan (2012). Health Statistics in Taiwan,

Note: Currently, Taiwan is not listed on the member countries of the World Health Organization (WHO), and the statistics of HALE for Taiwan were only published by the official statistics department in 2012.

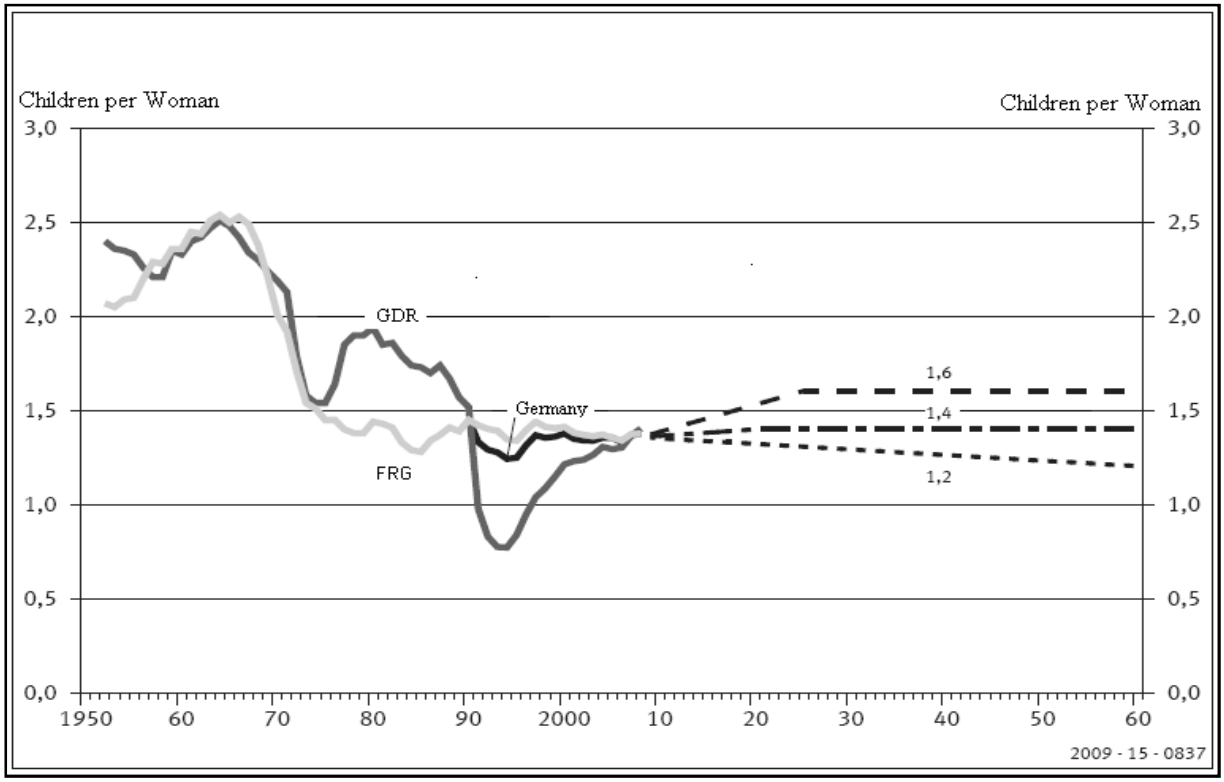
1.1.2 Trends in Total Fertility Rate and the Old- Age Dependency Ratio

Besides life expectancy, another major social issue is reflected in the total fertility rate (TFR). The indicator of total fertility rate is the average number of live births per woman in a year. The reproductive life span of a woman is usually defined in the age group 15 to 49.

In most developed regions, to replace a generation demands a total fertility rate of 2.1. Obviously, both countries will later face a decrease in its total population with 1.41 children per woman in Germany and 1.14 children per woman in Taiwan in 2009, which are remarkably below the replacement level.

Figure 1.2 depicts the long- term decline of fertility in Germany, whereby, during the period from the mid- 1940s to the mid- 1960s, the total fertility rate increase for 1.2 children per

woman from 1.4 to 2.6. This wave was called the Baby Boomer phase after World War II. However, since 1964 “Pillenknick” influenced the fertility rate, leading to the wave of the Baby Boomer generation being stopped.

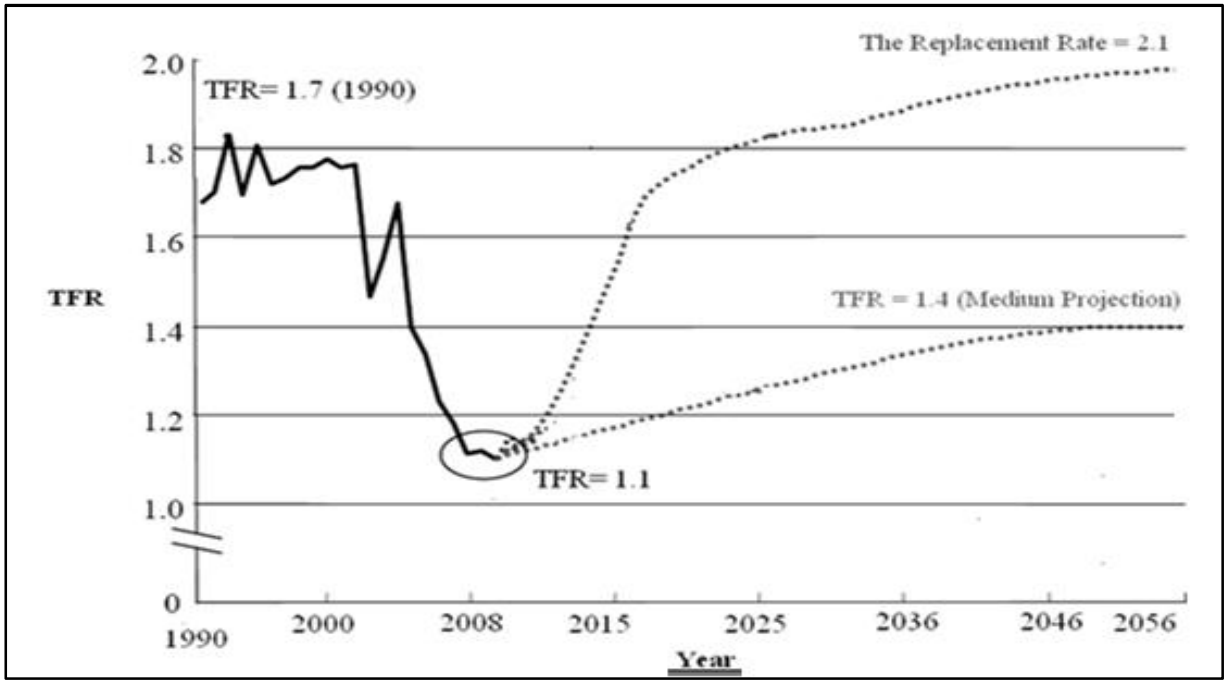


Source: Federal Statistic Office (2009). 12th Coordinated Population Forecast.

Figure 1.2 Total Fertility Trends in Germany, 1950- 2060

In Taiwan, the total fertility rate was decreasing from 7.0 children per woman in 1951 to 1.14 in 2010 and was expected to reach 1.4 children per woman by 2056. (see *Figure 1.3*) As in Germany, Taiwan experienced Baby Boomer phase during 1940s to 1960s. These generations are expected to reach retirement age by 2000 to 2020, which will confirm the rapid of the population.

According to the German 12th Coordinated Population Prospects (German: 12. Koordinierte Bevoelkungsvorausberechnung), by 2025, the total fertility rate will gradually increase to 1.6 children per woman; however, the amount will decline to 1.4 children per woman by 2060. In Taiwan, based on the Council for economic planning and development (C.E.P.D, 2009), the total fertility rate declined from 1.7 in 1990 to 1.1 in 2008, and it projected to rise to 1.4 children per woman by 2056.



Source: Council for economic planning and development (C.E.P.D), Executive Yuan (2008). Taiwan Demographic Projection 2008- 2056.

Figure 1.3 Total Fertility Trends in Taiwan, 1990- 2056

The issue of childlessness should not be ignored when referring to the total fertility rate. The proportion of childless couples has increased constantly and been caused by educational

attainment and other socioeconomic correlations. According to the data, the trends of fertility decrease and increasing childlessness have been confirmed in both countries. In Taiwan, the total fertility rate decline early in the mid- 1950s but in Germany it occurred, from the mid-1960s so the increase of childlessness has been a little delayed. The phenomenon of childlessness will become a consequential trend in developing and developed regions. Demographically, this situation changes the current and future structure of the total population, as it implies several sociological meanings such as the following: the proportion of the ageing population will increase; the pattern of family will shrink; female labor force participation rate will increase; the increase in the old age population dependency ratio will aggravate the burden of the working- age population. The foregoing phenomena will influence the care of those with disabilities or people with long- term care needs, especially for the frail elderly and will even effect life quality in old age. Moreover, economically, the reduction of the labor force will damage economic or national competency; it will be necessary to postpone the retirement age. Sociologically, it will also damage pension systems, especially for pay- as- you- go system and other social insurance schemes.

As people live longer, with low mortality, the ageing population will increase. Thus, the aged dependency ratio in both countries is significantly raised. The World Bank and the Council for Economic Planning and Development (C.E.P.D.) indicated that the old- age dependency ratio was 31.2 per cent in Germany compared to 14.4 in Taiwan in 2008. The trend has gradually risen in both countries. By 2012, the ratio reached 32 in Germany and 18 in Taiwan respectively. According to forecasts, by 2060, the aged dependency ratio will reach 63 or 67 in Germany and 76.9 in Taiwan. The wide gap between Germany and Taiwan is caused by the raised age of retirement and the extent of immigration in Germany and the serious depopulation in Taiwan, while the calculation assumes that the retired age is 67 years old by 2060, with Taiwan still calculated at 65 (Federal statistic office, 2009). (see *Table 1.4*)

Table 1.4 Old- Age Dependency Ratio in 2008, 2012 and 2060 in Germany and Taiwan (in %)

States	Selected Year		
	2008	**2012**	**2060**
Germany	31.2	32	63 or 67
Taiwan	14.4	18	76.9

Source: Germany: Federal Statistic Office (2009). 12th Coordinated Population Forecast and The World Bank, from: < http://data.worldbank.org/indicator/SP.POP.DPND.OL >; Taiwan: Directorate- General of Budget, Accounting and Statistics, Executive Yuan (2006). Health Statistics in Taiwan.

The old- age dependency ratio indicates that how many ageing populations are supported by a working population. In this regard, 3.1 of the young- and middle- age population will support an old person, compared to 6.7 to 1 in Taiwan in 2012. According to the official statistics from both countries, by 2060, 1.4 or .15 young- and middle- age people will maintain one elder in Germany, and 1.3 of the working population will support an old person in Taiwan. With the rise in old- age dependency, it can be seen that the heavy- burdened environment for those of working age will destroy the economic environment, and force the care resources to be poorly distributed between children and ageing populations. Therefore, it will become a very important issue for governments to phases in long- term care systems due to the care need gaps. While Germany has settled down the complete system, by contrast, Taiwan has a long way to go in overcoming the risk.

Obviously, a low fertility rate and continued extension of life expectancy will cause the ageing population to occupy a higher proportion of the total population. The proportion of the aged

population has increased rapidly and this trend did not just occur in developed countries, but also in developing countries and less- developed countries. Besides, according to research by the Department of Health and Human Service (HHS) in 2009 in the United States, about 70 per cent of individuals over age 65 will need at least some types of long- term care (LTC) services during their lifetime which, over 40 percent of them will need nursing home care services for some period (Burwell & Jackson, 1994). That means a positive correlation exists between the need for long- term care and age.

1.1.3 Informal care force and Female Labor Force Participation Rate

The phenomenon of extended life expectancy and low total fertility rate caused population ageing. The ageing population is itself growing older. About 70 per cent of individuals aged 65 and over will require at least some type of long-term care services during their lifetime. Moreover, over 40 per cent will need care in a nursing home for some period (WHO, 1999; USDHH, 2009). This investigation revealed that the growing ageing population would cause an increase in the number of those with long-term care needs, which would also influence the demand for long- term care services. Generally, there are two types of caregivers: the formal caregiver and the informal caregiver. Obviously, formal caregivers describes professional medical staff support or those who provide formal care in an institution, community or home. In contrast, an informal caregiver refers to a type of care that is provided by family members, friends, and neighbors and volunteers in a community or place of home. For the principle of ageing at home raised by the World Health Organization (WHO), informal caregivers play a very important role in home- based care. By the end of 2005 in Germany, about 46 per cent of

family care receivers are cared for exclusively by children, friends etc. without professional assistance (Rothgang & Igl, 2007), while compared to Taiwan, over 70 per cent of care receivers are cared for at home (Ministry of the Interior, 2012).

Generally, informal caregivers in long- term care system usually take on the caring for spouse, adult children, neighbors, and relatives. Women do more unpaid work than men do at almost all ages and whatever their employment status. However, both Germany and Taiwan had found it tough to support these circumstances to support this without female labor force participation stepping up.

The traditional care forces are females in Taiwan, e.g. female spouse, daughter, daughter in law and female relatives. Despite the progress of the times and the urgent pursuit of gender equality, and despite women are not the only care craft in the household or even in society, however, the main responsibility still falls on female shoulders. Because of the rise in female labor force participation, women no longer stay at home, shoulder the responsibility of care. With the participation rate growing gradually, acts of care will no longer take place at home, but will make demands on professional institutions or organizations in society.

In Taiwan, the female labor force participation rate increase from 40.4 per cent in 1989 to 49.7 per cent in 2008, compared to Germany's 42.7 per cent in 1989 and 52.0 per cent in 2008 (see *Table 1.5*). In Taiwan, most family caregivers are also female, at fact, which has consequences for the phase of care giving. Due to this circumstance, the overloading responsibilities of care cause higher level of stress. The increased female force participation rate in both countries causes the informal care force to decline.

Table1.5 Female Labor Force Participation Rate in Germany and Taiwan, Comparable in 1989, 1994, 1999, 2004 and 2008 (in %)

States	1989	1994	1999	2004	2008
Germany	42.7	47.1	48.3	49.2	52.0
Taiwan	40.4	45.0	43.9	47.6	49.7

Source: Germany: OECD StatExtracts- Labor Force participation, By sex and age, from:
< http://stats.oecd.org/index.aspx >;
Taiwan: Directorate- General of Budget, Accounting and Statistics, Executive Yuan, 2009.

The decline of the informal care force by parental caregivers will become a gradual trend. Both nations' governments have to establish a sound social scheme to consider both home- based care and economic conditions. In Germany, the Social Long- term Care Insurance Act in Social Code Book XI (SGB XI- Soziale Pflegeversicherung) defined the rights and level of assistance for informal and parental caregivers, including respite care, day care, personal pension and relevant social rights and a social security net for caregivers. In Taiwan, similarly, the Comprehensive Warm Flagship Plan (2007): Ten Years Long- term Care Program specifies assistance for informal and parental caregivers with respite care. In light of this, both Germany and Taiwan are searching for inspired programs and assistance to support the informal care force and keep the cares at home or nearby in the community. However, slow action cannot save a critical situation. Of course, Germany's care system is now a mature system, which operates its daily work under the law. Long- term care needs have become urgent in Taiwan for its society, and the related policies need a period of time to respond the issues.

1.1.4 The Principle of Ageing in Place in Taiwan

The above- mentioned issues illustrate the demographic changes in Germany and Taiwan. Here, in this section we will introduce the principle of ageing in place according to Confucian culture. The background to introducing the Ten Years Long- term Care program is comprised of demographic and, financial causes, while the main principle of social rights is an important driver as well. When Confucianism produced its writings on The Great Harmony two thousand years ago, social welfare and social care for residents finally achieved respectability in Chinese folk society. This book contains some views regarding disability and the elderly:

"... Provision is secured for the aged until death, employment for the able- bodied, and the mean of growing up for the young. Helpless widows and widowers, orphans and the lonely, as well as the sick and the disable, are well cared."

In addition, in other writings called the Rites of Zhou- The Role of Tah Seatu indicates that there are six guidelines to rule the country and bring people stability:

"... to be kind to the children, care for the old, to aid distressed, to relieve the poverty, to treat the disability with leniency and to stabilize the plentiful society."

The above two quotes could be regarded as a beginning of a guide for social welfare. Until now, these principles have still been deep- rooted in the scheme of social welfare policy in Chinese society, such as in Taiwan, such as the issue of care policy for the elderly and the disabled.

Since Confucianism has influenced the Chinese society for over two thousand years, in comparison with the social welfare scheme, Chinese society has its own model (Lin, 1994). The model of Confucian welfare state emphasizes that the household is the main supporting pillar in satisfying welfare demands (Jones, 1993). The role of the government is to strengthen the ability to provide welfare to households. Within traditional Chinese culture, the household shoulders the responsibility to care for family members (Saunders, 1996).

According to the report by the Ministry of Interior in 2005, about 60 per cent of the ageing population tend to live with their families or live in a familiar community, but do not want to stay in institutions. Besides, ageing in place is the aim of developing a long- term care policy in Taiwan. Hence, community care is regarded as a main point for long- term care policy, with home care as the highest priority and institutional care as the subsidiary measure. However, in recent years, institutional care has rapidly grown, and monopolizing the long- term care market. In contrast to home care has been marked time, which is almost contrary to the concept of ageing in place.

The above mentioned lifting of social rights has not only influenced levels of respect for care rights but also influences human rights. Under the circumstance of emphasizing human autonomy and respect for human beings, regarding the end period of ageing living, people have rights to choose how they receive health care and where they reside. According to the statistics, most elderly have a strong wish to choose where and how they age in place. The concept of the ageing in place provides a secure and familiar environment which connects the family and community and gives them both independence and autonomy (Wiles, 2011). This notion of ageing in place has become a main elderly care policy in the countries that have entered the pattern of an ageing society. The purpose of the policy is to provide residential care for the disabled in their familiar environment. Usually, the familiar environment refers to their family-

of- origin or a community nearby which can provide the support network. In Taiwan, due to the tradition of Confucianism, the household plays an important role in providing the supporting pillar. The elderly has a strong wish to age in her/ his familiar environment, near their family or community. The family members also regard this as a responsibility. Hence, ageing in place will no longer be just a slogan, as this concept has been deeply rooted in the culture for two thousand years. Thus, it can be seen that the long- term care policy in Taiwan should contain the principle of ageing in place to meet the needs and wishes of the people.

1.2 The Predicament of Long- term Care System in Taiwan

Taiwan's relationship to Chinese culture has seen it influenced by Confucianism for over 400 years, since 1662. As one of the four Asian Tigers (Hong Kong, Singapore, South Korea and Taiwan) located at an important economic and strategic position in Asia, its economic development and competency was able to rapidly attain the international level due to the advantage of its location, especially in the High Technology Industry and the emerging biological industry. With its economic development, a favorable balance of trade and a stable political scheme, Taiwan gained huge strength through it economy. Under these circumstances, Taiwan has enough capital to establish the infrastructure for and to complete a social security scheme.

Since 1995, the Taiwan national health insurance program was enacted, and increasing the quality of medical treatment and its environment was promoted. One result was the extending life expectancy.

In 1993, the proportion of ageing population in Taiwan was 7 per cent, an so it became an "ageing nation". An official authority forecasted that the proportion of ageing population in Taiwan would spend only 25 years (in 2018) from 7 per cent to 14 per cent (Council for Economic Planning and Development, 2008). Taiwan is experiencing rapid population ageing and this is some degree of demographic and social change. These are the elements forcing the society to face the issue and take account of the demands of target groups. Based on the Constitution of Taiwan article 155.:

The State, in order to promote social welfare, shall establish a social insurance system. To the aged and the infirm who are unable to earn a living, and to victims of unusual calamities, the State shall give appropriate assistance and relief.

This reveals that the basic conception takes social insurance as a main subject/ -principle. Therefore, since 1950, Taiwan has phased in many social insurance programs for its nationals, which include Servicemen Insurance (1950), Labor Insurance (1958), Civil Servant Insurance (1958), Farmer Health Insurance (1985), National Health Insurance (1995) and National Pension Insurance (2008). These social insurance are based on the concept of social policy, which shares responsibility for the risk of providing the protection for the economic and standards of living for Nationals.

A global ageing survey conducted by the Oxford Institute of Population Ageing in the United Kingdom indicated that Asia and Europe are two regions where a significant number of countries face severe population ageing in the near future. Even Asian countries will face rapid population ageing and the ageing speed will be even faster than in other European countries (Leeson, 2008). Under this circumstance, the social conditions and supports systems in the

developing East Asian countries have not much time to react and overcome this kind of challenge. In these countries, in order to overcome the difficulties, which were caused by the growing ageing population, both Japan and Korea have established Long- term Care Insurance (LTCI) to construct and sustain sound care systems in 2000 and 2008 respectively.

By contrast, Taiwan is experiencing rapid demographic change, financial stress over national health insurance and the urgent need for long- term care services. Unlike other countries where at social policy for the ageing population has been established, the care policy in Taiwan has been revealed as very weak and fragmented. Until now, a complete long- term care system has not been established, with only a patch- work system supporting the long- term care needs. Under the philosophy of Confucianism, the social welfare emphasizes the importance of informal sectors such as family members, communities, and religion, which means that these sectors shoulder a large responsibility for social welfare. These characteristics have influenced the cooperation between government and the informal sector. Traditionally, on the one hand, the government focuses on developing the economy while on the other hand it redistributes the responsibility for social care to the family, community, and religion.

Before enacting the Ten Years Long- term Care Program, Taiwan scholars generalized the three problems facing the establishment of long- term care in Taiwan (Wu, 1998; Wang, 2005; Chen, 2005; Yang, 2005; Wu, 2006; Cheng, 2005; Wu, 2006):

(1) *The fragmented nature of care- related authority and legislation*:

The care authorities for different objective population belongs to the different administrative departments in Taiwan, such as the Ministry of Interior, Ministry of Education, Ministry of Health, Ministry of Labor Affair and Ministry of Veterans, all of which have responsibilities for different populations and follow different legislation in their own systems. This kind of model

focuses on providing assistance to those that need it giving professional support. However, the current situation proves that this system will make the distribution of care resources more difficult and that the comprehensive care cannot be implemented very well through it (Wu, 2003; Chen, 2005). Besides, regarding the aspect of legislation, the different authorities have their own laws or regulations concerning long- term care, which creates disorder in the system and wastes resources.

(2) *Fewer service modes for the long- term care system*:

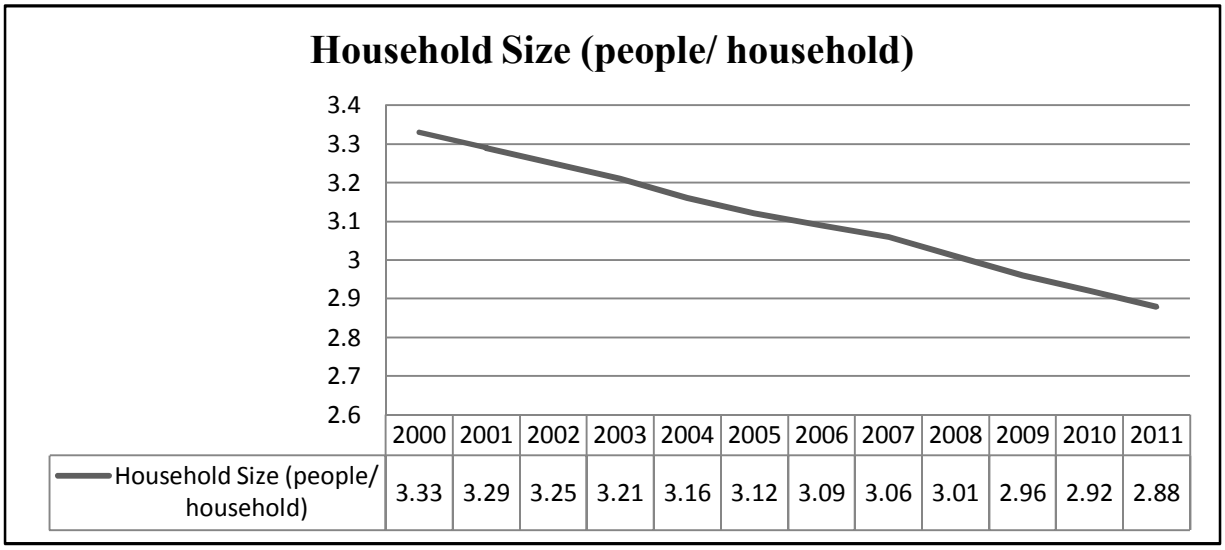
For a long time, within traditional Chinese culture, the responsibility for caring for the elderly is shouldered by the relatives especially by the spouse, daughter and daughter in law, i.e. the people with long- term care needs will be cared for at home. Under this circumstance, the manifold number of service modes cannot exert any influence. However, with the demographic change and social improvement, the demand on the manifold number of service modes has increased.

(3) *The lack of formal and informal care workforce in the long- term care system*:

The labor force in the long- term care system can be divided into two sections i.e. informal care and professional formal care systems. For the informal system, two phenomenon will drive the lack of informal care workforce. The household size in Taiwan increased from 3.33 people per household in 2000 to 2.88 people per household in 2011 (see *Figure 1.4*). Through the decrease of family members in recent years, the responsibility has gradually been transferred to the public sector.

Due to the above- mentioned circumstances, the responsibility for the establishment of care systems will fall on the government and nongovernment organization (NGO). To interpret the drivers of the establishment of care systems from the aspect of demographic change, we will

next continue to discuss the influence of the aspect of financial stress and its role in the existing system.



Source: Department of Statistics, Ministry of the Interior, Executive Yuan, Taiwan, from:

< http://statis.moi.gov.tw/micst/stmain.jsp?sys=100 >

Figure 1.4 The Development of Household Size in Taiwan, 2000- 2011

In discussing this issue, several turning points will be considered. First is the establishment of the National Health Insurance (NHI), second, the Ten Years Long- term Care Program in 2007, and the last one is the huge cohort of post baby- boomers becoming 65 years old by 2014 in Taiwan.

Before the establishment of National Health Insurance, the financial stress of medical expenditure (acute medical treatment and chronic care) was shouldered by aspects of specific social insurance, individual, family members and third parties, which refers to such elements as religion organizations, the popular rotation savings and credit associations and the

governmental social add scheme. The appearance of the population structure takes on a pyramid pattern with the numerous caregivers (female family members) making the demand for long- term care not seems to be an important issue for the whole society. In addition, here, the specific social insurance refers to the governmental protection policy for farmers, public servants (included teachers and military personnel) and labors. At that time, the economic status of the country was generally impoverished. Most people without protection and capital could not obtain equitable rights for receiving medical treatment, hence, many people died due to a lack of disposable income (Bureau of National Health Insurance, 2001). The social add scheme refers to the Public Assistance Act, implemented in 1980 in Taiwan. The act was enacted to care for low- income and middle- low- income households, the persons in need of assistance during an emergency or disaster, and to help them live independently. Moreover, the public assistance referred to in this act is divided into living support, medical subsidies, and emergency and disaster aid (the modification of Public Assistance Act, 2011). Currently, here, the medical subsidies are regarded as an additional financial assistance for payment of National Health Insurance. That means that the low- income and middle- income earner could obtain a whole or partial subsidy to pay the contribution to the National Health Insurance. Before 1995, this Act only focused on the low- income household, emergency and disaster aid. With the aging of the population and the increase in the number of disability claims, caused by the widening of the criteria, the financial pressures have been increasing gradually. Besides, due to the difficult social condition, the government did not dare raise taxes. Under this circumstance, the medical care system became weak and only focused on acute medical treatment while, in contrast, the long- term care service was regarded as an unnecessary scheme.

The most important reason was that the National Health Insurance was regarded as a social insurance scheme initially, and therefore, in order to implement control over the system, distributed resources efficiently and keep the cost of the administrative expenditure down, the

government established a Bureau of National Health Insurance to respond to the whole scheme. Since the Nation Health Insurance was established in 1995, most of the financial burden was transferred from the individual and households to central government. Generally, the expenditure on National Health Insurance was used in the following three fields: preventative health education, medical treatment, and care services. The three sectors were balanced very well in the first few years, but, due to the rapid demographic change, the black hole caused by medical prices and unfair calculations regarding contributions to the National Health Insurance, the government (Bureau of the National Health Insurance) gradually could not cope with such a huge expenditure. To concentrate on the effect of the rapid demographic change, the increased ageing population alone will make a huge impact on the financial status of the National Health Insurance.

According to a working paper by the Department of Health, Executive Yuan in Taiwan, the medical utilization of citizens aged 65 and over in the National Health Insurance revealed several significant increases during the period between 2000- 2010. Medical expenditure by people aged over 65 years old in the national health insurance average rose 87.9 per cent from 2000 to 2010, of which 104.1 per cent were female and 74.8 per cent male (see *Table 1.6*). During this period, the number of people age 65 and over increased about 30 per cent. Furthermore, the medical expenditure of people aged 80 and over is higher than people age 65 and over, a rise of 219 per cent in 10 years (see *Table 1.7*). With the post- war baby boomer generation continually entering 65 years old, the payments will keep increasing in the near future (Press of Department of Health, 2012).

In addition to the continual increase in medical expenditure, the poor health status at those aged sixty- five and over will increase as well. In comparison with the data for 2005 and 2009, the proportion of the elderly who suffered from serious illness or chronic disease was revealed

as increasing (Press of Department of Health, 2012) (see *Figure 1.5*).

Table 1.6 The Medical Expenditure of Citizens Aged 65 and over in the National Health Insurance (NHI)

Year	Medical Payment of the NHI (in million)			The Number of Citizens aged 65 + (in 10 thousand)		
	Sum	**Male**	**Female**	**Total**	**Male**	**Female**
2000	89,982.8	49,179.3	40,263.5	192.1	101.1	91.0
2001	93,711.2	51,281.0	42,430.2	197.3	102.7	94.7
2002	109,886.8	59,706.0	50,180.8	203.1	104.5	98.6
2003	116,083.9	62,486.3	53,597.6	208.8	106.3	102.4
2004	136,023.1	72,793.1	63,230.1	215.0	108.3	106.7
2005	141,044.1	75,113.9	65,930.2	221.7	110.5	111.1
2006	142,803.9	75,430.7	67,373.2	228.7	113.0	115.7
2007	149,924.7	78,425.3	71,499.4	234.3	114.6	119.7
2008	158,118.8	82,017.3	76,101.5	240.2	116.5	123.7
2009	164,715.3	85,102.8	79,612.5	241.3	116.9	124.4
2010	169,098.9	86,924.7	82,174.8	248.8	118.9	129.9
Decade Difference (in %)	**87.9 %**	74%	104.1%	**29.5%**	17.6%	42.7%

Source: The Press of Department of Health, Executive Yuan (2012). The Situation of Medical Expenditure of Citizens Aged 65+ in the National Health Insurance, Taipei, Taiwan.

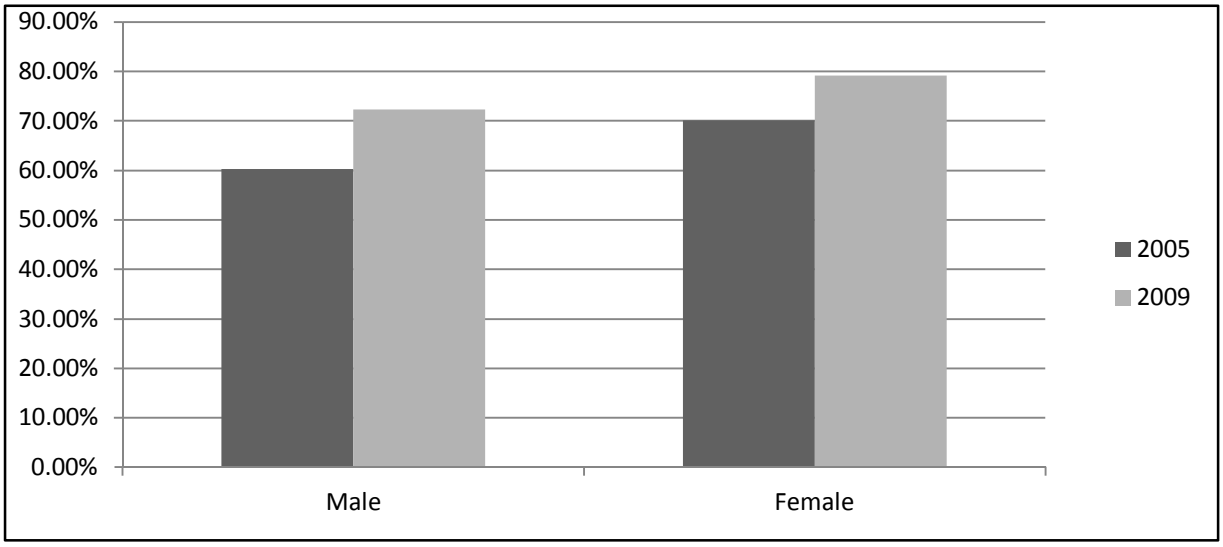
The above- mentioned statistics reveal that medical expenditure in the National Health Insurance increase with the growth of the age. Moreover, the proportion of the elderly who suffer from serious illness or chronic disease increased 12.03 per cent for males and 9.17 per cent for females between 2005 and 2009 (Department of Health, 2012). Under these circumstances, the financial pressure of the National Health Insurance will only become heavier. The care for the chronically ill will take up a large propotion of the expenditure, and this will rise rapidly in the near future, especially when the cohort of baby boomers reach 65 years old in three years. At that time, the financial situation of the scheme will become more difficult.

Table 1.7 The Medical Expenditure of Citizens Aged 80 and over in the National Health Insurance (NHI)

Year	**Medical Payment of the NHI (in million)**			**The Number of Citizens aged 80 + (in 10 thousand)**		
	Sum	**Male**	**Female**	**Total**	**Male**	**Female**
2000	16,638.5	8,786.5	7,852.0	30.1	14.5	15.6
2001	18,024.0	9,528.5	8,495.4	32.7	15.9	16.9
2002	23,696.3	12,540.6	11,155.7	35.3	17.2	18.1
2003	26,639.8	14,109.2	12,530.6	37.7	18.5	19.2
2004	33,045.1	17,512.0	15,533.2	40.3	19.9	20.4
2005	35,944.3	19,278.6	16,665.6	43.5	21.7	21.7
2006	37,622.5	20,373.1	17,249.4	47.2	23.7	23.5
2007	41,548.2	22,567.5	18,980.8	50.2	25.2	25.0
2008	45,738.2	24,883.9	20,854.3	53.5	27.0	26.6

2009	49,401.2	27,047.8	22,353.4	54.1	27.3	26.9
2010	53,002.1	29,064.2	23,937.9	60.5	30.4	30.1
Decade Difference (in %)	**218.6%**	230.8%	204.9%	**101.0%**	109.7%	92.6%

Source: The Press of Department of Health, Executive Yuan (2012). The Situation of Medical Expenditure of Citizens Aged 80+ in the National Health Insurance, Taipei, Taiwan.



Year	Male	Female
2005	60.33%	70.07%
2009	72.36%	79.24%

Source: The Press of Department of Health, Executive Yuan (2012). The medical utilization of citizens aged 65+ in the National Health Insurance, Taipei, Taiwan.

Figure 1.5 The Proportion of the Elderly who Suffered from Serious Illness or Chronic Disease in 2005 and 2009 in Comparison (in per cent)

1.3 Discussion and Conclusion

Germany and Taiwan are experiencing the urgent and rapid growth of long- term care needs. The demographic and social changes, the greater importance of social rights for long- term care drive the government to establish and enact appropriable care policies to respond to them. Germany and Taiwan have phased in some different types of policy for the rapidly increased ageing population and their long- term care needs. A common misunderstanding about the need for long- term care is that it will always only happen to the elderly. However, the official statistics reveal that the need for long- term care can occur at any age. Anyone may need long-term care at any time in one's lifespan (Baldwin, 2013). Age is thus not the issue of long- term care. Children and adults can suffer chronic diseases and disability before they enter the age. Although the definition of the need for long- term care has a number of implications, that they function is the main point to defining long- term care needs and developing care services.

This chapter begins with a look at the general situation in Germany and Taiwan. We focus on the elements, which relate to the issue of long- term care needs. As we know, the ageing population in both countries is growing fast. With the low fertility rate and higher levels of female labor participation, the traditional care force will be changed, and professional care providers (care manpower or care facilities) will take over these responsibilities. In this chapter, the remarkable situation of the low fertility rate in Taiwan was noted. It is the third lowest in the world and better than Macau and Hong Kong, reaching 1.12 births/ woman. It affects old-age dependency, eliminates the influence of the economic field, and make support for the elderly difficult in the near future.

Concerning the issue of "Ageing in Place", here we select Taiwan's status to expand on its

view of Confucian culture. Confucianism has influenced Chinese society for over two thousand years, and in comparison with the social welfare scheme, Chinese society has its own model. The model of the Confucian welfare state emphasizes that the household is the main supporting pillar for satisfying welfare demands (Jones, 1993). The role of the government is to strengthen the ability for people to provide welfare in the household. Returning to the issue of care, unlike in the western countries, the principle of ageing in place stars with the autonomy, respect, and social rights. As this concept in Taiwan has been influential for thousands years under the "Rule". Most of the elderly and care receivers in Taiwan choose to stay at home.

The demographic and social changes influence the need for long- term care services. Moreover, according to the research, the prevalent rate of dementia and age show a positive correlation. With people living longer, the rate of prevalence of dementia also rise. Based on official statistics in both Germany and Taiwan, the prevalent rate of dementia is increasing year by year. Until now, scientists have still not found a cure for dementia. Therefore, so far, we can only establish and provide a sound long- term care system for care receivers and their family members. At the beginning, the dementia sufferer has no apparent symptoms. Therefore, Germany has enacted the Level- 0 to support the care services. In Taiwan also, the Ten Years Long- term Care Program has provided care services to support the life quality of dementia sufferers.

Chapter Two illustrates the effects of demographic and social change, which drive the shift in the pattern of long- term care. Despite different variations in both Germany and Taiwan, it is almost certain that the urgent demand for long- term care reveals significantly. In the following chapters the social policies and welfare models related to long- term care in both countries will be described in order to understand and analyze the social and governmental responses.

Chapter 2.

The Measurement of Long- term Care Needs and Its Attribution

The ageing population is a group at high- risk of suffering cardiovascular disease, Alzheimer, and restrictions in active daily living. The World Health Organization (WHO) has estimated that the potential need for care would take up to seven to nine years of one's lifetime in 2004 and, moreover, extended the period from eight to ten years in 2008 (Lee, 2010). With the substantial progress of medical skills and the establishment of statutory health care insurance, the population in both Germany and Taiwan live longer. According to the above- mentioned statistics in both Germany and Taiwan, demographic and social change are driving the increase in long- term care needs (Freter, 2012). However, besides this, with people living longer, some associated diseases will mean there is need for long- term care services. Based on epidemiological statistics, the prevalence rate of dementia increased significantly with age, with about 5 per cent of people over 65 years old expecting to be affected by dementia and 20 to 40 per cent of those older than 85 and over (Sadock & Sadock, 2008). This confirms that a positive correlation exists between dementia and age. According to above the demographic statistics in both Germany and Taiwan, the prevalence of dementia is increasing and is driving the urgent need for long- term care services. Under this circumstance of the rising prevalence of dementia, the existing estimate for the level of long- term care should be adjusted.

2.1 The Measurement of Long- term Care Need with Dementia

In Germany, currently, people who suffered from Alzheimer's disease has reached 1.4 million, and it is predicted it will exceed 2 million by 2040. According to the current care evaluation, the people who suffer from Alzheimer's Disease cannot be included in the three aforementioned care levels; however, they do need some degree of long- term care, therefore, the Long- term Care Reform Act in 2008 added a level for these care receivers called care level 0 (Naegele, 2010; Focus, 2012).

The concept of long- term care needs (German: Die Pflegebeduerftigkeit) is one of the main cores strands of long- term care insurance in Germany (SGB XI § 14.). Germany's long- term care act defines persons are regarded as being in need of long- term care who, due to illness or disabilities, permanently require extensive assistance o perform basic and regulat activities of daily living (e.g. dressing and undressing, personal hygiene, toileting, eating) for a minimum periord of at least six months. (Naegele, 2009). The objects of the long- term care service in Germany are defined as anyone of age of the population who has serious disabilities. Four degrees of disability is determined by the time required i.e. the time required for at least two functions of Activities of Daily Living (ADLs) and required of Instrumental Activities of Daily Living (IADLs). (see *Table 2.1*)

According to the level of disability, the total number of dependent persons in home and institutional care is about 2.54 million (of which 1.77 million required home care and 0.77 million are in institutional care) in 2013. This trend will keep increasing. Based on the risk rate of requiring long- term care, approx. 0.7 percent of persons before they reach the age of 60 will need long- term care services, 4.4 percent in between 60 and 80 years of age, and 28.6 percent

in above the age of 80.

Table 2.1 Three Degrees of Disability under the Act of Long- term Care Insurance in Germany

Degree of Disability	**Frequency of Need for ADLs/ IADLs**	**The Time Require of ADLs/ IADLs**
Care Level 0	*The so-called "care level 0" indicate:* Individuals with considerable assigned limited, although a basic care and domestic help have been supplied, however the qualification does not reach care level I.	
Care Level I	ADLs: Once a Day IADLs: Several Times a Week	ADLs+ IADLs: 90 minutes (*of which 45 minutes needed for ADLs*)
Care Level II	ADLs: Three Times a Day IADLs: Several Times a Week	ADLs+ IADLs: 180 minutes (*of which 120 minutes needed for ADLs*)
Care Level III	ADLs: A Whole Day IADLs: Several Times a Week	ADLs+ IADLs: 300 minutes (*of which 240 minutes needed for ADLs*)

Source: Germany's Social Code Book XI § 15(German: Sozialgesetzbuch XI paragraph §15)

Assuming a constant probability of old age associated dependency, the Federal Statistical Office projected that the number of those on statutory long- term care insurance who will require such care will rise from 2.13 million (2.5 percent of the total population) in 2010 to 3.09 million (4.4 percent of the total population) in 2030.

Currently, there are 1.4 million people, who suffered from dementia in Germany. According to the statistics, about two- thirds of these suffered from Alzheimer's disease. This amount is rising by almost 300,000 year by year. This projected figure reveals that the need for long-term care will keep increasing in Germany. The prevalence of dementia rises steeply with age. In the age group of 65 to 69 year olds, the rate is 1.6 per cent. In addition, in the 80 to 84 age group, the rate rises to 15.7 per cent, while even in the age group 90 and over, the prevalence

rate of dementia is 41 per cent (Freter, 2012).

In Taiwan, the Ten- year Long- term Care Project indicated that persons who suffered illness or disabilities, permanently need care for a minimum period of at least six months, are recognized as in need of long- term care. (see *Table 2.2*) However, only the following four categories of people can apply for the benefits: the elderly aged over 65, aboriginal senior citizens aged over 55, mentally and physically disabled people aged above 50, and the elderly who live- alone but only have difficulties with the IADLs.

Table 2.2 Three Degrees of Disability under the Ten- year Long- term care Program in Taiwan

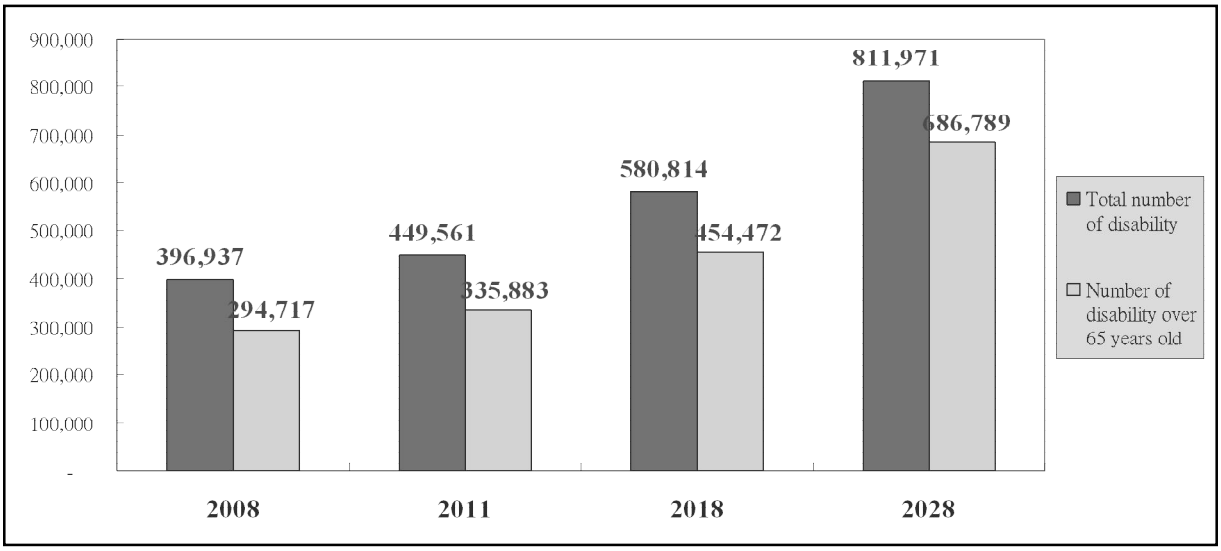
Degree of Disability	**Frequency for ADLs/ IADLs**
Care Level I- Moderate Degree	1-2 functions of ADLs
Care Level II- Severe Degree	3-4 functions of ADLs
Care Level III-Severest Degree	5-6 functions of ADLs

Source: Ministry of the Interior (2007). The Ten Years Log- term Care Project, Taipei, Taiwan.

The number of sufferers from disability and dementia was about 396,937 (1.7 percent of the total population) in 2008 in Taiwan. As the population ages, the disability population will increase. It is estimated to reach 811,971 (3.3 percent of the total population) in 2028 (Yun-Tung Wang et al, 2009). (see *Figure 2.1*)

Generally, the Barthel Index (Mahoney & Barthel, 1965) is used to measure the ADLs, which establish the degree of independence from any help, physical or verbal, however minor and for whatever reason. The index was categorized into ten activities and scales from zero- fifteen

points in various categories, depending on the need for help. (see *Table 2.3*)



Source: Wang, Y. T. (2009). The assessment of the needs of long- term care services in Taiwan, serial number: (98) 022.805, entrusted paper by the Council for Economic Planning and Development (C.E.P.D.).

Figure 2.1 The Estimated Number of Disabled in Taiwan

In addition to ADLs, with respect to the instrumental activities of daily living (IADLs) means an individual can live independently in a community (Bookman, Harrington, Pass and Reisner, 2007). Practically, the Lawton Scale is the common measurement for IADLs, which was categorized into five items (Lawton & Brody, 1969). (see *Table 2.4)*

The above-mentioned definitions for ADLs and IADLs are used to measure the need for long-term care in both Germany and Taiwan. However, these two measurements could not exactly reveal the degree of disability, and both Germany and Taiwan are now seeking an assessment measurement to allow decide the need for long- term care.

In Germany, people who suffer from Dementia can be supported and covered by the Germany's Long- term Care Insurance. In comparison with Taiwan, since 2008, dementia has been incorporated into the Ten Years Long- term Care Program. It can be assessed by a general disability in the basic activities of daily living (ADL) or by use of a clinical dementia assessment (CDR). According to the needs of care, appropriate services are then provided for the elderly

Table 2.3 Contents of Barthel Index

Activity	Score
FEEDING 0 = unable 5 = needs help cutting, spreading butter, etc., or requires modified diet 10 = independent	_____
BATHING 0 = dependent 5 = independent (or in shower)	_____
GROOMING 0 = needs to help with personal care 5 = independent face/hair/teeth/shaving (implements provided)	_____
DRESSING 0 = dependent 5 = needs help but can do about half unaided 10 = independent (including buttons, zips, laces, etc.)	_____
BOWELS 0 = incontinent (or needs to be given enemas) 5 = occasional accident 10 = continent	_____
BLADDER 0 = incontinent, or catheterized and unable to manage alone 5 = occasional accident 10 = continent	_____
TOILET USE 0 = dependent 5 = needs some help, but can do something alone 10 = independent (on and off, dressing, wiping)	_____
TRANSFERS (BED TO CHAIR AND BACK) 0 = unable, no sitting balance 5 = major help (one or two people, physical), can sit 10 = minor help (verbal or physical) 15 = independent	_____
MOBILITY (ON LEVEL SURFACES) 0 = immobile or < 50 yards 5 = wheelchair independent, including corners, > 50 yards 10 = walks with help of one person (verbal or physical) > 50 yards 15 = independent (but may use any aid; for example, stick) > 50 yards	_____
STAIRS 0 = unable 5 = needs help (verbal, physical, carrying aid) 10 = independent	_____
TOTAL (0–100):	_____

Source: Mahoney, F. I. & Barthel, D. (1965). Functional evaluation: the Barthel Index, Maryland State Med Journal 1965; 14:56-61.

Table 2.4 Instrumental Activities of Daily Living Scale (IADL)

A. Ability to use telephone	
1. Operates telephone on own initiative; looks up and dials numbers, etc.	1
2. Dials a few well-known numbers	1
3. Answers telephone but does not dial	1
4. Does not use telephone at all.	0
B. Shopping	
1. Takes care of all shopping needs independently	1
2. Shops independently for small purchases	0
3. Needs to be accompanied on any shopping trip.	0
4. Completely unable to shop.	0
C. Food Preparation	
1. Plans, prepares and serves adequate meals independently	1
2. Prepares adequate meals if supplied with ingredients	0
3. Heats, serves and prepares meals or prepares meals but does not maintain adequate diet.	0
4. Needs to have meals prepared and served.	0
D. Housekeeping	
1. Maintains house alone or with occasional assistance (e.g. "heavy work domestic help")	1
2. Performs light daily tasks such as dish-washing, bed making	1
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness.	1
4. Needs help with all home maintenance tasks.	1
5. Does not participate in any housekeeping tasks.	0
E. Laundry	
1. Does personal laundry completely	1
2. Launders small items; rinses stockings, etc.	1
3. All laundry must be done by others.	0
F. Mode of Transportation	
1. Travels independently on public transportation or drives own car.	1
2. Arranges own travel via taxi, but does not otherwise use public transportation.	1
3. Travels on public transportation when accompanied by another.	1
4. Travel limited to taxi or automobile with assistance of another.	0
5. Does not travel at all.	0
G. Responsibility for own medications	
1. Is responsible for taking medication in correct dosages at correct time.	1
2. Takes responsibility if medication is prepared in advance in separate dosage.	0
3. Is not capable of dispensing own medication.	0
H. Ability to Handle Finances	
1. Manages financial matters independently (budgets, writes checks, pays rent, bills goes to bank), collects and keeps track of income.	1
2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1
3. Incapable if handling money.	0

Source: Lawton, M. P. and Brody, E. M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. Gerontologist 9:179-186.

2.2 The Attributes of Long- term Care Recipients in Germany

The long- term care need (German: Die Pflegebedürftigkeit) is one of the core concepts in Germany's Long- term Care Insurance Act, which is presented in the German Social Code Book XI (SGB XI) Article 14 (4). The meaning of this core concept refers to the idea that care

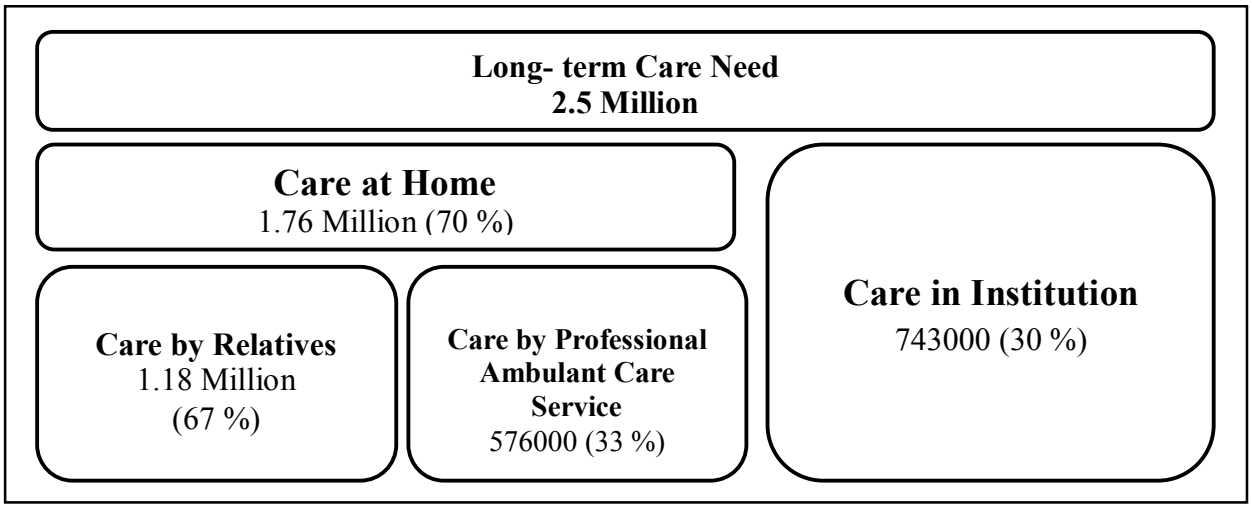
need is not regarded as an attendant risk anymore but, on the contrary, care need is looked upon as an independent and concrete social risk (Lin, 2000; Rothgang, 1996). Under this meaning, the long- term care system is regarded as an independent system included in the social security systems. Before implementing the long- term care insurance in 1994, the German social assistance program was the largest supporting system for providing benefits to care receivers.

2.2.1 The Proportion of Care Patterns in Germany

Based on the risk rate of requiring long- term care, approx. 0.7 percent of persons before they reach the age of 60 will need long- term care services, 4.4 percent in between 60 and 80, and 28.6 percent above the age of 80 (United States Department of Health and Human Service, 2009). Assuming a constant probability of old age associated dependency, the Federal Statistical Office projected that the number of those on statutory long- term care insurance who will require such care will rise from 2.13 million (2.5 percent of the total population) in 2010 to 3.09 million (4.4 percent of the total population) in 2030. This forecast reveals that the need for long- term care will keep the increasing in Germany.

After eighteen years of the social long- term care insurance act, the number of insured persons has reached 69.48 million on Social Long- term Care Insurance and 9.52 million on Private Long- term Care Insurance. The total number of beneficiaries is about 2.5 million, of which 1.76 million have home care and 0.74 million have institutional care (Federal Ministry of Health, 2012). About 70 per cent of the long- term care receivers accept care services at home, among them, 67 per cent of people are cared for at home by the relatives and about 33 per cent

depend on professional ambulance care services. On the other hand, about 30 per cent of people in need receive institutional care. (see *Figure 2.2*) The proportion reveals that family caregiving still plays an important role in Germany's long- term care system.



Source: Deutsche Pflegeheim Fond, from:

< http://www.dpf-investment.de/en/homepage/analyses.html >

Figure 2.2 The Proportion of Care Patterns in Germany

2.3 The supply of Long- term Care Service in Taiwan

Since the Ten Years Long- term Care Program was established in 2007, long- term care could be regarded as a system. That means, before 2007, long- term care was only a concept, which means rest homes, the disability of old people, and women. However, due to the rapid demographic changes in Taiwan, the whole society from individuals to the family were now

feeling the pressure to take responsibility for long- term care recipients. Under this circumstance, long- term care became a right, the formal and regular care service is urgently needed. Therefore, the government referred to the Golden Plan from Japan, and established the Ten Years Long- term Care Program in 2007. Long- term care has now become part of a system, which means that, the structure, funding, personnel and controls are stable to ensure the quality of care services.

Because of the pattern of social policy, the long- term care program has to be modified by continuing investigations and surveys. Therefore, statistics and service distribution reveals its importance in the system, as the intervention by the government drives the data and the results reflect the reality. By using this reliable data, the care system can be adjusted to make it suitable for people with care needs. In the following, the pattern of long- term care and the situation of its recipients in Taiwan will be introduced.

2.3.1 The Pattern of Long- term Care Service

The key characteristics of the Ten Years Long- term Care Program is care and ageing in place. That means that care services take place either at home or in the community. Consequently, until now, home and community care tends to be substantial, and institutional care reveals a slowing growth.

In fact, before the Ten Year Long- term Care Program was brought into force, the pattern of long- term care service revealed two patterns, which consisted of care at home and care in

nursing homes. For home care, as we discussed in Chapter one, most people were cared for by a female spouse, daughter, daughter in law or in a low- price care facility, as only a few rich care receivers could afford to hire a foreign caregiver or live in a professional nursing home. In addition, because of the lack of funding, space and profession care staff, most of the institutions are illegal, meanings that the quality of care service cannot be controlled. In order to respond to the situation, the government established the Ten Years Long- term Care Program to build a good structure and system to provide care services and support family- caregivers.

Ageing in place is a kind of principle of care service, since the World Health Organization launched this issue, based on human rights and respect, and most health care policies tend toward ageing in place. Care services are not the preserve of senior citizens, as illness can happen in each age level. Therefore, the concept is usually extended to care in place. Here, there are two types, which are developed to reach this target, i.e. home care and community care.

For the type of home care in Taiwan, the female family members and foreign caregivers mainly provide care services. Since the establishment of the Ten Years Long- term Care Program in 2007, and until now, due to the lack of professional care staff and the copayments still not being able to be shouldered by the underprivileged, the responsibility for care still falls on female spouses and daughters. However, under the training of professional care staff and the allowance from the government, the situation for this type of caregiver is better than before. The home caregiver provides professional basic nursing and hygiene care services, while, under this model, their function also includes social participation, connecting the care recipient and society.

In addition, before establishing the Ten Years Long- term Care Program, the number of partial

long- term care institutions is relatively fewer than the number of full institutions. However, due to the increase in the number of Alzheimer's disease sufferers, the day and night care institution will play an important role in supporting the family caregiver especially the female labor participator.

For full care facilities, the system offer stable growth. One reason is that the existing long-term care facilities could be legalized directly after the government provided assistance, and under their controls, the institutions can now upgrade hardware and software facilities to fit the bill. Most of the residents need intensive care. The other reason is that, the demarcation line between medical treatment and care services for intensive care is not easy distinguished in Taiwan, especially as under the budget of Nation Health Insurance (NHI), each hospital would like to keep the patient to obtain the payments from the health insurance. This situation forces the reduction in the development of full long- term care institutions. Consequently, the number of full long- term care institutions is increasingly stable.

2.3.2 The Attributes of Long- term Care Recipients

According to the official statistic, by 2014, there were 1,023 legal long- term care facilities and 25 continuing care retirement communities in Taiwan, which could serve 55,000 people. However, in reality, only 44,000 people receive care services by the two types of aforementioned facilities, cater for 1.6 per cent of whose residents are aged 65 and above (see *Table 2.5*).

Table 2.5 The Distribution of Continuing Care Retirement Community and Long- term Care Facilities in Taiwan (until 06/2014)

Pattern of Facility	**Amount of Facilities**	**The Number of Available**	**The Number of Available (in Reality)**	**Usage (in %)**
Long- term Care Facilities	**1,023**	**52,482**	**40,338**	**76.9**
Type of Long- term care	55	2,566	1,974	76.9
Type of Continuing Care	967	49,852	38,307	76.8
Type of Alzheimer's Disease	1	64	57	89.1
Continuing Care Retirement Community	**25**	**5,946**	**3,979**	**66.9**

Source: Director- General of Budget, Accounting, and Statistics, Executive Yuan (2014) The Distribution of Continuing Care Retirement Community and Long- term Care Facilities in Taiwan, from:

< https://www.dgbas.gov.tw/public/Data/41212161434198HDY1K.pdf >

After ten years of implementation, the proportion of care needs stands at 49 per cent of care for severe disability, 21 per cent for moderate disability and 30 per cent for mild disability. Those with severe disability need more care services, which are provided by the care work force. Compared with the degree of disability and economic status, it was found that about 55 per cent of the normal household apply for care services for severe care, while those with low-income household tends to apply for care services when facing mild disability. These might be caused by the differences in government subsidies and public payments. Moreover, the size of

the long- term program is still small, which leads to a better availability for economically disadvantaged groups in terms of advocacy and referrals (Lu, 2012)

According to the assessment of user needs of the county and city care centers, those who are required to accept 1 service occupy 57 per cent of care need, in which, 66 per cent of them apply for the home care service. Besides, those who are required to accept two services account for 27 per cent of care needs, of which 34 per cent apply for home care and respite services. This shows that, the demand for home services is indeed the most urgent among the care services (Chien, Chuang and Yang, 2013).

According to the analysis of the characteristics of family caregivers, the main caregivers of disabled families are still women. The care is provided mainly by children (49 per cent), followed by 35 per cent of spouses. (Lu, 2012). Only 30 per cent of family caregivers have full- time employment and 58 per cent have no employment. The needs that family caregivers have can be grouped primarily into respite services (shared caregiving, short breaks, alternative care, etc.), psychological and educational support programs (such as caregiving skills, related knowledge, counseling services) and financial support programs (such as family caregiver allowances, etc.)

In order to establish the Long- term Care Insurance Program in the near future, since 2010, and every two years, the Ministry of Health and Welfare takes the national sample survey for the issue of long- term care needs. The items include the estimated rate of ADLs & IADLs, the ability of communication, special or complex care type, a short portable mental status questionnaire (SPMSQ), social and family support and the workload of caregiver. Based on the result, 84.50 per cent of long- term care receivers live with family members, and approx. 6.82 per cent of people, who need long- term care services stay in full institutions, with, 5.75 per

cent of this category living alone (Ministry of Health and Welfare, 2015).

For caregivers, despite the Ten Years Long- term Care Program being established, the pressure of caregiving is still present despite the financial or physiological help. The design of the system for copayment for the economically disadvantaged is still somewhat stressful, and even though subsidies and allowances are granted by the government, the main pressure felt by the caregiver is economic. According to the Caregiver Strain Index by B. C. Robisen in 1983, about 36.32 per cent of caregivers are without any burden, however, 26.86 per cent of caregivers experience stress (Lee, 2013).

Concerning the attributes of long- term care recipients in Taiwan, and due to the newness of the long- term care program and the ineffective system, the pattern of care service follows the traditional culture i.e. care at home and care by the family members. In order to reach the goal from care in place to ageing in place, and lighten the strain of the caregivers, the Long- term Care Service Act and incoming Long- term Care Insurance Act play an important role in the care system in Taiwan.

2.4 Discussion and Conclusion

With the rapidly growing ageing population, the potential need for long- term care will be demanded urgently. Under the circumstance of existing care system, how to measure the long-term care recipients will be an important issue, which influences the normal operation of the system and the care resource that would need to be distributed.

This chapter illustrated the measurement of long- term care in both Germany and Taiwan under the existing care system. Both countries define persons who, due to illness or disabilities, permanently of for a minimum period of at least six months require extensive assistance to perform basic and regularly recurring activities of daily living (e.g. dressing and undressing, personal hygiene, toileting, eating and drinking). This are regarded as being in need of long-term care. Besides this, the index of Activities of Daily Living (ADLs) and the required Instrumental Activities of Daily Living (IADLs) are used to classify the degree of need for long- term care.

The demographic and social changes influenced the need for long- term care service. Moreover, according to the research, the rate of prevalence of dementia and age confirms a positive correlation. With people living longer, the rate of prevalence of dementia rises at the same time. Based on the official statistics in both Germany and Taiwan, the prevalence rate of dementia is increasing year by year. Until now, scientists have not found a cure for dementia, therefore, so far, we can only establish and provide a sound long- term care system for the care receiver and their family members. Before this can be achieved, one thing has to be considered, namely whether the existing estimation of the long- term care levels are appropriate this kind of disease. At the beginning, dementia sufferers have no apparent symptoms and the existing estimates do not include or consider the conditions for this kind of case.

The prevalence of dementia is increasing and is driving the urgent need for long- term care services. According to the former type of care evaluation, the people who suffered from dementia could not be included in the three care levels; however, they obviously do need some degree of long- term care. Therefore, both Germany and Taiwan enacted a new measurement for long- term care in 2008 (Long- term Care Reform Act) and 2007 (Ten Years Long- term

Care Program) respectively. Since the governments have considered the care needs for those with dementia, the attribution of the care recipients has been changed. According to the concept of ageing in place and the design of the care policy, both Germany and Taiwan show that family caregiving still plays an important role in the long- term care system. However, with the need for long- term care increasing, the lack of care skills and facilities will see care receivers and their families seek institutional care to support their role as carers.

Chapter 3.

Social Policy as a Response to Social Risks: Long- term Care Needs

3.1 The Concept of Welfare State, Social Insurance, and Social Security

When talking about the welfare state, the role of government should not be neglected. It is a concept of government for the commonwealth to protect and promote the economic and social wellbeing of its citizens. In this case, equality of opportunity, equitable distribution of wealth and public responsibility serve the citizens to sustain a good life. In other words, the welfare state is a political conception of government in a capitalist economy where the state is responsible for ensuring that all members of society attain a minimum standard of living through a redistribution of resources, progressive taxation and universal social programs, including health care and education.

The above-mentioned sections illustrate how social risk (long- term care needs) is prevented and solved by laws relating to social policy and the regime of the welfare state (related to long-term care policies). The following section will first discuss the concept and development of the welfare state and the relationship between social insurance and social security, which is concerned with long- term care needs.

3.1.1 The Concept of Welfare State

The welfare state is commonly considered a guide to social security by providing, for example, health care supply, social housing provision, education services, public pensions scheme, unemployment insurance, minimum wages policy, disability allowances, social assistance, children's benefits, and various forms of social services.

The term welfare state has three main interpretations. Generally speaking, it is a regime where the government shoulders the main responsibility for the basic living standard of citizens. The welfare is regarded as a right and, therefore, the government ought to provide and formulate comprehensive welfare or social policies to protect and prevent social risk and problems. That means the state accepts responsibility for the welfare of its citizens. It thus creates social safety nets to provide minimum standard welfare, including a minimum income for citizens. Besides, the welfare state there is also the offer of social protection for a range of contingencies (Briggs, 1961).

Regarding this aspect, it is necessary to distinguish clearly between the welfare state and welfare society. The concept of welfare state, within the model of the welfare state, government plays the primary role in leading programs or schemes directly. Indirectly, the private sector plays a functional role in contributing as a resource of redistribution. However, in terms of welfare society, to some degree, welfare is not actually provided by the government or official authorities, but directly from the cooperation of independent volunteers, non- profit charitable or for- profit institutions, and government services.

Ever since Karl Marx remarked on the inherent instability of capitalism, the concept of the

welfare state has been developed. In Germany, the primary practical implementation of the welfare state was instituted by German Chancellor Otto von Bismarck (Gregory & Stuart, 2003), who initiated social insurance, with sickness insurance in 1883 and accident insurance in 1884, which differed from the previous poor relief programs available in the world. These regimes influenced other European and Scandinavian countries and subsequently spread much of the world.

For the model of the welfare state, there are different institutional designs, which cover the citizens, risks, and problems. Each country has its own different circumstances depending on its economic system, historical background, traditional culture, political situation and welfare regimes. Therefore, researchers agree that welfare states were developed to satisfy those that needed help the most in a society (O'Brien & Penna, 1998).

Wilensky and Lebeaux (1958) addressed two models of social welfare. They formalized these as residual and institutional models of welfare. Residual welfare sees welfare as a safety net, which is only for those people who need it. It is often linked with the idea of dependency and the culture of dependency (Spicker, 2011). The government assumes that people have the ability to ensure their own welfare, hence, only those people suffering from poverty are the target of care by the government. Generally, residual welfare refers to remedial measures of aid, which the state provides only when people are in need.

In addition, institutional welfare is based on the view that people will have needs at some time. It places on emphasis on the responsibility of the state and argues that all the people ought to satisfy the principle of the social minimum, e.g. social rights. The state provides not only economic security to the socially- disadvantaged minority but also provides healthy conditions and an ageing friendly environment for all people. The recognition that everyone has needs at

some time e.g. in childhood, sickness, ageing and possibly when unemployed, means it is thus a social responsibility. In this way, needs are institutionalized in society (Spicker, 2011).

3.1.2 Germany: A Social State and Conservative Welfare Regime

The perspective of the regime emphasizes that the welfare state is not only a special political and economic set of relations but also systematically intertwines with other countries in term of aspects of legislation and organizations to construct a complex system. In this case, different countries have a different operational logic regarding welfare, which are affected by factors such as historical development, institutional characteristics of national organizations, and the resulting national role and its function. That means that, depending on the historical orbit, the main spirit of religion and the influence of sovereignty in each state, the pattern of a welfare regime will take different forms.

Due to the deep and comprehensive influence of the Catholic Church and conservative authoritarianism, in Europe, the corporatist welfare regime has spread widely. Among them, the Bismarckian Germanic welfare model is one of the most famous forms of corporatist welfare state also known as the conservative welfare state, which is concerned with maintaining order and the position. In order to achieve this goal, social insurance schemes (e.g. pension insurance, health insurance, unemployment insurance, accident insurance and long-term care insurance) were established to reward performance and maintain the position (Rothbard, 1978; Lorenz, 2004).

Traditionally, female spouses are protected by the breadwinners (male spouses) of a household, which ensures the stability of the traditional pattern of the family. The mutual aid associations of the 19th century (such as the Miners Insurance Fund) and the government's role influenced the establishment and operation of public insurance funds. As a self- managed benefits association, the mutual aid association, which is recognized as a quasi- public body by the government, follows the principle of corporatism (Becker & Busse, 2007). These associations are formally independent from the government, and its members must be forced to pay the contributions, which are deducted from their salaries. These premiums are often shared with the employers equally. The principle of the corporatism/ conservative welfare scheme has influenced Germany's social welfare model and the issue focus on in this dissertation of social insurance schemes e.g. Long- term Care Insurance (LTCI).

The regime of the Social State (German: Sozialstaat) was not a contingency in Germany. Despite it being formed in the 20th century, the spirit of the Social State was derived from the French Revolution at the end of 18th century. However, in early 18th century, the governments of European countries established regular army and civil service systems. Most of the countries, therefore, began to turn into modern countries. However, powerful and prosperous societies neglected human rights and could not protect people live without fair. Due to the despotism prevalent in Europe at that time, modern society had a status of repression and inequality. John Locke (1686; 1690) addressed this when he stated:

"All mankind, who will but consult it, that being all equal and independent, no one ought to harm another in his life, health, liberty or possessions …"

and,

"Government has no other end, but the preservation of property ..."

The requirement of the French Revolution established the base of social rights. The existence of security for all people ought to be a priority above all others. From the viewpoint of the social state, people had the rights to obtain social security from the government.

In modern countries, the nature of the idea that all is equal before the law has become the basic principle of social value. However, under the circumstance of restricted social resources, social classes cause huge diversity and, thus, a spreading out of many social problems. During this period, many European countries began to formulate a social policy, in order to respond these problems. This section will elaborate on the development of the German social state and its principles.

In Germany, after the industrial revolution, the social situation and conditions provided the opportunity for the formulation and execution of social policy. In 1884, the Welfare of General Assembly for Working Class (German: Centralverein für das Wohl der arbeitenden Klassen) which was established by the Kingdom of Prussia raised a Plan for General Prussian Elderly Care (German: Allgemeine Preussische Alters- versorgungsanstalt). It was the first official regulation in which at German government regarded welfare as a responsibility. Through it, the government would play a role promoting social welfare and it would be enacted through the power of social control, and the role of the local governments (Ritter, 1986).

In the 1850s, in order to reduce the expenditure on benefits against poverty, the Kingdom of Prussia enacted the Act for Medical Insurance Financial Subsidy (German: Unterstüzungskassengesetz). The act formulated that long- term or short- term workers and apprentices would be enrolled in this program and employers would have to pay part of the

contributions. However, the frail and elderly were not included in this program. It is quite remarkable that the contribution was able to be paid jointly by the employee and employer. This form of disbursement influenced the subsequent Bismarckian social policy and the federal social insurance that developed later in Germany.

After the German Empire (German: Deutsche Kaiserreich) was unified by Otto von Bismarck in 1871, in view of the rapid increase of the working class, he enacted many social policies to lasso the workers. The establishment of social insurance was a means to rape the working class. At the time, there were three pillars of social insurance supporting the social security net. Health Insurance (German: Die gesetliche Krankenversicherung) as the first bill, which was enacted in 1883 and established to provide health care for the largest segment of the German workers. Its health service was established on a local basis, with the cost divided between employers and the employed. The employers paid one-third of the contributions, while the workers contributed two-thirds (Holborn, 1969). One year later, Bismarck brought in an act of Accident Insurance (German: Unfallversicherung) and established the Organization of Employers in Occupational Corporations (German: Der Arbeitgeberverband in den beruflichen Korporationen) to administer the program, as a central and bureaucratic insurance office of the federal government. Germany's Emperor William the First stated (Social Security Online):

"those who are disabled from work by age and invalidity have a well- grounded claim to care from the state".

After that, the Insurance for Elderly and Invalid, the Statutory Pension Insurance (German: Das Gesetz zur Alters- und Invaliditätsversicherung, Die Rentenversicherung) was formulated in 1889, constituting the third pillar of social security net. Workers who were aged sixteen to seventy were forced to join the program, and the contributions were divided between

employers and the employees. To this day, the above- mentioned social insurances policies still influence the welfare system in many countries and play an exemplary role.

Otto von Bismarck was under the impression that social insurance could be a weapon for obtaining the loyalty of the working class and destroying socialism (German: Sozialismus). In particular, these programs were administrated by bureaucracy at the federal level, which had the ability to promote the performance of social insurance. In addition, in order to ensure the benefits, these programs were also supported by the employers and industry. Under the circumstances of these beneficial conditions, the first welfare state was founded.

The establishment of social welfare started from the uprising prevention. At that period, the welfare programs could only reluctantly meet the basic needs. However, industrialization caused social deconstruction, which meant that, the government was burdened with the responsibility of social care and protecting the people to avoid social risks by providing statutory social insurance.

After World War II, Germany's parliament followed the concept of social care and the principle of solidarity to formulate the Basic Law for the Federal Republic of Germany (German: Grundgesetz für die Bundesrepublik Deutschland) (Becker & Busse, 2007). According to the Article twentieth of the Basic Law:

"*the Federal Republic of Germany is a democratic and social federal state*."

Moreover, article twenty- eight of the Basic Law states that:

"*the constitutional system in the states ... is based on the principles of the republican, democratic and social state under the rule of the Law.*"

The Basic Law established the principle of the social state (German: Sozialrechtsstaat) to care for and ensure the basic living needs for minority groups in society by means of governmental actions (*Zacher, 1980*). That meant that the Basic Law regarded the principle of the social state as a responsibility of the government, which can also be seen as a governmental function to meet those needs. (see *Table 3.1*)

Table 3.1 The Principle of Social State in Germany's Basic Law

Social State and Basic Law	
Article 1	(1) Human dignity shall be inviolable. To respect and protect it shall be the duty of all state authority.
Article 3	(1) Men and women shall have equal rights. The state shall promote the actual implementation of equal rights for women and men and take steps to eliminate disadvantages that now exist. (2) No person shall be favored or disfavored because of sex, parentage, race, language, homeland and origin, faith, or religious or political opinions. No person shall be disfavored because of disability.
Article 6	(1) Marriage and the family shall enjoy the special protection of the state. (2) The care and upbringing of children is the natural right of parents and a duty primarily incumbent upon them. The state shall watch over them in the performance of this duty. (3) Children may be separated from their families against the will of their parents or guardians only pursuant to a law, and only if the parents or guardians fail in their duties or the children are otherwise in danger of serious neglect. (4) Every mother shall be entitled to the protection and care of the community. (5) Children born outside of marriage shall be provided by legislation with the same opportunities for physical and mental development and for their position in society as are enjoyed by those born within marriage.

Article 9	(1) All Germans shall have the right to form corporations and other associations. (3.1) The right to form associations to safeguard and improve working and economic conditions shall be guaranteed to every individual and to every occupation or profession.
Article 20	(1) The Federal Republic of Germany is a democratic and social federal state.
Article 28	(1.1) The constitutional order in the Länder (State) must conform to the principles of a republican, democratic and social state governed by the rule of law, within the meaning of this Basic Law.

Source: Deutscher Bundestag (2010). Basic Law: for the Federal Republic of Germany, official English translation; Naegele, G., Bäcker, G., Bispinck, R., Hofemann, K. And Neubauer, J. (2008). Sozialpolitik Und Soziale Lage in Deutschland: Band 1: Grundlagen, Arbeit, Einkommen und Finanzierung. VS Verlag, Wiesbaden.

The spirit and principle of the social state are laid down in the Basic Law (Articles 1, 3, 6, 9, 20, and 28), in which it clarifies the state's two responsibilities. First, the state should create an environment for a fair social order to balance social difference. Second, the scheme of social policy is designed to ensure citizens' minimum needs.

Zacher (1977) has ever addressed the issue of a definition for the term of the social state i.e. the Social State is a state, which guarantees and, if required, corrects the economically influenced proportions in a society, with the aim of offering each and everybody a life with dignity as a human by giving the members of this society a minimum amount of social welfare. This definition is commonly used to link two characteristics of the social state i.e. ideal and reality. Sometimes, in a normative way, the social state can be seen as the ideal means to create an environment of solidarity. In addition, the state formulates social policy to protect and prevent its citizens. That means that, the ideal of a social state is indeed realized in an existing state (Barrios, 1998).

Since the national social policy started in the end of 19th century in Germany, to date, the

pattern and the partition has became widely adopted. The establishment of social policy and the concept of social state is a result of long- term conflict and compromise between society and policy. Therefore, as the first paragraph of this chapter has indicated, the regime of Social State was not a contingency in Germany.

The establishment of a social security system/ social welfare regime implements the principle of the social state, which is supported by three pillars, i.e. Social insurance system (German: Sozialversicherung); Social compensation system and social delivery (German: Sozialentschädigung und soziale Förderung) and Social assistance (German: Sozialhilfe).

Social insurance refers to the establishment of compulsory insurance by the government based on its principle of authority to prevent social risk and maintain the standard of living. Its benefits are primarily not through taxes but by contributing to the respective insurance carrier and employer, which is controlled by the state. The system of social insurance is sometimes called a social network because it provides protection for the individual against personal emergencies. In Germany, despite the compulsory insurance and the volunteer insurance composing a dual model in the social insurance system, the different still exists in between. Both public insurance and private insurance are based on the concept of risk adjustment and solidarity to ensure the whole citizen. However, the difference is that the amount of contribution to the compulsory insurance is related to the insurant's income but is not based on the individual's condition. In this case, social insurance emphasizes the function of solidarity.

Currently, five pillars create the social security net in Germany, which consists of Health Insurance (German: Krankeversicherung); Accident Insurance (German: Unfallversicherung); Pension Insurance (German: Rentenversicherung); Unemployment Insurance (German: Arbeitslosenversicherung) and the weight bearing point - Long- term Care Insurance (German:

Pflegeversicherung). Germany's government established the five social insurances schemes, i.e. five pillars of social security to maintain citizens's basic needs. That means that, the five social insurances systems in Germany, has been the way to realize the concept of the social state.

Unlike the social insurance, the contribution is paid by employers and employees, with the social compensation and social delivery financed from taxation. Generally, the concept of social compensation is based on solidarity. In order to maintain equality and justice, as social insurance might not cover or satisfy the standard of living, social compensation will sometimes be provided when person's rights have been damaged in the process of promoting their welfare. The role of social compensation is to complement any failures of social insurance.

Since the social compensation system and social delivery is a measure for complementing the failure of social insurance, this means that, the target of achieving social compensation and social delivery could not be covered by social insurance, which is generally aimed at the frail and the vulnerable. In order to maintain the standard of living to a specific target, the Germany's government provides social compensation and social delivery to realize the concept of a social state.

As the last ditch feature of the social security net, social assistance refers to the range of benefits and services available to guarantee a minimum level of subsistence to people in need, based on a test of resources (London: HMSO, 1996). The country has to ensure the minimum standard of living for its people, otherwise it will fail to achieve the meaning of existence defined as a basic value of freedom and democracy.

In Germany, based on the dignity of human, the rights of liberty and the principle of the social state, people have rights to request social assistance. The optional model of settlement can be

classified into in kind assistance and subsidy assistance. But no matter which model is opted for, the criterion of assistance depends on the need for it. Nevertheless, social aid in Germany is not a long- term financial subsidy, but constitutes assistance in times of hardship.

Social assistance is a subsidiary and temporary form of help in individual situations of need. The principle of a subsidiary means that social assistance programs aid people in need without support from the third part, e.g. an institution, family members (Knöpfel, 2003). The individualization advocates under the circumstance of the equality and appropriate principle, and the country has to satisfy the needs of the individual (Baumann, Stremlow and Strohmeier, 2006).

After all, the principle of the social state in Germany is to assist the individual to return to a state of self- support, i.e. adults can satisfy their individual and family needs through their income. In addition, achieving a nominal level of self- help is a priority of the care measures taken by the government. The social care systems will intervene when that normal expectation is not met. As such the target of the intervention is only to help the individual return to the normal expectation of being self- supporting. (Zacher, 1985).

3.1.3 Traditional Confucianism Culture in Chinese Community: Taiwan

Due to the rapid development of the economy, researches into a Taiwanese social welfare policy started in the 1980s (Midgley, 1986; Deyo, 1987). Although many researchers tried to generalize the type of welfare regime for East Asian countries, the theory has not been

generally accepted and identified. Nevertheless, the common point is that, the welfare regime in East- Asian region is generalized as a "developmental/ productivist welfare regime" (Wood & Gough, 2006). However, many researchers find that the social welfare regime exists with large differences in East Asia (Amsden, 1985; Wade, 1990; Holliday, 2000; Walker, 2005). Especially in Taiwan, it tends towards being a "developmental welfare regime" which regard social policy as a tool of promoting economic development (Holliday, 2000; Ku, 2003).

In 1982, Chalmers Johnson first grouped Japan among developmental states (Johnson, 1982). After that, the developmental state theory was formed and named to explain the case of the four tiger economies in Hong Kong, Singapore, South Korea and Taiwan (Amsden, 1985; Wade, 1990). Wei- Yuan Zheng emphasized that the characteristics of developmental/ productivist welfare regimes can be categorized into four groups: universality, interim, contingency and historical orbit. First, universality refers to the state's autonomy and superior level of bureaucracy, with the state autonomy stressing that the government is always an independent force outside society. By using the high- quality bureaucracy (elite theory), the role of government become a power center to dominate all large scale societies (Domhoff, 2005). Therefore, the establishment of social welfare policy and public infrastructure can be decided by a government's performance and ability. Second, after the baptism of the World War II, all businesses languished around the world. East Asian countries also suffered serious level of destruction. As a result, planned economies were implemented by most East Asian countries, As in order to recover and promote the growth of the economy governments adopted many measures such as exerting control over the financial system, market intervention, support of strategic industry and the restraint of welfare demands. Third, the contingency entailed the authoritarian regime of a predominant one party system. The common measure was that governments would control a society using legislation, investigation, and supervision (Zheng, 1999).

For quite a long time, Confucianism influenced East Asian culture deeply and extensively determining the relationship between family members, social policies, the way of life and even attitudes towards the elderly. Most research reveals that this unique East- Asian welfare model is rooted in Confucianism (Jones, 1993; Berger, 1984; Huang, 1995), and its main doctrine concerning social welfare is revealed in a Book (Jin Xin I) by a representative figure of Confucianism: Meng Zi (372 BC- 289 BC):

"If poor, they attended to their own virtue in solitude; if advanced to dignity, they made the whole kingdom virtuous as well."

Confucianism emphasizes that the function of the household and its relationship to other family members is connected by the doctrine of Five Moral Principles (or: Five Confucian Relationships) which states that:

"Paternity has affection, the monarch and his subjects have righteousness, Couple has distinction, brothers have order, friends have faithfulness."

Besides this, the Three Cardinal Guides of Confucianism indicated that:

"Ruler guides subject, father guides son and husband guides wife."

From these listed principles, it can be seen that the viewpoint of Confucianism regarding social welfare stresses the leading role of the government, the form of hierarchy and the function of the household, i.e. the household gives the full play on this system. That means that the government enacts and organizes the related social welfare programs or policies and the whole

system shifts around the centralization of authority. The household takes responsibility and stands as the first line to directly support family members. For instance, the Statutory Health Insurance in Taiwan is attached to the National Health Insurance Administration, Ministry of Health and Welfare, as a single insurer, which organizes, controls and has vested interest in this system. Contributions depends on the different categories of occupation that have different level of compensation from the government, a kind of design that is typical of Confucian culture.

In addition, this viewpoint was used to analyze social welfare policy in Taiwan (Jones, 1990). Because of the influence of Confucianism for over twenty- five hundred years, the pattern of social welfare policy and society in Taiwan is usually regarded as a "Confucian Welfare State" which means that the power of government will take priority on public policies and moreover, the role of care will be shouldered by family and the local neighborhood (Jones, 1993). That means that family and the individual will play an important role in providing social welfare in Taiwan. Yeun- Wen Ku (2003) has complied a comparative table for comparing the welfare indices of Taiwan's and Germany's welfare states. (see *Table 3.2*) Here, Taiwan and Germany are selected as an object to compare the degree of each indicator.

Table 3.2 Welfare Index Comparison of Germany and Taiwan

Welfare Index	**Germany**	**Taiwan**
Welfare Demand	High	High
Social Security Expenditure	Middle (+)	Low
Social Investment	High (-)	High (+)
Social Stratification	High	Middle

Gender Difference	Middle	High
Uncoverd Rate	Middle (-)	High
Individual Responsibility	Middle (-)	High
Family Responsibility	Middle (-)	High
Private Market	Middle (-)	Low (-)

Source: Ku, Y.- W. (2001). The Measurement Indicators of Welfare System: Taiwan in The Context of International Comparison, National Science Council.

From this comparison, we can see that Taiwan conforms to a developmental welfare regime. The characteristics of this regime show that the aim of the social policy is to promote the development of the economy; moreover, the whole wage level is relatively low with long working hours. The high- degree of social investment means that the private sector does not play an important role in this system. Taxation in Taiwan is thus relatively low when compared to other welfare countries, which leads the low level of social security expenditure. Hence, we can generalize that the role of providing social welfare in Taiwan will be shouldered by the family and by individuals.

According to the above- mentioned interpretation, generally, there are five characteristics of social welfare policy in Taiwan (Chan, 2011). First, from ideal social policy to real legalization: the principles of social security policy are written down in the Constitution (from Article 152 to Article 157), in which it clarifies the state's responsibility for the elderly, adolescents, the disabled, laborers and farmers. However, the constitution in Taiwan was regarded only as a political guideline by most people, which means that, few policy makers were concerned with the meaning of social welfare in the constitution before the 1990s. It was thus only used as a passive measure to solve an individual's or family's poverty. Until now, many ideal social

policies have been enacted which means that the character of social welfare policy changed from passive intervention to positiveprovision and protection. Second, the need for welfare: like other welfare countries, Taiwan's social welfare policies started with in relation to children and poverty. Then it was extended to people with disabilities, the ageing population, aborigine, disadvantaged females, disadvantaged families and the whole citizenry. Third, social welfare delivery service: the type of welfare service in Taiwan is a mixed model (dual model) which is composed of selective welfare services and universal welfare services. Generally, the establishment of comprehensive health insurance in Taiwan is considered a watershed, which divides two phases of welfare delivery service. Before the exact of health insurance, the social welfare service depended on social aid, which was based on mean test of people in need. Since health insurance was established the social welfare delivery services was a variety of the universal model, which provides comprehensive protection with requiring of needs. Fourth, social welfare policy stresses the social insurance: since the 1950s, this model of social insurance has existed in Taiwan. Until now, social policy in Taiwan chose the social insurance as a priority, due to its low cost, which burdened by the state and the common value in Taiwan's society- pay first then enjoy. Lastly, a centralized administration: in the era of centralization, the state as a political form of resource allocation may due to political control reasons. However, after political democratization, due to the needs of social equity and avoiding the risk of economic crisis, the state's role in this allocation of resources would be greater (Gough, 2000). Under this concept, at present, social insurance, such as health insurance and labor insurance in Taiwan is led by the state, which is seen as a single insurer.

From the above mentioned viewpoint, although the social welfare policy in Taiwan started early, the lack of a long- term scheme lead the whole system to become weak and even in a rut. In this regard, the establishment of social policy does not positively solve the social problem but negatively stabilized society.

In Taiwan, the construction of a social welfare system is still developing. However, the frequent elections influence the establishment of social policies. In order to obtain or maintain political power, the director sometimes formulates the policies, which includes short- term benefits attract voters. On the whole, social welfare system falls short of a long- term scheme.

3.1.4 The relation between Social Insurance and Social Security

Generally, under the principle of social welfare, social security refers to any program designed to protect society from the instability caused by individual catastrophes. In which, an important core issue of social security is that the government have to lighten or avoid the citizen's economic predicament to maintain their living conditions with dignity. That means, under the circumstance of social equality and social justice, the state shoulders the responsibility to protect the people through three types of welfare, namely social insurance, the social compensation system, and social assistance. These three types carry out in practice the principle of the social state in Germany. In this part, we will expound on the relationship between social security and social insurance.

Since social security is sometimes used to refer specifically to social insurance, more generally, it is a term used for personal financial assistance, in whatever form it may take (Spicker, 2011). In this regard, social insurance mostly is defined as the measures of social security. That means that, in order to achieve the concept of solidarity, social insurance centralizes the social risk with a strong hand and transfers it to individuals. The purpose of risk sharing is the principle of

social insurance.

Under the social security net, social insurance provides protection for people, which ensures their economic ability to sustain a basic standard of living conditions when suffering from illness, occupation injury, disability or old age. As a scheme of social protection, social insurance is different from general business insurance (life insurance) and social assistance, in which the business insurance emphasizes the relationship between premium and risk. Generally, both of them decide the number of benefits. The term social assistance refers to the range of benefits and services available to guarantee a minimum level of subsistence to people in need, based on a test of resources (mean- test determination). Unlike business insurance and social assistance, social insurance concentrates on the contribution rather than a premium. The word of contribution represents the meaning of solidarity of social member and the meaning of mutual help.

Social insurance has interpreted the principle by using the two words social and insurance. The word social means that which is compulsory under the principle of solidarity and mutual aid. Insurance refers to how it operates in society. Social insurance is seen as a tool of property redistribution to achieve the guarantee of social balance, which is mostly is sponsored by the state. It applies to protecting disadvantaged minorities to prevent them living in straitened circumstances and to help them maintain basic living conditions. However, there is an exception. For instance, in Germany's health care insurance, under the required wage range, it is compulsory for people to participate in the health care insurance, and people who are above the required wage range can join in the public health insurance voluntarily or chose private health insurance.

Besides, it is a risk management technique primarily used to hedge against the risk of a

contingent, uncertain loss that may be suffered by those individuals or entities, that have an insurable interest in scarce resources, by transferring the possibility of this loss from one interested person, persons, or entity to another (Gollier, 2003). Social insurance is also a transferring mechanism of risk- sharing, which achieves the aim of social security. Furthermore, the contribution for social insurance is used for the purpose of this social insurance. For example, the contribution of statutory long- term care insurance can only be used for the benefit of those suffering long- term care needs. Of course, this model has its own background in each state. However, this characteristic of social insurance is different in each state. In several social insurance systems, the contribution is financed not only by those insured but also from a government subsidy.

Another important characteristic of social insurance is revealed in dual models. Most states settle for one central insurer, which administer the fund and the system directly. However, for instance, the system of health care insurance and long- term care insurance in German has multiple insurers, i.e. public or private concerns, which create the complete social security net for health care and people in need of long- term care.

3.2 The Concept of Social Policy and its Relation to the Welfare State

Social policy is used to respond to the social risks and problems, which concern the course of people's daily lives. Social policy guides for the shifting, maintenance and creation of living conditions that improve to human welfare (Alcock, Daly and Griggs, 2008). In summary, it considers the ideas and delivery of social welfare and the relevance of politics and societies,

for instance, health, old age, disability, housing, income maintenance, and education.

It is very important to illustrate the duty of government while describing the relationship of social policy and welfare. Concerning with the definition of social policy on public action, Marshall concentrated narrowly on the following (Marshall, 1967):

"Social policy is not a technical term with an exact meaning… it is taken to refer to the policy of governments with regard to action having a direct impact on the welfare of the citizens, by providing them with services or income"…

In his argument, the policy of government directly affects the citizens' welfare, which includes social insurance, social aid, healthy care, and housing policy. Pete Alcock (2008) extended Marshell's definition, and indicated:

"…based upon a distinct empirical focus- support for the well- being/ welfare of citizens provided through social action…. So social policy refers both to the activity of policy- making to promote well- being and to the academic study of such actions"

According to the above- mentioned definition by Peter Alcock, support for the welfare of citizens, could be illustrated by the concept of social policy. In this case, for the purpose of the creation of the welfare state, the government formulates a series of social policies to achieve this target. The welfare state here is a political system and regime, which determine itself to social rights. Through political intervention, social policy develops types of strategies to solve social problems. In other words, the welfare state and social policy are general concepts legitimizing political intervention to protect underprivileged groups in society, reducing social inequalities, and promoting human capacities for action and self- reliance (Kaufmann, 2010).

Social policy involves many social science disciplines, e.g. sociology, economics and politics and is founded in many areas of society. Generally, social policy is composed of four parts of social currency, e.g. social issues, social problems, social groups and social services. For social issues, due to the development of society, the people pay close attention to specific new social issues that then forced the government to respond to the issues. For instance, the rapidly increased ageing population stimulates the government to concern itself with the economic security of the elderly and provide long- term services. Furthermore, the social problem it refers to apply to social conditions, processes, societal arrangements or attitudes that are commonly perceived to be undesirable, negative, and threatening to certain values or interests (Jamrozik & Nocella, 1998). For example, there are substantial numbers of homeless people and problems of violence, alcoholism, and drug abuse, which impact society, and hence the political body has to face and even solve the problems.

Moreover, a social group means a specific group. Usually, it can be seen as a disadvantaged group. In order to meet the demands of these groups, the state has to formulate programs to promote their abilities and opportunities and, furthermore, to maintain their rights to a basic standard of living, e.g. children- and adolescent assistance, female working rights and economic security for senior citizens. Finally, social services are regarde as a procedure which delivers a service from the public to an individual. It appears in the form of a social insurance, social assistance, social benefit and individual social services. (Alcock, Erskine and May, 2003)

The above- mentioned social components of social policy could be generalized into the following five aims of social policy. To reduce the gap between rich and poor (Alcock, May and Wright, 1998), to maintain social justice by reallocating resource, to prevent and cope with

emerging social risks and problems, to compensate for the effect of social problems and to ensure and improve the life situation of individuals and groups (Naegele, Baecker, Bispinck, Hofemann & Neubauer, 2008).

However, nowadays, under the circumstance of problems that are highly differentiated and specialized, a unilateral power cannot solve social problems completely. That means that neither support through the family and social networks nor private provision and the establishment of personal insurance or social insurance could resolve these social problems successfully. Attention must also be paid to the ways in which these problems can be dealt with by social institutions: government and official authorities, social groups, charities, local associations, neighbors, families, community and religious organizations. Social institutions are networks of relationships that carry out essential social functions. The key concept in this case refers to the network and co- operation, i.e. the co- work of the public- and private sectors, the network between family and community, which enable social problems to be solved and prevents social risk.

Summing up the above- mentioned arguments, social policy is the part of a public policy that has to be aware of social issues such as public access to health care or other social programs. The aim of social policy is to improve human welfare and to meet the human need for education, health, housing and social security. Therefore, a government formulates a series of social policies to create a welfare state to protect and promote the economic and social well-being of its citizens. It is based on the principles of equality of opportunity, equitable distribution of wealth, and public responsibility for those unable to avail themselves of the minimal provisions for a good life (Commission on Social Determinants of Health, 2007).

In a more general sense, welfare means the well- being of individuals or a group, which is

provided by governments, non- governmental organization (NGO), or a combination of both in a mixed economic model. Therefore, the welfare regime could be defined as the sum of all rules, principles and methods, explicit or otherwise that determine a society's policymaking, organization, and realization of measures in order to provide and secure its current concept of welfare (Daniel, 2008).

A welfare state is a concept of government where the state plays the primary role in the protection and promotion of the economic and social well- being of its citizens. Its development will be concerned with how far it should extend, demands for changes, which can be affected by improved technology, shifting social or economic factors and demographic trends such as lower birth rates and people living longer. Therefore, as the government has discovered welfare state, which means people are living longer and enjoying a healthier life (Department for Work and Pensions, 2005).

3.3 The Response of Conquering Social Risk- Cases from Germany and Taiwan

Modern states often establish as mandatory the protection and obligation to intervene in individual- and market affairs. It is widely accepted by sociologists that individuals and their families have to take responsibility regarding personal risk. However, under the circumstance of social and demographic change, the nature of the problem will be affected, i.e. the responsibility will be transferred from the individual or family to the society even at the national or public level. Therefore, this kind of change will drive public decision- making, and furthermore establish an institutionalized security system to protect the foundation of the

rationalization of social risk. It is worthwhile to note that countries have to involve the public sector, if the current personal, third sector, market, public assistance are unable to provide the way to guarantee the subject of social risks.

Esping- Andersen (1990) indicated that there are three reasons that personal risk will be transformed to social risk: 1. the accident looks like a personal density, however, it will influence social harmony and welfare systems; 2. the whole society recognized the accidents which became a misgivings and 3. the individuals cannot overcome issues by themselves. Besides this, the prevalence of long- term care needs reveal the direct correlation with age. People live longer because of the progress in medical skills and the improvement of living standards/ conditions, which are generalized by the social cause and effect. Moreover, the demographic and social change, the structure of households and the relations between family members have changed the pattern of long- term care activities, which occurs throughout the whole society. Therefore, the need for long- term care contents the concept and the meaning of social risk. In view of above- mentioned reasons, it will be significant meaningful for the government to respond to long- term care needs by establishing a mandatory social security system (Thiede, 1990).

Germany's Federal Ministry for Youth, Family and Health (currently: Federal Ministry of Family Affairs, Senior Citizens, Women and Youth) launched a report in 1984, which indicated that the characteristics of risk for long- term care could be regarded as an attendant risk i.e. it is caused by disease, disability or ageing. For this reason, the need for long- term care is not explicit stated but is coped with by the social protection programs e.g. long- term care policies or social assistance programs (Schulte, 1996).

Trustees German Old- age Assistance (German: Kuratorium Deutsche Altershilfe) launched a

report in 1974, which indicated that from the aspect of social policy, long- term care needs have become a general life risk, i.e. a social risk. Moreover, the then related social policy/ scheme could not completely meet the demands of people in need, which drove those seeking assistance away from the social assistance scheme.

At that time, the social assistance program in Germany covered the cost of care at home or more commonly in an institution. The level of benefits depended on the levels of resource and on the level of need of assistance. In 1990, about 80 per cent of people in institutions relied on a regional and local social assistance scheme for the cost of care, which took account of one-third of total expenditure on social assistance in former West Germany (Glendinning & Igl, 2009). The heavy financial pressure would crowd out other expenditures on social assistance.

In Taiwan, traditionally, long- term care needs are not regarded as a risk but related to personal density. That means that, the individual or the household have to shoulder the responsibility to care for themselves or family members, due to the influence of Confucianism within the Chinese community. At the beginning, the government in Taiwan did not realize the importance of the need for long- term care, after all, at the time of the zero hour (German: Stunde Null), the issue of care was not regarded as a primary concern. However, with the advent of demographic- and social changes and the rising demand for social rights to care, the personal density has ben transformed to the social level i.e. it has been regarded as a kind of social risk.

The need for long- term care and the care needs of the ill belong to a different social security system. Regarding the concept of social risk between them, the issues are as follows: first, the incidence of need for long- term care will lower than care needs caused by disease (Lin, 2000). Most people will face only a one- time accident for care and last to the end of life, whereas, an

individual can suffer various illnesses at any time. Second, according to the official statistics, in 1992, 0.5 per cent of people aged less than 65 years old needed long- term care, people with age between 80- 85 years old occupied 10 per cent and 25 per cent of people aged more than 85 years old have needed long- term care (Infratest Sozialforschung, 1992). Therefore, it could be stated generaly that the age level will determin the need for care, i.e. the older the age, the higher the need for long- term care. Third, people who suffer from a disease can accept medical treatment and recover and return to a healthy status. However, the treatment for long- term care can only main the status or postpone the depravation. Therefore, one of the key issues in Germany's Long- term Care Insurance is that disease prevention and the rehabilitation service take precedence (Social Code Book XI Article 31.).

Based on the above- mentioned illustration, long- term care need is different from the illness from disease which caused the need of care on their concept. Moreover, the long- term care receiver not only requires the care service but also income for maintaining a basic standard of living. Therefore, the need for long- term care is related to the concept of risk of income discontinuity. In order to avoid the issues, the contribution and the indemnification for the informal caregiver in Germany's Long- term Care Insurance system is supported by the pension insurance system, family system, unemployment insurance system, accident insurance system, health insurance system and social aid scheme. For this reason, the five pillars of German social security system reveal their independence and co- operate with each other to support the system.

The older a person's age, the higher the need for long- term care. Improved medical technology and treatment skills can extend and save lives. However, the aspects of extending an active life expectancy and assuring a quality of life cannot be guaranteed by medical technology. Furthermore, especially in the family structure, the support for care becomes weak, such as the

elderly living alone and older people without children. If the government pushes them back on family responsibility, the social situation and even the social security system will collapse (Thiede, 1990). Therefore, the need for long- term care is regarded as a kind of social risk, and in order to respond to the issue, the government establishes a social policy to mitigate and even avoid the risk.

3.4 Discussion and Conclusion

Titmuss (1974) indicated that the social policy contains action- oriented and problem- oriented aspects. He stated further that social policy is intended to meet basic personal needs and maintain the legitimate social order. Normally, social policy to the policy of governments with regard to action which have a direct impact on the welfare of the citizens, by providing them with services or income. The central core consists, therefore, of social insurance, public (or national) assistance, the health and welfare services, housing policy (Marshall, 1965; Titmuss, 1974). The above mentioned issue of long- term care is regarded as a kind of social risk in both Germany and Taiwan. Under these circumstances, appropriate policy- making will be needed to confront the issue.

We should first clarify that demographic change drives the long- term care policy as a solution, and within the welfare state, urgent long- term care need is regarded as a social risk. This chapter elaborates the relation within the welfare state, social insurance and social security in Germany and Taiwan.

What we commonly realize is that the welfare state acts as a guide to social security. However, essentially, since the welfare is regarded as a right of citizens, the government ought to shoulder the responsibility to prevent social risk and to maintain the basic standard of living conditions. In order to achieve the goal, three types of welfare are mostly used by the government, which are social insurance, social compensation, and social assistance. Here regarding this issue, the long- term care system in Germany and Taiwan are strongly related to social insurance, therefore, in this chapter, the relation between social insurance and social security net has been underlined. One of the important characteristics is that, social insurance centralizes the social risk and transfers it to the individual. In this regard, under the social security net, social insurance plays the role of ensuring financial support when facing the risks.

As the target of comparison, Germany and Taiwan own their own welfare model to complete the welfare regimes. Since the 1990s, Gøsta Esping- Andersen launched the four types of welfare states and afterward the whole research started a great mass favor to compare welfare models through cross- country comparative studies. However, this research focused on western regions, while for eastern countries, less of them addressed this generalization. Since Gøsta Esping- Andersen, Alan Walker and some scholars from Asia launched their analyse, the status of welfare models in East Asia could systematically be realized by the academic circle.

East Asia has been influenced by Confucianism for 2500 years and it has driven the attitude to living and regulations for living and even governmental administration. The characteristic of Confucianism on social welfare reveals the centralization of authority, and the household's full role in it. Under this circumstance, the household takes the responsibility and stands on the front line to directly support Family members.

By the influence of this culture, Taiwan is usually regarded as a Confucian welfare state. The

design of social welfare policy in Taiwan is thus always related to Confucianism, meaning that the government takes responsibility for public policies, while the family and the neighborhood shoulder the role of care. Besides, taxation in Taiwan is lower than in other welfare countries. However, when talking about social welfare, the financial resources available should not be ignored. Hence, the support for welfare in Taiwan will be mostly shouldered by the family or individuals.

Unlike the culture in Taiwan, the Bismarckian- influenced German welfare model is concerned with maintaining the order and the position. In order to reach this goal, some social insurance programs were established at the outset, such as pension insurance, health insurance, unemployment insurance, accident insurance. Through the social compensation, social delivery and social assistance, three pillars support the establishment of the Social State in Germany. The principle of the Social State in Germany is to assist the individual to returning to a state of self- reliance.

The social welfare system in Germany possesses the advantage of clear basic principles and long- term planning. The social welfare system in Taiwan has not reached complete maturity yet, meaning that, there is still a large space to fit it to grow to maturity. To establish a sound and long- term scheme is the current target.

Chapter 4.
The Perspective of Party Politics and the Current Social Security Scheme in Taiwan

4.1 The Development of Social Welfare Policy in Taiwan

Taiwan was ceded to the Empire of Japan by the Qing Empire through the Treaty of Shimonoseki, after the First Sino- Japanese War in 1895. In 1945, Taiwan became independent from Japan because of the outcome of World War II. During the period of colonization, Taiwan had no any kind of social welfare policy and no welfare scheme was put in place by the Empire of Japan. In 1949, the Republic of China (R. O. C) lost mainland China in the Chinese Civil War to the Communist Party of China and resettled its government to Taiwan. Since 1950 Taiwan composes the vast majority of the R. O. C territory, and this is one of many reasons why the Taiwan R. O. C is commonly known as Taiwan.

Since the Labor Insurance Act was established in 1950 in Taiwan, it can be regarded as the initiating age of social welfare. Until now, in order to complete the establishment of a social security net, a series of social policies has been formulated. (see *Table 4.1*) According to the Research, Development and Evaluation Commission, Executive Yuen defined the scope of social welfare in Taiwan in 1993; social welfare was divided into three categories, which include social aid, social insurance and social service. First, the main purpose of social aid is to solve and lighten the problem of poverty. A society always contains at the disadvantaged minority, which need to be protected by the state. Then, social insurance aims to cover and protect the whole population while sharing the risk. The concept of risk sharing is the main purpose of social insurance. In Taiwan, since the labor insurance was formulated, and until now,

several social insurance schemes have continually been enacted, such as, Farmer's Health Insurance in 1987, National Health Insurance in 1994 and the upcoming Long- term Care Insurance. The third category refers to the social service, which focus on specific groups such as child welfare, youth welfare and elderly welfare.

In the face of rapid demographic change and economic development by globalization, new social risks and social issues have confronted society with new problems, and thus the above-mentioned categories were redefined by the Ministry of Interior in 2004, which added two further categories, i.e. economic security and health care system respectively. The health care system is the most important mission at present. For instance, the forthcoming long- term care insurance and act for long- term care service aims to respond to the rapid ageing of the population and the increased number of dementia patients.

Taiwan's society is facing a growing demand for Long- term Care. The growing ageing population means an increasing number of care needs and expected growth for the coming decades (Schulz, 2010). Moreover, the number of traditional informal caregivers has been decreasing, of which, the increased rate of participation in the labor force of married females, lower fertility and informal caregivers of care needs to people are themselves elderly, are the most important causes of this phenomenon. With the increase in conformation about how to know gradually how to use and apply for social security program to promote and support their quality of life elder care service will not only be an upcoming main stream in the medical care field but also in the social care field.

In order to promote active ageing for the elderly and to care for the elderly comprehensively, Executive Yuan enacted and phased in many related programs to care for minorities since 1980.

Table 4.1 The Main Social Policies in Taiwan (1949- to present)

Social Policy	Social Assistance	Economic Security	Social Insurance	Social Service
1949 - 1979	**1979:** The Act for Social Establishment in Taiwan	**1972:** Plan for Fairly Prosperous and Secure.	**1950:** Labor Insurance act. **1956:** Act of Insurance for Military Personnel. **1958:** Act of Insurance for Public Servants.	**1965:** People's Livelihood Guiding Principles. **1968:** Guiding Principles for Community Development. **1969:** Guiding Principle for Social Construction. **1973:** Children Welfare Act.
1980 - 1987	**1980:** Act for Social Assistance.	**1980:** Plan for Economic Development in Taiwan.	**1987:** Farmer's Health Care Insurance.	**1980:** Elder Welfare Act. **1980:** Disability Welfare Act. **1987:** Young People Welfare Act.
1993 - to date	**1995:** Child and Youth Sexual Transaction Prevention Act. **1997:** Sexual Assault Crime Prevention Act. **1998:** Domestic Violence Prevention Act.	**1995:** Provisional Regulations on Welfare Benefits for Elderly Farmers. **1997:** People with Disabilities Protection Act. **1997:** Credit Union Act. **2004:** Labor Pension Act. **2007:** People with Disabilities Rights Protection Act. **2007:** National Pension Act. **2011:** Gender Equality in Employment Act.	**1994:** Health Care Insurance. **1999:** Unemployed Insurance **2012:** Long- term Care Insurance. (upcoming)	**1997:** Social Worker Act. **2001:** Volunteer Service Act. **2004:** Guiding Principles for Social Welfare Policy. (modification) **2006:** Charity Donations Destined for Social Welfare Funds Implementation Regulations. **2003:** Children and Youth Welfare Act. **2015:** The Long- term Care service Act.

Source: Laws and Regulations Database of Taiwan, form: < http://law.moj.gov.tw/index.aspx >

Note: All translations in this Table are bsed on the official Law and Regulations Database of The Republic of China (Taiwan).

For instance, the Senior Citizens Welfare Act (2009), National Health Care Insurance (1995), Comprehensive Warm Plan (2008), Comprehensive Warm Flagship Plan- Ten Years Long-term Care Program (2008), Long- term Care Service Act (2015) and the forthcoming compulsory Long-term Care Insurance, etc… .On top of these, Executive Yuan is now stressing the need to introduce a long- term care system to promote the quality of elderly healthy living and develop professional care nets. The emphasis on these plans could offer an important opportunity for the achievement of long- term care service.

As we know, the long- term care policy is related to the state's social welfare polices and its historical development. To help understand the principle and current situation relating to Taiwanese social welfare policy, this section will introduce the concept of social policy and its development in Taiwan.

Social policy is regarded as a series of measures by the state to respond the social risks and social issues, which constitute the components of the welfare state. It also offers a guide to the shifting, maintenance, and creation of living conditions that improve human welfare (Alcock, Daly & Griggs, 2008). Consequently, as a welfare state, Taiwan's Constitution includes ten categories to guide the social policy (see *Table 4.2*).

Due to rapid industrialization and economic growth in the 1970s in Taiwan, the economic power of Taiwan was termed the Taiwan Miracle. As it developed alongside the growth experienced in Singapore, South Korea, and Hong Kong, Taiwan became known as one of the Four Asian Tigers. No doubt, the economic boom brought a rapid accumulation of wealth and the improvement in the standard of living, however, behind the economic boom existed, an imbalance between economic development and social welfare in Taiwan, which has led to serious social problems such as inequality of a distribution, high unemployment rate, and social

Table 4.2 Ten Categories Regarding Social Policies in the Constitution and Additional Articles of the Constitution in Taiwan

The number of Articles	Categories	Explanation
Article 152	Employment Policy	The State shall provide a suitable opportunity for work to people who are able to work.
Article 153	Policy for Laborers and Farmers	(I)The State, in order to improve the livelihood of laborers and farmers and to improve their productive skill, shall enact laws and carry out policies for their protection. (II) Women and children engaged in labor shall, according to their age and physical condition, be accorded special protection.
Article 154	Policy for Industrial Relations (Capitalists and Labors)	Capital and labor shall, in accordance with the principle of harmony and cooperation, promote productive enterprises. Conciliation and arbitration of disputes between capital and labor shall be prescribed by law.
Article 155	Social Welfare Policy	The State, in order to promote social welfare, shall establish a social insurance system. To the aged and the infirm who are unable to earn a living, and to victims of unusual calamities, the State shall give appropriate assistance and relief.
Article 156	Welfare Policy for Women and Children	The State, in order to consolidate the foundation of national existence and development, shall protect motherhood and carry out the policy of promoting the welfare of women and children.
Article 157	Policy for National Health	The State, in order to improve national health, shall establish extensive services for sanitation and health protection, and a system of public medical service.
Additional Articles of the Constitution: Article 10 (V)	Policy for Universal Health Insurance	The State shall promote universal health insurance and promote the research and development of both modern and traditional medicines.
Additional Articles of the Constitution: Article 10 (VI)	Policy for Gender Equality	The State shall protect the dignity of women, safeguard their personal safety, eliminate sexual discrimination, and further substantive gender equality.
Additional Articles of the Constitution: Article 10 (VII)	Policy for Physically and Mentally Disabled Citizens Protection	The State shall guarantee insurance, medical care, obstacle- free environments, education and training, vocational guidance, and support and assistance in everyday life for physically and mentally handicapped persons, and shall also assist them to attain independence and to develop.
Additional Articles of the Constitution: Article 10 (VIII)	Policy for Social Welfare Service	The State shall emphasize social relief and assistance, welfare services, employment for citizens, social insurance, medical and healthcare, and other social welfare services. Priority shall be given to funding social relief and assistance, and employment for citizens.
Additional Articles of the Constitution:	Policy for Retired Military Servicemen	The State shall respect military servicemen for their contributions to society, and guarantee studies, employment, medical care, and livelihood for retired servicemen.

Article 10 (IX)		
Additional Articles of the Constitution: **Article 10 (XI)**	Policy for Aboriginal Protection	(I) The State affirms cultural pluralism and shall actively preserve and foster the development of aboriginal languages and cultures. (II) The State shall, in accordance with the will of the ethnic groups, safe guard the status and political participation of the aborigines. The State shall also guarantee and provide assistance and encouragement for aboriginal education, culture, transportation, water conservation, health and medical care, economic activity, land, and social welfare, measures for which shall be established by law. The same protection and assistance shall be given to the people of the Penghu, Kinmen, and Matsu areas*.

Source: The Constitution of Taiwan, Promulgated by the National Government on 1.1.1947 and becoming effective on 12.25, 1947.

Note: Penghu, Kinmen, and Matsu are Taiwan's three biggest islands, which are located in the area between China and Taiwan. According to the Constitution of Taiwan, the free area of the Republic of China consists of four islands (Taiwan, Penghu, Kinmen and Matsu).

inequality.

Rapid economic growth led to the Taiwan Economic Miracle. Today Taiwan has a dynamic, capitalist, export- oriented economy with gradually decreasing state involvement in investment and foreign trade. The trade surplus is substantial, and foreign reserves are the seventh largest in the world as of 2013 (International Monetary Fund, 2013). The abundance of property created the formulation of social welfare policies in the 1990s and in the 2000s respectively. In this period, social policy in Taiwan laid particular emphasis on governmental intervention to ensure a basic living standard. This residual welfare model influenced social policy in Taiwan. However, when economies experience a slump in the world, all welfare countries reduce social welfare benefits and the scope of welfare to maintain their financial levels. Thus in Taiwan, the trend of social policy changed from passive social assistance to positive social insurance i.e. from residual welfare to institutional universal. Through the concept of risk sharing, social insurance increases the responsibility on the individual and family, and even on the community to ensure people's needs. Consequently, the government in Taiwan tried to phase in a serial of multiple social policies to protect and promote the security of life and property for all residents. To compare and analyze the policy of long- term care, the welfare model in one's country could be one of the main impact factors, which will affect the nature and principle of social policies for long- term care. Furthermore, for Taiwan, located in the circle of the Chinese community, the welfare model has been influenced by traditional Chinese culture. Therefore, the following section will be based on these categories to illustrate the types of welfare in a comparison between Germany and Taiwan.

4.1.1 The Perspective of Party Politics

In Taiwan, the social welfare regime started in a conservative way (Wang, 2002). With the opening of society and politics, since the 1980s the government in Taiwan has raised many social welfare policies to establish the social security net protecting people in need. The social welfare policy in Taiwan reveals a strong political party- oriented approach. There are two large political parties in Taiwan, the *Kuomintan of Chinese (Chinese Nationalist Party)* and *Democratic Progressive Party*. The two political parties have a different position on the political regime and even on the regime of social welfare policy (see *Table 4.3*).

Hou- Sheng Chan (2008) selected six aspects to compare the different social welfare ideologies of the Chinese Nationalist Party and Democratic Progressive Party in Taiwan. These six aspects refer to the main ideology, social welfare regime, care for children and youths, elderly economic security, governmental intervention, and determination.

The Chinese Nationalist Party has existed for a long time, marked by the establishment of the Republic of China, Taiwan (is different from the People's Republic of China/ Mainland China) in 1894. At that time, the economic circumstance in China was very depressed. Besides, the traditions of Confucianism influenced Chinese society for almost two thousand years. For reasons mentioned above, the spectrum of the main ideology of the Chinese Nationalist Party stands at the center- to- right, which is closer to capitalism. The ideology combines both the doctrine of the mean of Confucianism and capitalism simultaneously. Until now, for its social welfare ideology, the Chinese Nationalist Party emphasizes individual responsibility strongly. Individual responsibility refers to the family's role, sharing risk with other people and lower levels of governmental intervention. Consequently, the ideology of the social welfare regime of

Chinese Nationalist Party primarily stresses using social insurance (Wang, 2002).

On the contrary, in its main ideology, the standpoint of the Democratic Progressive Party is partial to the center- to- left, which is closer to socialism (Chan, 2011). The Democratic Progressive Party claims that the government must shoulder full responsibility for the protection of the people, i.e. to provide a universal allowance especially on the issue of ensuring the standard of living of the elderly without a means test.

Table 4.3 The Social Welfare Ideology of the Chinese Nationalist Party and Democratic Progressive Party in Taiwan

Distinguish	**DPP** (Democratic Progressive Party)	**KMT** (Chinese Nationalist Party)
Main Ideology	*Center- to- Left* (Middle to the market of Socialism)	*Center- to- Right* (Middle to the market of Capitalism)
Social Welfare Regime	Active protection by the government	Social insurance and social assistance
Care for Children and Young People	Government takes full responsibility	The family takes primary responsibility
Elder Economic Security	Governmental revenue model	Social insurance model
Governmental Intervention	*Higher* (Less than in the social democratic regime)	*Lower* (Higher than in the liberal welfare regime)
Determination	Universal social allowance- the distribution is based on equality	Universal social assistance- the distribution is based on the disadvantaged minority

Source: Chan, H. S. (2008). The Development of Social Welfare Policy in Taiwan: Welfare Debates between the Left and the Right, published in the Conference of Dushisha University in 2008.

Generally, the center- to- right Chinese Nationalist Party considered that unless the family lost its function, the government should not replace the function of the family. As opposed to the KMT, the Democratic Progressive Party claims the government has to shoulder the responsibility of protect people in need.

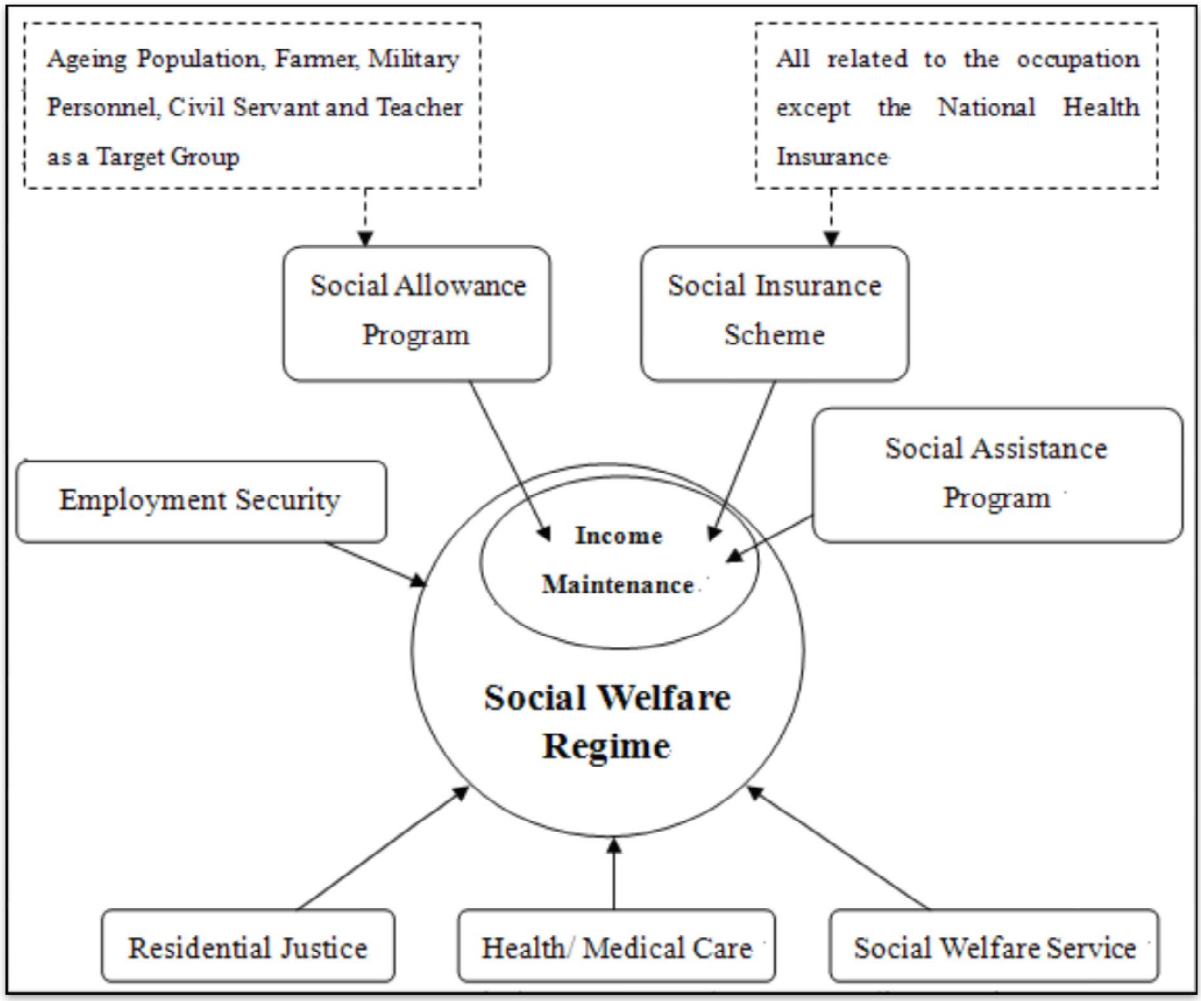
The pattern of the household is based on the model of the nuclear family, which drives social and family change. Under this circumstance, it meant more care needs for the elderly, children, low- income groups, the disabled, and the unemployed. Concerning the issue of long- term care needs, the next section will introduce the development of care policy from the aspect of party politics.

4.2 The Current Social Security scheme and related care policies

Taiwan's Constitution indicates that the Republic of China (Taiwan), is founded on the Three Principles of the People, and is a democratic republic of the people, to be governed by the people and government for the people. In this, the government for the people is regarded as the people's welfare/ livelihood. When Dr. Sun Yat- Sen started to formulate the three principles of the people, the establishment of Chinese socialism was his concern. To date, this principle influences society in Taiwan, including the establishment of social policy.

The Additional Article 10 Section 8 of Taiwan's Constitution indicated that the state shall emphasize social relief and assistance, welfare services, employment for citizens, social insurance, medical and healthcare, and other social welfare services (Lin, 2006; Sun, 2011).

However, in order to respond to social issues/ problems and complete the social security net, the Ministry of the Interior in Taiwan defined the scope of social welfare into six groups e.g. social insurance, social relief/ social assistance, social welfare service, employment security, residential justice and health/ medical care (Ministry of the Interior, 2012) (see *Figure 4.1*). Among these, the income maintenance system is supported by social insurance schemes, social allowance, and social assistance programs. While National Health Insurance covers the whole population, the others exist stronger occupational approach.



Source: Ministry of the Interior (2012). Taipei, Taiwan

Figure 4.1 The Relationship of Social Welfare Groups in Taiwan

In this regard, the whole system of the social security net operates primarily with on the model of social insurance, and then comes the model of social allowance, before, finally, the model of social relief/ social assistance is regarded as a line of defense to protect disadvantaged minorities (Ministry of the Interior, 2004). The financial expenditure for social welfare in Taiwan is composed of social insurance, social allowance, and social relief/ social assistance (Wang, 2002). The following sections will discuss the social insurance schemes and social assistance programs related to long- term care.

4.2.1 The Social Insurance Schemes

At the end of 19th Century, health insurance was established by Otto von Bismarck in Germany, and social insurance schemes spread widely and provided experience and lessons for modern countries around the world. As a public authority, social insurance became a mechanism of social risk management in modern countries (Neubourg & Weigand, 2000; Forss, 2000; Esping- Andersen, 1999).

The development of a social welfare regime in Taiwan was established later than in other modern countries (15 years later than the American social security system in its 1935 Act and 67 years later than the establishment of German Sickness Insurance in 1883). Since 1950, Labour Insurance has been established, and now, the insurance takes the form of a multi-pattern social insurance scheme. The social insurance scheme in Taiwan includes Labour Insurance (1950); Insurance for Military Personnel (1953); Civil Servant and Teacher

Insurance (1958); National Health Insurance (1994); Employment Insurance (2002) and the National Pension Act (2007). (see *Table 4.4*)

Currently, the social welfare policies in Taiwan are based on and follow up the Guiding Principles for Social Welfare Policy (Ministry of the Interior, 2003). The model of social insurance is to assist the citizen in the event of loss of income, sickness, old age and unemployment and to provide protection against crisis caused by several factors including economic, retirement, unemployment and occupational accident. By using the economic power of the majority to compensate for losses and damage to the minority, peace and order can be protected from disturbance by a few individuals (Taiwan Agriculture Information Center, 2001). In this regard, the social insurance scheme in Taiwan includes occupational accident insurance, national health insurance, national pensions, employment insurance and long- term care insurance. Social insurance ensures income security for both individuals and family; in the meantime, according to the principle of justice, social insurance has to provide a subsidy for the poor to maintain their economic security (Minister of the Interior, 2012).

4.2.2 The Program for Social Assistance and Social Welfare Service

The social allowance scheme in Taiwan provides long- term subsidies, with specific purposes for approved specific groups, such as farmers, the ageing population or expectant mothers, and moreover, the function of social allowance is to supplement the lack of social insurance (Yang, 2000). So far, the social allowance scheme in Taiwan includes e.g. Living Allowance for Mid or Low- income Household (1987), Low- income Child Care Allowance (1994), Old- age

Table 4.4 Current Social Insurance Scheme in Taiwan

Branch of Social Insurance	Target Group	The Type and Benefits
Labour Insurance Act	The following workers above 15 full years and below 65 years of age shall all be insured under this program as insured persons, with their employers, or the organizations or institutes to which they belong reckoned as the insured units: ***1.****Industrial workers employed by the public or private factory, mine, salt field, range, pasturage, forest or tea plantation with more than five employees, as well as workers employed by a communication or transportation enterprise, or by a public utility;* ***2.*** *Workers employed by a company or firm with more than five employees;* ***3.****Employees in a journalistic, cultural, non-profit organization or cooperative enterprise with more than five persons;* ***4.****Employees of government offices or public or private schools who are not legally entitled to join civil servants' insurance or the insurance of teachers and employees of private schools;* ***5.****Workers employed in fishing production;* ***6.****Persons receiving vocational training in vocational training institutes registered with the government;* ***7.****Members of an occupational union who have no definite employer or who are self-employed; and* ***8.****Fishermen who belong to Class A of Fishermen's Association and are either self-employed or do not have a definite employer.*	The types and benefits of Labor insurance coverage are categorized as the following: ***1.****Ordinary insurance: There are five different kinds of benefits which are maternity benefits, injury or sickness benefits, disability benefits, old-age benefits and death benefits.* ***2.****Occupational accident insurance: There are four kinds of benefits which are injury and sickness benefits, medical care benefits, disability benefits and death benefits.*
Act of Insurance for Military Personnel	The Military Personnel stated in this Act refers to the ranking Officers, Noncommissioned Officers, and enlisted soldiers currently in service.	The Insurance is divided into four categories: Death, Disability, Retirement and Parental leave without pay. The Beneficiary of the Retirement payments, Disability compensations and subsidies for Parental leave without pay is the insured person himself; And the beneficiary of the Death indemnity is determined by the insured person from the following relatives listed below: ***1.****Spouse;* ***2.****Children;* ***3.****Grand Children;* ***4.****Parents;* ***5.****Siblings and* ***6.****Grand Parents.*
Civil Servant and Teacher Insurance Act	The insurance object includes the following personnel: ***1.****The full-time staff to the statutory authority;* ***2.****The full-time faculty in the public school;* ***3.****According to the Private School Law, the full-time faculty in private foundation or school which registered and approved by the competent educational authority.*	This insurance includes disability, retirement, death, burial, and parental leave five dependents.
National Health Insurance Act	Any national of the Republic of China must meet one of the following requirements in order to become beneficiaries of this Insurance: ***1.****Those who have previously subscribed to this Insurance within the last two years and have a registered domicile in Taiwan, or having established a registered domicile for at least six consecutive months in the Taiwan area prior to subscription of this Insurance;* ***2.****The following individuals who have established a registered domicile in the Taiwan area at the time of becoming a subscriber: (1)Civil servants or full-time and regularly paid personnel in governmental agencies and public/private schools;(2)Employees of publicly or privately owned enterprises or institutions;(3)Employees other than the*	In case the beneficiaries encounter illness, injury, or maternity, the contracted medical care institutions shall provide medical services, drafting fee schedules, drug dispensing items, and regulations governing fee schedule pursuant to Paragraph 2 of the Medical Benefit Regulations, as well as Paragraphs 1 and 2 of

	insured prescribed in the preceding two items but are otherwise employed by particular employers;(4)Newborns in the Taiwan area;(5)Spouse and offspring of government officials assigned abroad.	Article 41.
Employment Insurance Act	An employed worker over 15 and under 65 years of age and with one of the following statuses is required to join this employment insurance program as an insured person through his employer or the organization to which he or she belongs: ***1.****A ROC national;****2.****A foreign national, Mainland Chinese citizen, Hong Kong citizen or Macao citizen married to a ROC citizen and having acquired legal residency in ROC.*	The benefits from this employment insurance program are divided into the five following categories: ***1.****Unemployment benefits;****2.****Early reemployment incentives;****3.****Vocational training living allowances;****4.****Parental leave allowances;5.National Health Insurance premium subsidies for unemployed insured persons and dependants enrolled with the insured person.*
National Pension Act	Citizens under 65 with their household registered in ROC and are qualified for one of the following should, except for those should participate or have already participated in other related social insurances, take part in the Insurance and become the insured persons: ***1.****Aged 25 or above and non-recipient of old age benefit of related social insurances;* ***2.****Before the implementation of this act, recipient of old age benefit of other related social insurances with insurance period less than 15 years, or lump sum payment of old age benefit of other related social insurances less than NT$ 500,000, except for insurance period or lump sum payment of the old age benefit of the labor insurance and* ***3.****Within 15 years of the implementation of this act, recipient of old age benefit of other related social insurances with insurance period less than 15 years, or lump sum payment of old age benefit of the labor insurance and other related social insurances totally less than NT$ 500,000. But for recipients of old age benefit of the labor insurance before the implementation of the pension scheme of the labor insurance, the insurance period or payment for old age benefit of the labor insurance is not calculated.*	The Insurance contingencies of the National Pension Insurance include old age, maternity, mentally/ physically disability and death. Payments to the insured people during the validation of the insurance when contingencies happen include old age pension payment, maternity payment, mentally / physically disability pension payment, death payment and surviving family pension payment.

Source: Laws and Regulations Database of The Republic of China (Taiwan), from: < http://law.moj.gov.tw/Eng/ >

Note: All translations in this Table are based on the official Law and Regulations Database of The Republic of China (Taiwan).

Farmer Allowance (1995), Subsidization for Medical Treatment and Auxiliary Appliances for the Disabled (1997), Living Allowance for Mid or Low- income Senior Citizens (1998), Subsidization for the Living, Nursing, and Maintenance Expenses of the Disabled Amended Provisions (1999), Old- age Allowance (2002), Housing Subsidy (2007), Subsidy for Disabled Senior Citizens Receiving Long- term Care Services (2008). Generally, the items of the social allowance scheme in Taiwan cover the fields of social welfare service, employment security, residential justice and health/ medical care. The Guiding Principles for Social Welfare Policy indicate that the model of social relief/ social assistance in Taiwan is regarded as a line of defense, which maintain living standards for economically disadvantaged minorities. The Public Assistance Act in Taiwan was enacted in 2010, which provided care for low- income and middle- low- income households, assisted persons in need during an emergency or disaster and helped them to live independently. In this act, the social relief/ assistance is divided into living support, medical subsidies, and emergency and disaster aid for low- income households (Public Assistance Act, 2010).

In the social welfare service system, social workers play an important role in assisting an individual, a family, a party and a community to promote, develop or resume its social function and to pursue his welfare, relying on his professional knowledge and technique of social work (Social Worker Act: Article 2.). Unlike the social insurance, social allowance, and social relief/ social assistance, the object of the social welfare service is unclear as it depends on the social workers' professional knowledge to determine the conditions and processing model for the subject (Lai, 2009).

Since the Social Worker Act was enacted in 1997, the social welfare service in Taiwan entered a new era. The social welfare service became a systematic and professional model. The Concept of the Social Worker Act indicated that in order to establish a professional service

system of social work it needed to promote the professional status of social worker, to define rights and obligations of social worker, and to assure the rights and interests of the target of service (Social Worker Act: Article 1.). Besides, social workers mainly focus on disadvantaged minorities and look to achieve social justice. Nowadays, the social welfare service in Taiwan emphasizes the fields of family policy, welfare programs for children and youths, elderly welfare, the welfare service for disabilities, aborigine policy, marriage immigrant policy, low-income household policy and the labor welfare service.

4.2.3 The Fields of Health/ Medical Care

Currently, the primary issue on the health/ medical care is devoted to creating an age- friendly environment, promoting and maintaining good national health conditions. Moreover, the government keeps driving the reform of the national health insurance, ensuring its sustainable operation and promoting medical quality. Besides, face with the rapid increased in long- term care demand, a complete long- term care system is necessary. Especially, with the fact of rapid population ageing, reduction in family structures and the changing political atmosphere, Taiwan's society currently faces huge change in the fields of economic environment, financial tax model, labor market, income distribution and educational structure (Conference on Sustaining Taiwan's Economic Development, 2006).

For these reasons, the government has to constantly modify the direction of political, economic and social conditions to provide a complete social security net. Since the "Guiding Principles for Social Welfare Policy" was published in 1945, until now, it experienced a series of

modifications in 1994, 2004, and 2011 respectively. That means the social welfare policy has already become an important issue for the governmental administration (Tseng, 2007). In this period, several remarkable social welfare policies linked with care needs were established, for instance: Provisional Regulations on Welfare Benefits for Elderly Farmers (1995), Senior Citizens Welfare Act (2007), People with Disabilities Rights Protection Act (2007), Public Assistance Act (2010), Ten Years Long- term Care Program (2007) (see *Table 4.5*). Besides these, the Ten Years Long- term Care Program (2007) and Long- term Care Service Act (2015) will be elaborated explicitly in the following sections of Chapter 6.1 and Chapter 6.2.

To generalize the above- mentioned details, although the modern social security system in Taiwan has been established since 1945 and even regarded as a benchmark within Southeast Asian countries, until now, the whole system in Taiwan has not been completed yet. The social policies in Taiwan, based on the viewpoint of Richard Titmuss (1958) were provided with three models respectively e.g. the residual welfare model, the industrial achievement- performance model and the institutional- redistributive model.

Before abolishing martial law in 1987, Taiwan's social security system existed as a dual model, which constituted the residual welfare model and the industrial achievement- performance model. Due to cooperation with the United States of America after World War II, Taiwan has always been influenced by the American political system, its economic market, and social welfare regime. At the very start, the social welfare model in Taiwan tended toward the residual welfare model, which cares for the disadvantaged minority and avoided the social issues/ problems caused by the minority groups simultaneously. At this time, the government actively developed the economy to improve the people's general well- being, to satisfy the people's need and to improve people's living standards.

Table 4.5 Current Care and Income- Protection Policies for the Elderly and Disability in Taiwan

Branch of Care Policy	Target Group	The Aim of Act	The Type and Benefits
Provisional Regulations on Welfare Benefits for Elderly Farmers	1.Age 65 and over; 2.The standards of farmers shall be prescribed by the central agricultural competent authority.	This Act is enacted in order to care and increase the welfare for the elderly farmers.	The elderly farmers who meet the eligibility conditions of the preceding article may apply for welfare benefits. Since January 2012, the benefits have been justice to 7,000 NT Dollars (about 175 Euro) per month, until their death.
Senior Citizens Welfare Act	In this Act, elders are people who are aged above 65 years old.	The Act is formulated to assert the dignity and health, to maintain the standard of living, to protect the rights and to facilitate the welfares of elders.	To ensure the standard of living of elders, the living subsidies, special care subsidies and the annuity will be planned and executed gradually. To protect their property, the municipal and city/county governments shall encourage the elders to put them in trust. To provide continuing care for incompetent elders, the municipal and city/county governments shall provide or work with private institutions to provide the home- base, community-base and institutional services. A 50% discount shall be given to elders while taking public/private transportation (airplanes, cars/trains, or ships), entering amusement parks, and participating in art facilities, domestically.To assist the care providers of incompetent elders, the municipal and city/county governments shall provide or work with private institutions to provide Temporary or short-term break care service and Provide trainings and workshops to care providers. The authorities concerned shall establish or coordinate with private institutions to establish the following elderly welfare institutions, based on the need of the elders:1.Long- term care institutions;2.Caring institutions;3.Other elderly welfare institutions.
People with Disabilities Rights Protection Act	People with disabilities in this Act refer to those who with the deviation or loss resulting from physical or mental impairments, are limited or restricted to be engaged in the ordinary living activities and participation in the society; and they, after processes of evaluation & assessment by the committee composed of professionals from medicine, social work, special education and employment counseling and evaluation, can be regarded as suffering one of the malfunction categories and issued a disability identification.	This Act aims to protect the legal rights and interests of people with disabilities, secure their equal opportunity to participate in social, political, economical, and cultural activities fairly while contributing to their independence and development.	**1.**Rights and Interests of Health and Medical Care: *The competent authorities of individual levels in charge of health shall integrate medical care resources and provide individualized health and medical care service for people with disabilities, and assist welfare care facilities／institutions for people with disabilities to provide the required health and medical care services*;**2.**Rights and Interests of Education: *The competent authorities of individual levels in charge of education shall actively help people with disabilities to receive schooling, and people with disabilities in school ages who are receiving medical care or social welfare services, and solve their related educational issues*;**3.**Rights and Interests of Employment: *The competent authorities of individual levels in charge of labor shall, according to the actual need of people with disabilities, process by themselves or consolidate resources of private sectors to provide*

			access free and individualized occupational reconstruction services;**4.**Support Service;**5.**Economic Security: *The economic security for people with disabilities are to be planned and executed, step by step, by life subsidies, day care and residential care subsidies, caregiver allowance, and pension／annuity insurance*;**6.**Protection Service.
Public Assistance Act	1. The low-income households described in this Act shall qualify under the following conditions: they are approved by their local municipality competent authority via application; their average divided monthly income among each person in the household falls below the lowest living index; and their total household assets do not exceed the specific amount announced by the central and municipality competent authorities in the year of application;2.Or, The Middle-income. Their average divided monthly income among each person in the household falls below the amount 1.5 times as much as the lowest living index and shall not exceed the expenditure described in the third paragraph of the above article; Their total household assets shall not exceed the specific amount announced by the central and municipality competent authorities in the current year.	This Act is enacted to care for low-income and middle-low-income households, assist persons in need during an emergency or disaster, and help them to live independently.	**1.**Living Support: *In principle, living support shall be paid in cash. However, according to the actual circumstances, proper public assistance institutions, social welfare institutions, or other families may be entrusted to provide shelter*;**2.**Medical Subsidy: *The insurance premium for low-income households to cover the National Health Insurance shall be paid from the budget of the central competent authorities*;**3.**Emergency Aid;**4.**Disaster Aid.

Source: Laws and Regulations Database of The Republic of China (Taiwan), from: < http://law.moj.gov.tw/Eng/ >

Note: All translations in this Table are based on the official Law and Regulations Database of The Republic of China (Taiwan).

Besides the residual welfare model, the industrial achievement- performance model also played an important role in the social welfare regime in Taiwan before the abolition of martial law. In order to calm down the revolt by disadvantaged minorities and assuage the labor movement, the government in Taiwan regarded the industrial achievement- performance model as a tool to maintain social order and consolidate political power. At the time, the construction of the welfare regime in Taiwan protected not only the disadvantaged but also improved the welfare of public servants, military personnel and school staff (Lu, 2004).

After several decades of development, the social security net in Taiwan progressively completed the system. Currently, the advancement of democratic ideology and the rapid economic development have influenced the social welfare regime in Taiwan. In order to pursue justice in society and just values, the social welfare regime in Taiwan has tended to adopt the institutional- redistributive model. Here, social welfare not only addresses social issues/ problems but also prevents and mitigates social risks for family and individuals, such as illness, disability, unemployment, ageing and death (Wu, 2003). Therefore, according to the Guiding Principles for Social Welfare Policy in 2012, currently, the social welfare policy in Taiwan focuses on social insurance, social relief/ social assistance, social welfare service, employment security, residential justice and health/ medical care to complete the social security system (Ministry of the Interior, 2012).

Population ageing is now regarded as a primary issue for state development. At the same time, the care for the elderly and the complete social policy will strongly influence how later life is experienced around the world. As well as in Taiwan, under the circumstance of the baby boomer after World War II, increasing life expectancy and the reduction of the fertility rate, the number of people aged 65 and over is projected to reach 30 per cent of the total population by 2050 in Taiwan.

Beyond economic action and production, a further area of concern relates to the cost of providing for need that is especially associated with later life e.g. income support, healthcare and social services (Lloyd- Sherlock, 2010). Despite the Senior Citizens Welfare Act and People with Disabilities Rights Protection Act established in 1980 respectively, the government and the wider society did not emphasize the importance of senior groups. With the rapid population ageing, how to respond to this situation will be a major issue in Taiwan. After several decades of modification, the Senior Citizens Welfare Act was completed in 2007. At first, the start of the act indicates that it is formulated to support the dignity and health, to maintain the standard of living, to protect the rights and facilitate the welfare of the elderly. Besides the above- mentioned act, currently, in the face of increasing long- term care demand, the major issue of the government is to establish a long- term care system and long- term care insurance.

The above- mentioned issues are the official social and care policies, which are established by the government. However, in the historical process of the whole of humanity, the non- profit organization is an indispensable element in social security schemes. Therefore, the following section will introduce the role of religion in Taiwan.

4.2.4 The Role of Religion

In the aspect of the history of welfare services, religious organizations have a long tradition of intervening in the assistance of the old and the poor than government has(Leiby, 1985; Kramer,

1981; Wang, 2009). Since the Elizabethan Poor Law, which was regarded as a beginning of governmental intervention in welfare affairs, religious organization did not disappear, on the contrary, they became one of the main dual systems in welfare services.

In Taiwan, with the development and progress of the economy and industry, the religious welfare service has two different models, which are the western Christian/Catholic Church system and the local temple (Buddhism/ Taoism) system (Wang, 2009). The Christian and the Catholic church in Taiwan has a long tradition since Christianity was introduced into Taiwan one hundred years ago. At that time, the welfare service was related to the then current social issues e.g. poverty support, orphan acceptance, and medical services. With social and economic development, the church has grown in strength and taken this opportunity to establish branches and accumulate a large capacity. Until now, the items covered by church welfare services include educational development, old- and disability assistance, family, children, and adolescent helper and the provision of long- term care.

Unlike the development of Christian/ Catholic Church system, which started to react to the then dominant social problems, the welfare service of the local temple (Buddhism/ Taoism) system developed with the economic and the extension of the national welfare regime (Wang, 2009). At the beginning, the Buddhism and Taoism systems were established in local regions or communities, which provided welfare services, i.e. poverty support and long- term care services for the elderly and the disabled near the temples. With the development of the economy and industry, the contents of this welfare service were expended as well. Moreover, the Buddhism and Taoism system had been influenced by Confucianism for over a thousand years in some of its concepts and its principle of welfare service affairs. In comparison to the western church system, the local temple system stresses on the function of the family, and the Christian/ Catholic Church system emphasizes the position of the organization i.e. the church

branches. Both systems offer different patterns for arranging welfare services. In the western system, it can be seen that the central Council of the Christian or the Catholic Bishops Conference mostly organize welfare affairs by using the church branches in the regions or communities. However, the local Buddhism and Taoism system provide welfare services through the organization of volunteers who have the same religious faith.

Currently, the two systems have different development paths. The western system is trying to take root in the communities and regions e.g. World Vision and Young Men's Christian Association. While the local temple system, is developing through international organizations such as Fo Guang Shan and Tzu Chi Foundation. Nevertheless, the both systems still play an important role in welfare affairs in Taiwan.

4.3 Discussion and Conclusion

This chapter focused on the issue of how the perspective of political parties influenced the long- term care policy in Taiwan. For the two biggest political parties, the Chinese Nationalist Party and the Democratic Progressive Party offer different points of view on social welfare ideology.

The Chinese Nationalist Party stands at the center- to- right closer to capitalism. Therefore, the ideology for its social policy stresses individual responsibility. The standpoint of the Democratic Progressive Party is close to the center- to- left and is thus closer to socialism, which claims that the government takes the most responsibility for the people.

The Chinese Nationalist Party has held the reins of government for almost fifty years, and the ideology of social welfare policy has been influenced deeply by its perspective. Therefore, the characteristic of the social welfare regime tends toward social insurance and social assistance programs, e.g. National Health Insurance, Labor Insurance etc.

Furthermore, the social welfare policy in Taiwan follows the Guiding Principles for Social Welfare Policy, which is based on the social insurance, social allowance, and social assistance schemes in order to take responsibility to ensure the standard of living conditions of the people.

Besides the social welfare scheme, based on the aspect of the history of welfare services, religious organizations have a longer tradition intervening in assisting the old and the poor than the government has. There are two different models tat provide religious welfare services, which are the Christian/ Catholic Church system and the local temple (Buddhism/ Taoism) system. With the social and economic developments, both systems have grown with Taiwan's economic status. Currently, both religious systems provide welfare services including educational development, old- and disability assistance, family, children, and adolescent assistance, and besides, for a long while, both of them provided the long- term care services before the regular long- term care system was established.

In Taiwan, the ageing population, the prevalence of chronic disease and disability has increased over the past decade. These dysfunctions or lack of self- care skills, in addition to the health and medical services, also requires extensive long-term care services. Besides, the demographic and social change that influenced the pattern of care at home and in society, moreover, the financial pressure of health insurance has deepened due to the growth of an ageing population, and the prevalence of chronic disease has driven the demand for appropriate

care policies.

In 2004, the Executive Yuan established a long- term care preparatory team to draft the long-term care program. After three years of discussion by experts and academics in the fields of social welfare and care systems, the final report has been sent to Executive Yuan. In order to respond to the rapid increase in long-term care needs, Executive Yuan approved the Ten Years Long- term Care Program in 2007. To map out distribution of 81.736 billion NT Dollars to invest in funds with the aim of constructing a diverse, community- based, high quality, affordable and gender balanced long-term care system in urban and rural areas, ethnic, cultural, professional, economic and health conditions of differences in ten years (Ministry of the Interior, 2008). The basic goal of the Ten Years Long- term Care Program for the country is to establish a comprehensive long-term care system, protect the physically and mentally ill so they can get appropriate services to enhance independent living skills, and improve the quality of life in order to maintain dignity and autonomy.

Chapter 5.
The Current Long- term Care Policies in Taiwan

5.1 The Ten Year Long- term Care Program: 2007 to 2017

In order to react to the predicament of the care system, the call for reform from society and the upsurge in social rights for care pushed by Executive Yuan to establish The Ten Year Long- term Care Program in 2007 established long- term care in Taiwan. As a flagship sub- scheme from the Big Warm Social Welfare Program, the scheme will be implemented from 2007 to 2017.

The short- term target was to develop the basic model of care service in the period from 2007 to 2011, then, from 2012 to 2015, the middle- term target extended the target group and created the care service network, before, finally, the long- term target is to link up the Long- term Care Insurance Act. The funding of The Ten Year Long- term Care Program comes from tax and the governmental budget. Several years after implementing the scheme, the government found that the financial status could not cover the funding anymore in the near future. Therefore, Executive Yuan is now preparing to phase in the pattern of social insurance to constitute the long- term care system. The already existing The Ten Year Long- term Care Program will be treated as a base to contribute to the foundation for the long- term care system and prepare for the incoming long- term care insurance.

However, the importance of The Ten Year Long- term Care Program cannot be ignored. Its role

was to create the foundation before implementing long- term care insurance. The following section will focus on illustrating the contents of The Ten Year Long- term Care Program and will introduce the main foundation that was established for the incoming long- term care insurance.

5.1.1 The Eligibility of People and Long- term Care Service

The definition of eligible people is a basic precondition for planning the long- term care service. Reviewing the literature, long- term care can be defined as a set of medical and nursing treatments, personal care, and social services delivered over a sustained period (usually at least 6 months) to those with disabilities. The aim of the long- term care is to sustain and promote functional ability (Kane & Kane, 1987). Furthermore, William Weissert (1991) extended the service target of long- term care. He considered that the service should include all ages of people who suffered chronic disease, mental or physiological and the disability and the care service could be provided in home, in institutions or non- institutions. His definition influences the service target of long- term care in Taiwan. In Taiwan, based on Weissert's definition of the long- term care, researchers extended the service target from those with disability or people who suffer chronic disease to the ageing population, informal caregivers and potential targets i.e. dementia, mental retardation, HIV (Human Immunodeficiency Virus), cerebral palsy or people who suffered serious accidents and cannot provide for themselves.

Currently, the Senior Citizens' Welfare Act (1980) and the Disability's Welfare Act (1980) influence the eligible of people for long- term care services. Based on the above two acts, the

eligibility of people could be roughly defined as seniors and disability. Since 1980, the government has established many acts and programs to provide security or service to target group. Until now, after the definition of the set of acts (from 1998- 2007), those eligible could be determined completely. (see *Table 5.1*)

Table 5.1 The Definition of Eligible people in Acts for Long- term Care

Acts	Period (year)	Definition of Eligible People
Reinforcement Program for Senior Care	1998- 2007	senior
Triple- years Plan of Long- term Care for the Senior	1998- 2001	senior
Precursory Plan for Constructing the Long- term Care System	2000- 2003	(a) above 20 years old (b) at least a ADLs functional disability or light dementia
The Welfare Act for Aboriginal Senior	2002	the aboriginal senior who age 55 and over
The Scheme for Care Service and the Development of Industry	2002- 2007	(a) the general disability (b) dementia
Taiwan Community 6 Star Plan	2005- 2008	(a) senior (b) dementia
The Conference for Sustaining the Economic Development- the Group of Social Security	July, 2006	disable senior

Source: The Ten Year Long- term Care Program, Executive Yuan, Taiwan.

Originally, due to the limited resources and the fast increase in the ageing of the population, those aged 65 and over who lost at least one ADLs (Activities of Daily Living) function or the live- alone elderly who have lost IADLs (Instrumental Activities of Daily Living) should only be included in the target group for long- term care service. However, considering the care demand for separate age levels, those with disabilities aged at least 50 years old and aborigines aged over 55 could also be included in the care system. According to the statistics and estimate by Executive Yuan, the separate service target will increase due to the numbers from 2007 to 2020. (see *Table 5.2*)

Table 5.2 The Statistics and Estimation of Separate Service Target (in number)

Target	2007	2010	2015	2020
65 plus and at least 1 ADLs	227,595	249,607	301,990	370,256
65 plus, IADLs and live alone	6,042	6,670	8,093	9,798
Aborigine 55 plus and at least 1 ADLs	757	926	1,154	1,246
Disability 50 plus and at least 1 ADLs	11,117	13,121	15,947	16,830

Source: The Ten Year Long- term Care Program, Executive Yuan, Taiwan.

5.1.2 The Integrated Care Management System

The long- term care system is a very complicated, multiple element environment. It involves the aspect of care receivers and the aspect of the care system. In order to maximize the effectiveness and care quality, moreover, to satisfy the demand of care receivers, case

managers will play an important role as bridge between both the individual and the care system.

Care management refers to a series of resource purveyance, integration, and negotiation, which will promote resource using and ensure the level of service provided by the care system (Orme & Glastonbury, 1993). In Taiwan, since 1998, according to the Three- years Long- term Care program for Seniors by the Ministry of Health, a long- term care management center has been established in each city. Its function is to simplify the process of care integration, which includes case developing, case selecting, case assessment, plan drawing, service connection, service control, re-assessment, and case closing (Wu, 2003). (see *Table 5.3*) (see *Figure 5.1*)

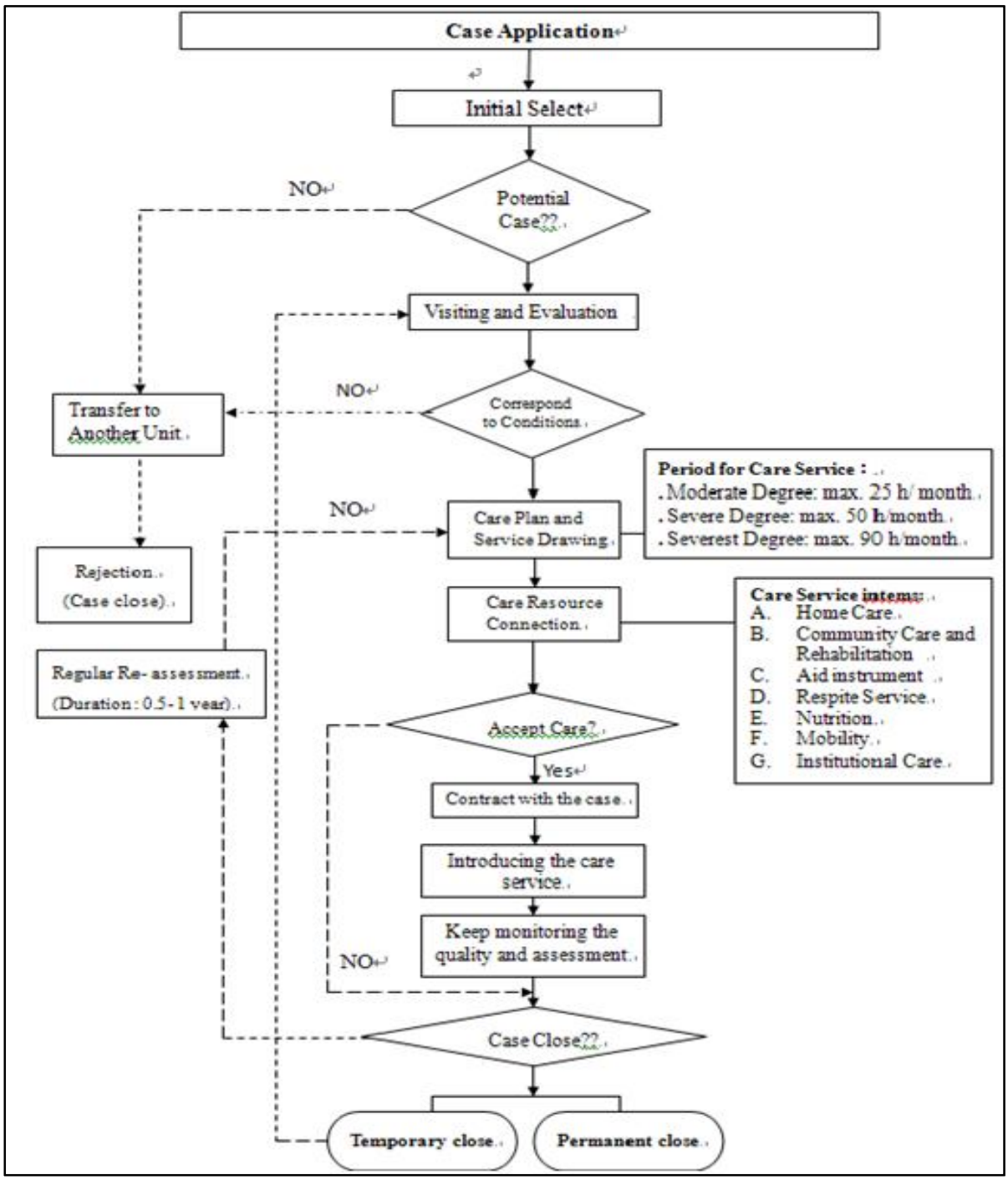
Table 5.3 The Process of Care Management in Long- term Care Management Center

Process/ Responsible Items	**Responsible Departments**	**Explanation**
1. Case Developing	1. Case Initiative 2. Hospitals 3. District Public Health Centers 4. Nursing Associations 5. Social Affairs Departments 6. Self Development 7. Community Development 8. Other Departments	Combine with the social work department.
2. Case Selecting	Long- term Care Management Center	Combine with the departments of household affairs, labour affairs and social affairs.
3. Case Assessment	Self-operated department (Long- term Care Management Center) and Outsourcing	From three aspects: 1. District Public Health Centers 2. Nursing Associations 3. Private Sectors
4. Plan Drawing	Long- term Care Management Center	Drawing out by the qualification and disable degree

5. Service Connection	Long- term Care Management Center	Service Providing from care system
6. Service Control	Long- term Care Management Center	Service quality monitoring
7. Case Re-assessment	Long- term Care Management Center	1. Regular valuation (6 months and 1 year) 2. Face to face interview
8. Case Closing	Long- term Care Management Center	

Source: Wu, S. C., Wang, C., Lu, B. C., Chung, C. Y., Chang, M. and Dai, Y. T. (2003) Construction of Long-term Care System Pilot Program- The Second Year Plan, Ministry of Health and Welfare.

The establishment of Long- term Care Management Center will involve the determination of a case. The funding of The Ten Year Long- term Care Program is supported by the governmental annual budget. Therefore, the determinative organization has to possess a governmental power to execute a fair assessment of the case. Besides, the evaluation of the case (care- demand index) will follow a recognized regular and index to determinate. Currently, the evaluation of the case follows several concepts, which included individual information, health status (include mental, physiological status and active daily functions), social support, and financial status. Generally, the content of the care- demand index has to include basic information about the case, and demand an evaluation and care plan to integrate the whole care environment.



Source: Executive Yuan (2007). The Ten Year Long- term Care Program, Taiwan.

Figure 5.1 The Process of Care Integration in Long- term Care Management Center

5.1.3 The Development of Caregiver in Long- term Care System

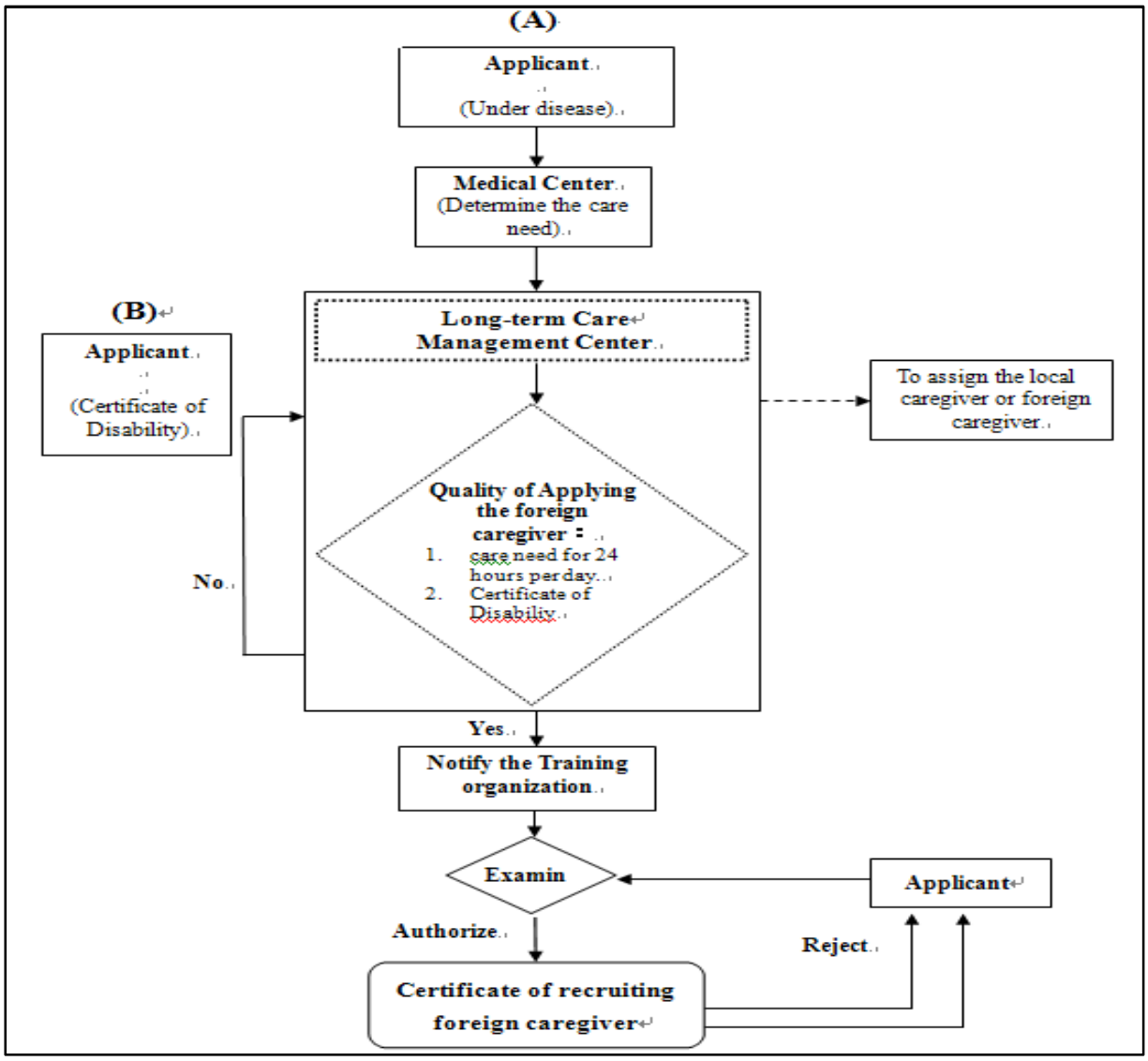
Social care for seniors involves medical treatment, individual care, and social care, which creates a wide service demand. In order to create a complete, continued care service, the system needs multiple professionals from the health industry, e.g. medicine, nursing, social work, physiotherapy. However, the human resources demands in the long- term care system appears unsettled and unreasonable, especially on the care staff. They provide the care service directly to the care receiver. Currently, the care policy in Taiwan does not formulate a long-term workforce plan. Therefore, the recruiting of care staff will face difficulties, which will harm the long- term care system (The Preparatory Task Force on Long-term Care, 2005).

The professionals in the field of medicine, nursing, social work and physiotherapy existed for a long time. Each training schedule and the system have already set down completely. These professionals can directly guide in the care system without the gap. Traditionally, the care responsibility is shouldered by the spouse or the family and relatives. However, due to social change and the formulated care policies, the type of caregiver has gradually changed from the family to the professional care staff. According to the contents of The Ten Year Long- term Care Program System, the Council of Labor Affairs and Department of Health, Executive Yuan is responsible for the training of the professional care staff, which set up the courses to teach professional skills to relatives and examine them.

However, the above sector mentioned that the care policy did not concern the development of long- term workforce and it reacted very slowly, which led to the demand gap being widened very fast. Therefore, foreign caregivers were introduced from Southeastern Asian Countries, e.g. Thailand, Vietnam, Indonesia, and Myanmar.

According to The Ten Year Long- term Care Program, the Long- term Care Management Center is responsible for the assessment of the recruited foreign caregivers. The new application process for the foreign caregivers formulates that the applicant has to be evaluated by the medical centers, which are first selected by the Department of Health of Executive Yuan. Then, the Long- term Care Management Center will be determined whether the applicants have the quality to be recruited as the foreign caregiver. Of course, it depends on the aspect of the government whether the rights of the local caregiver shall be protected. (see *Figure 5.2*)

Generally, the local caregiver holds a low social level with a low salary in Taiwan. How to promote the status of the caregiver will be an important issue, which involves labour policy, migrant policy, and the issue of economic status. The Ten Year Long- term Care Program plans to establish the professionalization of caregivers by training and examinations. Besides, education at university or technical university will play an important role in establish professionals in the long- term care system.



Source: Executive Yuan (2007). The Ten Year Long- term Care Program. Taiwan.

Figure 5.2 The Process of Application for Foreign Caregiver

5.1.4 The Purveyance of Care Service and Compensation

According to The Ten Year Long- term Care Program, the purveyance of benefit is an in- kind payment. The degree of disability will be distinguished into three levels: (1) *moderate level*:

1-2 ADLs disability or IADLs live- alone senior, (2) *Severe level*: 3-4 ADLs disability and (3) *Severest level*: 5 ADLs disability. The compensation and the payment of care service will follow a means- test system to provide for the care receiver.

Care service is used to satisfy the active daily life functions of those with disability in the community or at home. Based on The Ten Year Long- term Care Program, the purveyance of care service is as follows:

(a) *Moderate Disability (include live- alone senior with IADLs disability)*: 50 minutes per day.

(b) *Severe Disability*: 100 minutes per day.

(c) *Severest Disability*: 3 hours per day.

Despite the funding of The Ten Year Long- term Care Program coming from taxes and the governmental budget, the care receivers have to pay for the care service partially. According to the Project, the payment will be based on the means- test concept, that means that the government will give a financial subsidy (≒ 25 EUR per Day) to the impoverished household or individual (care receiver). (see *Table 5.4*)

Table 5.4 The Means- test Concept in The Ten Year Long- term Care Program

Income- related Group (Household)	**Financial Subside Model**
Low- income Household	100 percent subsidized by the government
Mid- income Household	90 percent subsidized by the government; 10 percent paid by the household
Normal- income Household	60 percent subsidized by the government;

	40 percent paid by the household

Source: The Ten Year Long- term Care Program, Executive Yuan, Taiwan.

With the concern for individual dignity and the trend of ageing in place, the care service in The Ten Year Long- term Care Program establishes and provides following care service models in the long- term care system e.g. home care service, home nursing, community care (community rehabilitation), meal service, respite care, mobility and institutional care (The Ten Year Long-term Care Program: Middle- term Project: 2012 to 2015, 2012).

5.1.5 The Achievement of The Ten Year Long- term Care Program

Since The Ten Year Long- term Care Program was implemented in 2007, we can identify several general achievements, which are: 1. to develop the multi long- term care service model; 2. to establish the ladder- type subsidies and partial burden mechanism; 3. to establish a convenient single service window.

1. To develop the multi long- term care service model:

In order to enhance the public's right to choose their services, the Government gave priority to the development of home and community service programs, including care services (home services, day care and family care), which are mainly to assist with daily life activities. Besides, it sought the maintenance and improvement of physical and mental functions, such as home care, community and home rehabilitation. Moreover, it develops the model of supporting the

provision of respite services to family caregivers, and assisting the transport of persons with moderate or severe disability.

2. To establish the ladder- type subsidies and partial burden mechanism:

In order to enhance the affordability of the use of long- term services and to provide effective utilization of care resources, different subsidy rates and quotas are provided according to the level of disability of the elderly and the family's economic situation. The level of disability is divided into mild, moderate and severe levels. The higher the degree of disability, the higher the amount of governmental subsidies could be supported. In order to cultivate user- oriented concepts and avoid wasting resources, the disabled can only partially pay for the use of the services within the subsidy amount, except for those with low incomes. The ratio depends on the degree of disability and the economic status of the disabled. According to The Ten Year Long- term Care Program, the government subsidiezes 70 per cent of the financial burden for the general household and 90 per cent for a low- income household.

3. To establish convenient single service window:

The long- term care and management center is set up in each city and county government to carry out the long- term care management. People with long- term needs can apply through various care centers to assess the extent and need for their disability, qualification, caregiving, linking service resources, single service window for disabled persons and their families.

As long as the program has been run, both the number of service projects or the number of users are able to grow steadily year after year. However, there is still a gap from the expected target, so how to improve and create a service consistent with long- term needs, is the gal in the future that parties need to work together to achieve. In addition to the services provided by the county and municipal governments, the development of the rest of the service resources is not

consistent in all counties and cities. In particular, remote areas often have a special geographical environment, inconvenience and long staff recruitment is not easy, all of which will affect the investment and expansion of service resources.

According to relevant statistics, since 1992, there have been 80,148 persons, who have obtained the certificate of completion of the service. However, actually, a total of 14,314 persons work in the area of care service. The ratio of continuing care workers was not as expected by The Ten Year Long- term Care Program (Chien, Chuang and Yang, 2012). In order to assist the county and municipal governments to promote the long- term plan, the Ministry of the Interior and the Department of Health provide subsidy funds and different levels of subsidies depending on the financial status of the county and city governments. However, the subsidy cannot be provided to the local government on time, which will affect the willingness of some civil organizations participate the long- term care system. In 2015, Executive Yuan enacted the Long- term Care Service Act to solve the aforementioned problem and predicaments. Section 5.2 will illustrate its principle and the main content of the Act.

5.2 The Long- term Care Service Act

Long- term Care service is an important issue, which becomes a consensus for the whole national in Taiwan. Since 2007, Executive Yuan established The Ten Year Long- term Care Program to set up three- phase schemes to construct a sound long- term care system. *Short-term target (from 2008 to 2011)*: to develop the basic service model, *middle- term goal (from 2012 to 2015)*: to enlarge the service target group and to improve the network for service

resources and *long- term strategy (from 2016 to 2017)*: to link up with the upcoming long- term care insurance. The previous section mentioned and introduced the content of The Ten Year Long- term Care Program, after which, the next phase for the creation of a sound long- term Care system- Long- term Care Service Act was launched in 2015.

The aim of formulating the Long- term Care Service Act is to improve the development of the long- term care system, ensure service quality and link up with the upcoming Long- term Care Insurance. The main issue of the Long- term Care Service Act is to conclude regulations for organizations and caregivers in the long- term care system, as by their implementation the professional evaluation system will improve and ensure the quality of the long- term care service.

The Act was launched by Executive Yuan, and consented to the Legislative Yuan (parliament) in 2015 in Taiwan. The role of Long- term Care Service Act is very important for the upcoming Long- term Care Insurance, because of the unity of the authority for the different long- term care organizations. As mentioned, there are many authorities in the long- term care system in Taiwan, which include the Ministry of Health, Ministry of Interior, Veterans Affairs Commission and Council of Agriculture. (see *Table 5.5*) Commonly, it will lead the unbalance of resource distribution; besides this, it will also bring the disorder rules, which cannot be followed.

Table 5.5 The Current Structure and Authorities of Long- term Care in Taiwan

Authorities	The Target Group	Long- term Care Service
Veterans Affairs Commission	Veterans	Veterans Home/ Department of Veterans Service

Council of Agriculture	Aged Farmers	Woman on the farm to run a side job
Ministry of Interior	Poor, Mild Disability Citizens	Intermediate care facility/ Home service/ Dementia day care center/ Community center
Ministry of Health	Poor, Severe Disability Citizens	Nursing home/ Nursing and rehabilitation

Source: Wu, S. C. (2009). Long- term Care and Practice in Taiwan, Asia Forum on Ageing 2009, Singapore.

Due to the gradually extended life expectancy and continually low total fertility rate, Taiwanese society became an ageing society in 1997 and will become super- aged society in 2025 (Council for Economic Planning and Development, Executive Yuan, 2008). The ageing population accompanies chronic disease, a complex care model, and shortage of caregivers in the household, which are caused by structural change (The Long- term Care Service Act, 2015). Besides this, the long- term care provides home care, community care and institutional care for people in need. The Ten Year Long- term Care Program has helped settle down the foundation of the long- term care system, however, the main service target is still restricted and separated into different authorities and acts. In order to link up with the upcoming Long- term Care Insurance, which covers the whole population, in 2015, the Executive Yuan launched the Long- term Care Service Act to improve the long- term care system. The Act has a two year preparatory period, and in 2017 the Act will formally be brought into force.

The Long- term Care Service Act consists of 55 articles in seven Chapters, which contains a profile of the Long- term Care Service Act, long- term care service and system, the management of care staffs and institutions, the rights and interests for care receivers, retributions and annexations.

Stating its purpose at the outset, Chapter 1 also illustrates that to develop a long- term care service, ensure the quality of service and the rights of the care receiver, the Executive Yuan established the Long- term Care Service Act to improve the long- term care system. This chapter also defines the authority and the terms of the Long- term Care Service Act (Article 1.- 6.). Chapter 2 formulates the assessment and service modes for the long- term care system. For the assessment modes, the Act defines the evaluation process and organizations, in which a case manager responds to the care plans of individual cases (Article 7.- 10.). Chapter 3 defines the quality of the care staff. The act stipulates that care staff have to attend advanced studies. The importance of this chapter is that the care staff have to maintain the privacy of individual cases (Article 11.- 13.). Given the increased use of institutional care services, Chapter 4 formulates the system of quality assurance for long- term care institutions. Moreover, the Act lays down the standard and process of assessment for long- term care institutions (Article 14.- 30.). Chapter 5 illustrates the rights and interests of the care receiver (Article 31.- 34.), while finally, the Chapters 6 and 7 define the retributions and annexations for the Act (Article 35.- 55.). As the main Law for Development of Long- term Care System, the Long- term Care Service Act focuses on the integration of long- term care sources in Taiwan to support care receivers.

5.2.1 The Competent Authority for Long- term Care Service

The main function of the Long- term Care Service Act is to integrate the long- term care system effectively and ensure the dignity of the care receiver (Wu, 2011).

Currently, the long- term care system in Taiwan has many authorities and sources of law, which respond to their own target groups. For instance, the Senior Citizens' Welfare Act (1980), People with Disabilities Rights Protection Act (2011) and Children and youngster Welfare Act (2003) are planned and subsidized by the Ministry of Interior, Executive Yuan. The Ministry of Health, Executive Yuan is in charge of the Nursing Staff Act (1991) and Mental Health Act (2007). Moreover, the Ministry of Veterans oversees the Veterans Affairs Regulations (1964). (see *Table 5.6*)

Table 5.6 The Authorities and Sources of Law for Long- term Care System in Taiwan

Laws and Regulations	Authorities	Explanation
Senior Citizens' Welfare Act	Ministry of Interior, Executive Yuan	Response for the long- term care organization such as: day care, nursing care institution and care center (for moderate degree of disability)
People with Disabilities Rights Protection Act	Ministry of Interior, Executive Yuan	In charge of long- term care organization, day care institution and service center.
Children and Youngster Welfare Act	Ministry of Interior, Executive Yuan	Set up children's affiliated educatation organization, pre-school institution.
Nursing Staff Act	Ministry of Health, Executive Yuan	Specify the nursing home and nursing mental house.
Mental Health Act	Ministry of Health, Executive Yuan	Set up the rehabilitative center and community rehabilitative center.
Veterans Affairs Regulation	Ministry of Veteran, Executive Yuan	The Ministry of Veteran installs the Veterans Home and self- paid nursing home for caring for veterans.

Source: Wu, S. C., Wang, C., Lu, B. C., Chung, C. Y., Chang, M. and Dai, Y. T. (2003) Construction of Long-term Care System Pilot Program- The Third Year Plan, Ministry of Health and Welfare.

The different acts conform to different standards, contains and degree for the evaluation. For instance, both the Senior Citizens' Welfare Act by the Ministry of Interior and the Nursing Staff Act by the Ministry of Health set up nursing home organization. However, the standard and quality of the care staff are totally different. Besides, the service quality is not unified and assessed. The implementation of the Long- term Care Service Act will solve the problem of multiple authorities and so unite the sources of the law.

Therefore, the Long- term Care Service Act divides the authority to manage the care system. In Article 4, the following matters are declared as managed by the central competent authority:

1. Provision of long-term care services, establishment of national long-term care policies and regulations and planning, establishment and promotion of the long-term care service system;
2. Supervision and coordination of long-term care executed by municipalities and counties (cities);
3. Planning for the protection of the interest of long-term care service users;
4. Development of and rewards to long-term care institutions, as well as evaluations to be carried out by the central competent authority as provided
   (see *Paragraph 3, Article 39*);
5. Cross-county/city assistance and supervision of long-term care institutions;
6. Planning for the management, incubation and training of long- term care providers;
7. Planning, raising, allocation and subsidies of funding for long-term care;
8. Research, development and monitoring of the information systems and service quality of long-term care;
9. Planning and promotion of international cooperation, exchange and innovative services of long-term care services;
10. Coordination of long-term care services in areas lacking resources.

In Article 5, the following matters are outlined as managed by the local competent authority:

1. Provision of long-term care services, the establishment of long-term care policies under jurisdiction and planning, promotion, and execution of the long-term care service system.
2. Execution of the long-term care service policies, regulations and relevant plans established by the central competent authority.
3. The performance of local long-term care service training.
4. Supervision and evaluation of long-term care institutions under jurisdiction and appraisal to be performed by the local competent authority in accordance with Paragraph 3, Article 39.
5. Planning, raising, allocation and subsidies of local sources of long-term care funding.
6. Rewards to long-term care institutions in areas of development difficulties or where resources are lacking.

The competent authority shall provide subsidies for service as stated in Article 4 second paragraph in accordance with the level of disability and the economic status of the family. If any other legislation also allows for an application for the same nature of service subsidiary, only one application is filed.

The evaluation as outlined in Article 4 in the second and third paragraphs may be outsourced to a professional organization. The standard and method of evaluation, the qualification of staff and other relevant matters is tol be published by the central competent authority. The amount or percentage of subsidy as set forth in the fourth paragraph is determined by the central competent authority (The Long- term Care Service Act, 2015).

5.2.2 A Legal Foundation for the Employment of Foreign Care Force

The traditional household shoulders the care function when family members are faced with the need of care. Most of them are the female, e.g. female spouse, daughters, daughter in law and female relatives. However, the current economic environment, the unsupported social environment and the issue of gender equality drive young people to choose not to marry, and have children and more women want to devote themselves to a career. Under the circumstance of increased labour force participation and without a sound support system to respond to specialized care functions, the informal care force is weakened.

In order to fill up the gaps, the government in Taiwan imported foreign nursing workers from South Asia, e.g. the Philippines, Thailand, Indonesia and Vietnam, to try to lessen the lack of its care force. However, due to the situation of a high domestic unemployment rate, the introduction of foreign guest workers will be assssed by the government and balanced with the public opinion.

Since the end of the 1980s, Taiwan has imported numerous “guest workers” to deal with the so- called 3D industries i.e. Dirty, Danger and Difficult industries. Over the past two decades, Taiwan has experienced an immigrated boom composed largely of spouses of ROC nationals from the Chinese mainland and Southeast Asian countries like Vietnam, Indonesia, the Philippines, and Thailand. These new immigrants, more than 90 percent of whom are female, numbered more than 410,000 at the end of 2008 (Government Information Office, 2010). *Table 2.9* illustrates the number of foreign residents in Taiwan from 1992 to 2009. More of the same Germany’s status, the number of female foreign residents is higher than males in Taiwan, due to the circumstance of married immigration. (see *Table 5.7*)

Table 5.7 Foreign Residents in Taiwan from 1992 to 2009

Year	Foreign Residents (Persons)			
	Sub-Total	**Male**	**Female**	**Under 15 Years**
1992	44,441	29,134	15,307	5,653
1993	94,601	67,802	26,799	5,880
1994	159,305	113,184	46,121	5,954
1995	220,537	149,796	70,741	6,189
1996	253,906	166,546	87,360	6,416
1997	268,670	168,518	100,152	6,482
1998	296,629	177,175	119,454	6,201
1999	339,186	185,806	153,380	6,015
2000	388,189	183,171	205,018	5,356
2001	383,663	167,094	216,569	4,615
2003	405,284	157,046	248,238	9,918
2004	423,456	157,905	265,551	9,796
2005	429,703	156,370	273,333	9,177
2006	428,240	156,559	271,681	8,452
2007	433,169	163,575	269,594	8,059
2008	417,385	160,987	256,398	7,332
2009	403,700	152,242	251,458	7,186

Source: National Immigration Agency (2010). Statistics of foreign residents in Taiwan.

In recent years, the care workforce has revealed the unbalanced situation in Taiwan. The supply of workers and demand caused a difficult situation. The wage standard of the domestic care

worker is higher than the foreign career. Besides, because of the coordination and flexibility of the foreign care worker, Taiwan's government abolished prohibitions allowing private households to introduce foreign care workers. Faced with the imperative of the demand for care, the similar regulations are needed.

Unlike Germany's situation, in Taiwan, these guest workers have to leave and go back to their motherland when they have stayed over three years. Therefore, until now the issue of the immigrants growing older has not existed in Taiwan. However, regarding the issue of the care workforce, according to the above statistics, most of the immigrants are female, who devote themselves to the care sector. When talking about the long- term care policy, this immigrant workforce cannot be ignored, as the issue of balancing domestic careers and immigrant career will be an important issue for Taiwan in establishing its care system. If the foreign workers stay longer, they have to go back to their own countries and apply again through an agency. Such agencies charge high fees as, according to the report, foreign workers have to pay 120,000 NTD (New Taiwan Dollars ≈ 3000 Euro) to an agency (Apple Daily News, 2016). In comparison, the basic wage for foreign works is 500 Euro per month, and so this will not be easy to pay. Besides, it means that care receivers are not able to receive the complete care package. Family members and care receivers have to get to know new foreign care workers every three years. Since the government allows the foreign workforce to enter in 1989, the unbalanced situations still remains in the labor market. In order to solve the problem, in 2016 the Taiwan government abolished the regulation and foreign care workers were allowed to stay for 12 years and be included in the social security system to ensure their social rights.

Regarding the issue of foreign care workers in the Long- term Care Service Act, a key point is that foreign workers can be hired on an individual basis to provide care in private households and professional facilities. Although foreign care workers generally provide care work in

private households is in Taiwan, however, this labour still lacks a legal foundation regarding the standard of qualifications required and its role. Besides, individual care workers should receive designated training supported by the central competent authority. Any foreigner who enters Taiwan for the first time after the implementation of this Act and is hired by a family of a disabled person in order to perform individual care work, the employer may file an application for such a care provider to receive supplemental training determined by the central competent authority.

5.2.3 The pattern of Long- term Care Service and its Development

Long-term care services are divided into four types based on the manner they are provided in the Long- term Care Service Act (Article 8- 12):

1. Home Service: Physical care services, Daily life care services, Domestic chore services. Food and nutritional services, Auxiliary appliance services, Necessary home facility adjustment and improvement services, Psychological support services, Emergency rescue services, Healthcare services and Services for prevention of other or aggravated disability conditions (Article 10).
2. Community- based Services means a certain location and facilities are put in place in a community to provide day care, family care, temporary housing, group homes, small-size multi-function services and other integrated services (Article 9). It includes the Physical care services, Daily life care services, Temporary housing services, Food and nutritional services, Auxiliary appliance services, Mental support services, Healthcare services, Transportation services, Social participation services and Services for prevention of other

or aggravated disability conditions (Article 11).

3. Institutional Services mean the persons receiving care move into the long-term care institutions where full-time care or night care services are provided (Article 9). It includes Physical care services, Daily life care services, Food and nutritional services, Residential services, Healthcare services, Assistive device services, Psychological support services, Emergency rescue services, Family member education services, Social participation services and Services for prevention of other or aggravated disability conditions (Article 13).
4. Family Caregivers means Fixed- location and home supportive services provided to family caregivers. It includes 1. Provision and referral of relevant information, Long- term care knowledge and technical training, Respite care services, Emotional support and referral of group services, Other services that help promote the capability of family caregivers and the life quality thereof (Article 14).

The Long- term Care Service Act expresses to promote the development of long-term care related resources, improve service quality and efficiency, enrich, and balance services and human resources, the central competent authority shall establish a long-term care service development fund. The amount of the fund as set forth in the previous paragraph shall be at least Twelve Billion NT Dollars and shall be budgeted over five years (Article 15). The fund will be sourced from the governmental budget (Business and Estate Tax), the health and welfare surcharge contributions (Alcohol and Tobacco Tax), donation and proceeds from the fund to support the care service.

According to the original design, the Long- term Care Service Act was enacted in 2015, and after two years, the Act will be followed by the implementation of the Long- term Care Insurance Act. However, because of the change of ruling party, the DDP (Democratic

Progressive Party) would like to extend The Ten Year Long- term Care Program to develop the long- term care system. Therefore, the Long- term care Service Act will be put to one side until the complete policy for long- term care has been enacted.

5.3 Discussion and Conclusion

In order to reflect on the predicament of the care system in Taiwan, the government took lessons from the Japanese "The Ten Year Strategic Golden Plan" by establishing The Ten Year Long- term Care Program in 2007. As a forerunner for a long- term care system in Taiwan, the Ten Year Long- term Care Program achieved several goals which are developing the multi long- term care service model, establishing the ladder- type subsidies and partial burden mechanism and establishing the convenient single service window. Before implementing The Ten Year Long- term Care Program, long- term care in Taiwan was regarded as a patchwork, lacking a complete set of systematic regulations to be followed.

The program established the fundamental structure for implementing the Long- term Care Act in the near future. The Program includes the definition of long- term care needs, compensation for care services, care patterns and established competent authorities. However, after implementing it for ten years, several problems appeared, such as the financial status of the program, the lack of numbers in the care working force and the distribution of the long- term care service. In view of this, the government enacted the Long- term Care Service Act to establish a more sound system.

The main purpose of the Long- term Care Service Act is to complete a long- term care system that provides long-term care services, and ensure quality of care and support services, develop universal, diversified and affordable services and guarantee the dignity and interest of the persons receiving the services and for the care providers.

In order to enact the Long- term Care Insurance in the near future, the government in Taiwan launched the Long- term Care Service Act to establish a regular long- term care environment in 2015. The act addresses the fact that the government has to ensure the quality of long- term care services. Besides, long- term care resources have to be well distributed. The Act will come into force in 2017, which means that, in two years, the environment has to be prepared and settled to improve the long- term care system.

After the enacting of the Long-term Care Services Act, the next stage in the construction of Taiwan's long-term care system is to establish the long- term care insurance legal system. The long- term care services Act currently adopted by the Legislative Yuan, sets out only a few directions for the most important elements, but the actual operating authorities have to make their own arrangements with the administration.

The most controversial issue in the Legislative Yuan is Article 15 of the Long- term Care Service Act, which aims to promote the development of long- term related resources, improve the quality and efficiency of service, and enrich and balance the service and human resources. The long- term care development fund should be set up to provide minimum 12 billion NT Dollars in five years. However, the distribution and its effectiveness will be the main issue.

According to the Long- term Care Service Network Plan verification report published by the National Developmental Commission (2014), the role of the service location is unclear.

Besides, the Long Service Network Plan and The Ten Year Long- term Care Program lacks a plan of integration. Therefore, how to integrate the long- term resource development, avoid duplication and thus a wasting of funds will be important issues for Article 15 of the Long-term Care Services Act, as well as the Long- term Service Network Plan and The Ten Year Long- term Care Program.

Chapter 6.
Social Insurance Approach for the Long- term Care System in Germany

6.1 The Social Policy and Its Principle in Germany

The beginning of Germany's social policy is inseparable from the transition to capitalistic production methods. The centralization of wealth caused the disparity between the rich and the poor to grow meaning people had no ability to satisfy their basic needs themselves and or even of their family members. Loss of dependence on the state, of course, led people to seek a revolution to find a new solution or through a new regime. Furthermore, the accumulation of wealth also provides sufficient finance to build social welfare. In order to avoid such an uprising, the German empire instigated serious social policies in the middle of the 19th century. The starting point of these policies was to care for workers. In this period, these policies aimed to support the family, introduce poor Act amendment and establish social insurance, which become the embryo for the future (Solsten, 1995).

The new social welfare system developed after Germany's unification in 1871. Its decentralized structures were used to provide an increasing range of benefits. From this point on, most social welfare programs in Germany were not administered by state bureaucracies, but executed by local government or private organizations. After World War II, the economic system in Germany was commonly regarded as a social market economy. Under this model, Germany's government sught a middle path between socialism and laissez- faire economic liberalism (i.e. a mixed economy) to combine private enterprise with government regulation to

establish fair competition. Besides, a balance was maintained between a high rate of economic growth, low inflation, low levels of unemployment, good working conditions, social welfare, and public services through national intervention, in combination with the capitalist mode of production (Lin- Hi & Suchanek, 2009). The belief was that society should protect all its members from economic and social need. Hence, society should take responsibility for its members; moreover, society is composed by the people, and from this viewpoint, solidarity will be the only power to protect those people in need, which is the key concept of German social policy. Protection is provided by the program of social insurance, which the insured contribute to in the understanding that they may someday need it (Solsten, 1995).

The development of Germany's social policy reached a culminating point in the period of large coalitions (German: große Koalition) and the social- liberal coalition (German: sozial- liberal Koalition) during the 1970s. In this period, the field of family policy (German: Familienpolitik), children- and adolescence assistance (German: Kinder- und Jugendhilfe) and social service (German: Soziale Dienste) was created gradually. With the fifth pillar of: social insurance in the middle of the 1990s, the social security net was completed. With the establishment of the EU (European Union), and as a main member, Germany's social policies have to be modified in a manner that is consistent with the other European Union countries. *Table 6.1* shows the timetable of Germany's social policies in the six fields, which are labor legislation/ labor protection, industrial relations, the policy of the labor market, social insurance, social aid and family policy.

Table 6.1 Time Chart of Germany's Main Social Policies (1839- to date)

	Labor Legislation/ Labor Protection	Industrial Relations	Policy of Labor Market	Social Insurance	Social Assistance/ Social Care	Family Policy
1839 - 1871	**1839:** Prussian Regulation for the Employment of Young Workers in Factories **1845:** Prussian Factories Act. **1853:** Act on the Factory Inspectors				**1842:** Act for Poverty Relief	
1871 - 1918	**1878:** Act for Female Working Protection (Factories Act) **1891:** Act for Working Protection (Factories Act) **1903:** Act for Children Working Protection	**1916:** Act for Aid Service		**1883:** Act for Health Insurance **1884:** Act for Accident Insurance **1889:** Act for Invalidity and Old Age Insurance **1911:** Social Insurance for Employed; Social Insurance code Book of the German Reich		
1918	**1918:** Court Order	**1918:** Act for Labor	**1927:** Act for	**1923:** Empire Mine	**1922:** Act for Young	

- **1933**	about the Regularization of Working Hours for Industrial Workers **1923:** Act of Working Hours	Wage Agreement **1920:** Working Councils Act	Employment Agency and Unemployment Insurance	Employee's Act	Welfare **1924:** Empire Assistance Act	
1933 **-** **1945**	**1935:** Act for Maternity Benefit **1938:** Working Hour Act	**1933:** Act for Order of National Work	**1933:** Act for Trustee of Labor **1934:** Act for Arrangement of Labor Employment	**1933:** Act about the Assembly of Social Insurance **1938:** Act about the Old Age Insurance for the German Handcraft	**1938:** Protection of Young Person Act	**1935:** Act about the Grand of Children Assistance in Family with Many Children
1949 **-** **1989**	**1951:** Employment Protection Act **1952:** Maternity Protection Act (laws protecting working mother- to- be and nursing mothers) **1960:** Young Labor Protection Law **1969:** Act for Continued Payment of wages **1973:** Working	**1949:** Act for Wage Agreement **1951:** Germany's Montane Codetermination Act **1952:** Industrial Constitution Law **1955:** German Employees Act **1976:** Worker Participation Law	**1969:** Labor Promotion Act **1985:** Promotion of Employment Act	**1955:** Act for National Health Doctor **1957:** Reform of Retirement Insurance. **1971:** Accident Insurance for Students **1981:** Social Security for Self- employed Artists. **1988:** Act for Health	**1961:** Federal Social Assistance Act **1961:** Act for Young Welfare. **1974:** Act for Severely Disability Person	**1954:** Act for Family Allowance **1985:** Act for Child Benefit (paid for at least 6 months after the child's birth to compensate the parent who takes time off work to look after the child)

	Guarantee Act **1975:** Working Place Regulation			Reform		
1989 - 2007	**1994:** Working Hour Act **1995:** Continued Payment of Wages and Salaries Act **1996:** Employee Assignment Law **2000:** Law on Part-Time Work and Temporary Employment Contracts	**1996:** Act for Works Council **2001:** Reform of Industrial Constitution Law	**1996:** Part- time/ Partial Early Retirement **1997:** The Third Social Code Book: Working Promotion **2003:** The First and Second Version for Modern Service on Labor Market **2004:** the Third Version for Modern Service on Labor Market **2004:** The Fourth Version for Modern Service on Labor Market (SGB II)	**1989:** Act for Retirement Insurance **1992:** Law on the Stabilization and Structural Reform **1994:** Act for Long-term Care Insurance (SGB XI) **1997:** Reform for Retirement Insurance **2001:** Reform of German Pension Scheme **2003:** Modernization Act for Health Insurance **2004:** Retirement Income Act. **2004:** Sustainability Act for Retirement Insurance **2007:** Age Limits Adaptation Law for	**1993:** German Social Welfare Law for Asylum Seekers **1995:** Act for Social Assistance **2001:** Basic Security at Old Age **2004:** Social Code book II (basic security for job seeker) **2004:** Social Code Book (Act for Social Assistance)	**1990:** Social Assistance for Children and Young People (SGB VII) **1995:** Reform for Family Benefits **2004:** Parental Leave Act **2006:** Parental Benefit Act

			Retirement Insurance **2007:** Statutory Health Insurance Competition Strengthening Act		
2008 - to date	**2009:** The new Version of Employee Assignment Law **2009:** New Version of Act for Working Place Security **2011:** the Modification for Civil Code	**2010:** Reform for Act for Wage Agreement	**2008:** Reform for Long- term Care Insurance **2010:** The Reform for Health Insurance	**2011:** The Modification of Social Code Book X	**2010:** Reform and New Population for Federal Training Assistance Act

Source: Naegele, G., Bäcker, G., Bispinck R., Hofemann K. and Neubauer J. (2008). Sozialpolitik und Soziale Lage in Deutschland: Band1.: Grundlagen, Arbeit, Einkommen und Finanzierung, VS Velag, Wiesbaden.

Germany's social policy is composed of different systems. Each system operates by its self fundamentally, while each system has strong link with others. To generalize the above-mentioned time chart of Germany's main social policies from 1839 to present, the social policy in Germany can be divided into several fields, e.g. *Social insurance/ social security and social protection*: Health Insurance, Retirement Insurance, Long- term Care Insurance, Accident Insurance, Unemployment Insurance/ Unemployment Allowance, Social Assistance, Benefit for Asylum; *Financial and economic system under the principle of social state (tax- financed transfer) and income re- distribution*: Parental Allowance, Children Allowance, Accommodation Allowance, Educational Promotion, Provision for War Victims; *Policy for Health care system*: Ambulate Medical Care, Stationary Medical Care, Long- term Care, Rehabilitation, Pharmaceutical medical care, Health Promotion; *Social service/ social protection and Family Policy*: Children and Adolescent Assistance, Elder Assistance, Invalid Assistance, Obligor Counseling, Assistance for Addicts; *Working rights/ working protection/ working market policy*: Protection for Young- Person Workers/ Working Security/ Employment Agency, Career Counseling, Settling-in Allowance, Promotion for Training and Further Education and Employment-creation Measure; *Policy for Professional systems/ professional organizations*: Provision for Civil Servants, Sustenance for Professional Workers, such as: Physician, Pharmacist, Nursing, Artist, Architect and Docent; *Social policy in European Union*: The European Union has extended its scope gradually since 1993 (Naegele et al, 2008).

So far, twenty- eight countries have participated in the European Union. This integration in Europe brings forth consideration of new social issues and problems, which influence the formulation of social policy in each member country. In order to conform to the principle of the social state, social policies in Germany are designed to provide social protection and maintain a standard of living for its people. Therefore, three situations could be observed; first, the target of whole policy fields in trying to cover the whole population reflects the mission to create a

social security net. Second, under the circumstance of the social state, the principle of solidarity is the core that links the individual and society. Third, an important issue is that the completely political systems start from the individual and then extend to the family. Social policy in Germany is regarded as a steady power, which looks after both individual autonomy and family support.

The above- mentioned sectors illustrate the development of social policy and its contents in Germany. Focusing on long- term care needs, German government followed the principle of social policy and the social state, by establishing the social long- term care insurance system to protect against social risk and maintain social right.

6.2 The "Fifth Pillar" of Social Insurance System

The need for long- term care has become an important issue for developed countries since the 1940s. Most OECD countries were asked to establish a systematic coverage system for increasing long- term care needs by citizens, especially for people with care demands and informal caregivers in households.

Germany's circumstance of experiencing population ageing lasted for at least three decades. Before implementing the long- term care insurance, Germany became one of the oldest countries in the world with its low total fertility rate, extended life expectancy, ageing immigrants, a higher female labor force participation rate and the deflation of the structure of households, which created elements of social and demographic change. These caused a

fundamental change in German society and its demography. Beside the rising demand for social care rights, gradually these above- mentioned factors drove the government to implement comprehensive and systematic long- term care policies to cover and care for the entire population in Germany.

In response to the demand for a complete long- term care policy, the Germany Federation (German: Bundesdeutschland) formulated the Long- term Care Act in 1994, which is represent in the German Social Code XI- Long- term Care Insurance (German: Sozialgesetzbuch XI.- Pflegeversicherung) to provide a complete and systematic system of care for people in need. Besides, the statistic reveals that across their whole life people have 50 per cent chance of needs (Rothgan, 2008). Therefore, the implementing of a long- term care policy will become an important issue in Germany.

Of course, policymaking has its place and role at that time, as after several years implementing them, the policies might become outdated and even fail to provide response to the current situation. Regarding Germany's Long- term Care Insurance, in facing the problems of exceeding expenditure, current social status change and the increase of Alzheimer's Disease patients, the federal government (German: Bundesregierung) formulated the Quality Assurance Reform on Long- term Care Act (German: Pflege- Qualitätssicherungsgesetz) in 2001 and the Long- term Care Further Development Act (German: Pflege- Weiterentwicklungsgesetz) in 2008 respectively. An old German saying: *After the reform, before the reform* can actual describe these reforms for Long- term Care Act. The social long- term care insurance and mandatory private long- term care insurance make up the parallel system of long- term care insurance in Germany. However, to related these issues to the current situation in Taiwan i.e. single- insurer National Health Insurance and its purpose in this dissertation, we will not focus on and discuss the system of Germany's mandatory private long- term care insurance, but focus

on its social statutory long- term care insurance.

After twenty years of discussion during the period from 1974- 1994, Germany phased in long-term care insurance gradually, becoming one of the countries that implemented the social insurance approach for a long- term care system for people in need.

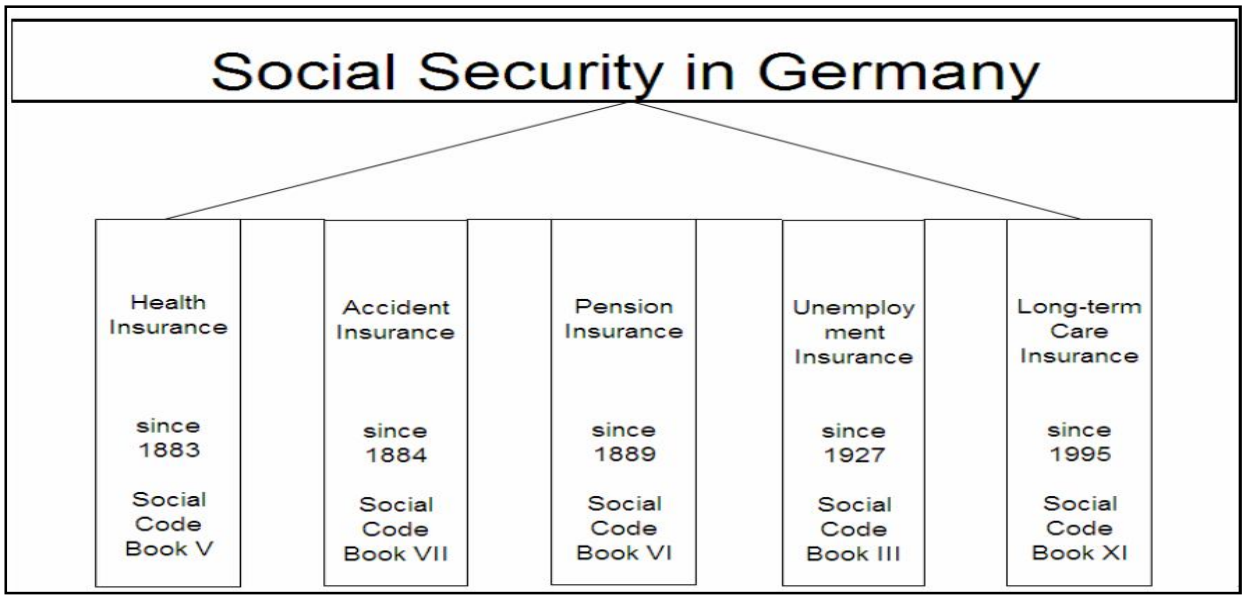
Germany has a long traditional of experiences in establishing a comprehensive social welfare nets. Since 1883, Bismarck, the Reich Chancellor launched the large- scale health care insurance scheme to provide the security for a healthy life. This social legislation began the epoch of the model of the German social state (German: sozialestaat). Bismarck's social legislation started with the Health Insurance Act (German: die gesetzliche Krankenversicherung) in 1883, continued afterwards by the Accident Insurance Act (German: die gesetzliche Unfallversicherung) in 1884, the Invalidity and Old Age Insurance Act (German: die Invaliditäts- und Altersversicherung: heute Retenversicherung) in 1889 and the Unemployment Insurance Act (German: die Arbeitslosenversicherung) in 1927. These are regarded as milestones in the development of the German Social State on the one hand, and of completing the German social security system by implementing the above- mentioned social insurance on the other hand (Gregory & Stuart, 2003).

These four pillars create the social security system, and after a hundred- year development, achieved the coverage from 20 per cent of all employees and 10 per cent of all population by social legislation to the current level of almost 98 per cent of all the population by following the respective social security schemes (von Schwanenflügel, 2006). In other words, these four pillars build a social security net to protect the citizens of Germany.

Until 1994, however, these four pillars lone could not shoulder the risk of long- term care

anymore. In the history of German social security, 1994 could not be ignored. In this year, the fifth pillar of the social security system was established by the federal government. The Social Long- term Care is regarded as the German Social Code XI- Long- term Care Insurance (German: Sozialgesetzbuch XI: Pflegeversicherung). (see *Figure 6.1*)

The each pillar has its own system and is self- independent; however, they work together to provide solidarity in the community of the social security system covering the whole population in Germany.



Source: von Schwanenflügel, M. (2006). The German Long-term Care System and Future Reform, Speech on the occasion of a visit in Seoul, South Korea.

Figure 6.1 Five Pillars of Social Security in Germany

The Social Code XI clearly defines the beneficiaries, contents and specifications of the insurance and the informal caregiver in households, e.g. family member/ relatives and neighbors are included (Leu, 2001). With the scheme and its mode of health insurance, since

1995, Germany's Long- term Care Insurance has covered the whole population in Germany through the public and private sectors, which includes to the statutory long- term care insurer and private long- term care insurer.

The Long- term Care Insurance is regarded as the fifth pillar of the German social security system, and had its three special aims. First, the Long- term Care Insurance is regarded as having a role in rebuilding the principle of the social state. As a contribution of salary related social insurance, the co-payment of contributions equally with employers will be an important issue. Second, the design of the income ceiling will not influence and damage the economic status and working rights for holding the current position (German: Bundesministerium für Arbeit und Soziales, 2012/ 2013). Besides, the role of household has been redefined. Traditionally, the household is regarded as an economic unit and a place of shelter, however, under the German Long- term Care Act, the household is redefined as a care- related location, despite it having already having been so for a long time (Lin, 2009).

6.3 The Background of introducing Long- term Care Insurance

From the 1980s, Germany began to concentrate on the introduction of long- term care insurance, which is regarded as a fifth pillar of the German social security system to cover the whole population in Germany (Walker & Naegele, 2009).

In order to establish a sound and systematic long- term care policy, before implementing the Long- term Care Insurance Act in 1994, the Federal government and the German society spent

about 20 years researching, preparing and discussing the scheme.

Before implementing the long- term care insurance, Germany experienced many phenomenon such as demographic and social change and financial pressures on existing health insurance and the social aid scheme.

Table 6.2 Ageing Population in Germany, 2000- 2030 (in per cent)

Year	**2000**	**2000**	**2020**	**2020**	**2030**	**2030**
Age Level	65+	80+	65+	80+	65+	80+
Percentage of all population	16.4%	3.6%	21.6%	6.3%	26.1%	6.8%

Source: Karlsson, M., Mayhew, L., Plumb, R. and Rickayzen, B. (2004). The Comparative Effects on UK Public Expenditure of Implementing Long- term Care Systems as Practised in Japan, Germany and Sweden, paper presented to the Staple Inn Acturial Socirty, London.

The official statistics reveals that German society is ageing. (see *Table 6.2*) This has been caused by two demographic issues i.e. extended life expectancy and a low total fertility rate. The trend of further life expectancy (at age 65) in Germany is also extending. (see *Table 6.3*)

Table 6.3 Further Life Expectancy in Germany at Age 65 in 2006/ 2008 and 2060

	Year	**Female**	**Male**
Further Life Expectancy (at age 65)	2006/ 2008	20.5	17.3
	2060	25.5	22.3

Source: The German Federal Statistic Office (2009). 12th Coordinated Population Forecast.

Wiesbaden, Germany.

Moreover, according to Germany's 12th Coordinated Population Prospects (German: 12. Koordinierte Bevoelkungsvorausberechnung, 2009), by 2025, the total fertility rate will gradually increase to 1.6 children per woman in Germany. Demographically, this situation changes the current and future structure of the total population, in which it has several sociological implications as follows: the proportion of the ageing population will increase; the pattern of the family will shrink; female labor force participation rate will increase; the increase in the old age population dependency ratio will aggravate the burden on the working-age population. These phenomena will influence care for the disabled or people with long-term care needs, especially for the frail elderly and even the life quality of the old age. Moreover, economically, the reduction of the labor force will damage economic or national competency; postponement of retirement age. Sociologically, it will also damage the pension systems, especially for the pay- as- you- go system, and other social insurance schemes.

Before implementing long- term care insurance in 1994, the increasing number of disabled and ageing population gradually loaded the burden on the existing Health Insurance and social aid scheme (Glendinning & Igl, 2009). At that time, almost 100 per cent of people who lived in 24-hour care centers applied for social aid from former east Germany, and even in former west Germany, the proportion will also reach 80 per cent. Such a huge expenditure will destroy the last defenses of the social security system (Schaaf, 1994). Under the above- mentioned circumstances, the federal government had to find an optimal long- term care policy to help people in need. Finally, in 1994, the Long- term Care Insurance Act was formulated by the government. The legislation process of the Long- term Care Insurance Act integrated the internal voices and opinions by continually negotiating many aspects in German. At that time,

compared with neighbor countries- the Netherlands and Austria, which have implemented the long- term care insurance, Germany needed an independent social security system for long-term care to protect the people in need and solve the financial pressures on the social aid scheme.

6.3.1 The Historical Development of Long- term Care Insurance Act

Since the Council for German Elderly Aid (German: Kuratorium Deutsche Atershilfe) launched a report entitled An Assessment of Institutional Cure for Geriatrics and the Expense Burden of the Insurer of Statutory Health Insurance in 1974, one issue of long- term care insurance has deeply concerned the internal society in Germany (Althammer, 2004).

During these 20 years, the German government and parties launched many projects and drafts for preparing and establishing the long- term care policy. Finally, in 1992, with the support of the former German Chancellor Dr. Helmut Kohl, the social insurance based long- term care policy obtained a consensus in Germany. In 1993, the federal cabinet launched a Draft for the Long- term Care Insurance Act (German: Entwurf eines Gesetzes zur sozialren Absicherung des Risikos der Pflegebedürftigkeit Pflege-Versicherung), and in the next year in 1994, after confirmation by the German parliament, the German Long- term Insurance Act was established officially and became a fifth pillar of German social security system after the Health insurance, Accident Insurance, Invalidity and Old Age Insurance and Unemployment Insurance Act.

Germany's Long- term Care Insurance implemented and levied contributions on 1st January in

1994, and after four months in the same year, it started to afford the benefits for care receivers. Based on the Social Code Book XI (German: Sozialgesetzbuch XI), the key concepts of Germany's Long- term Care Insurance are: 1. a concept of taking heath protection and rehabilitation services as a precedence (German: Social Code Book XI Article 31.), the concept is used to discover the care in need early and avoid the disable depravation; 2. home care plays a priority role in the long- term care system (Social Code Book XI Article 3.), as the care receiver stays in a familiar environment to achieve the aim of ageing in place (Huang, Lai and Wang, 2010), and 3. a principle of individual independent and self- determination (Social Code Book XI Article 2.), preserving the dignity of life helps the care receiver or people with disability obtain a balance in the status of one's body, mind and spirit (Lin, 2010).

6.4 The Overview of Germany's Long- term Care Insurance

Since 1988, based on the fast increase in demand for long- term care, health insurance (German: Die Krankenversicherung) started to cover those with severe care needs in the system through home care allowance and community care at home in 1991. That meant that, before implementing Germany's Long- term Care Insurance, the statutory health insurance provided a limited subsidy for people with severe care needs at home (Schulte, 1998). In other words, the Health Reform Act of 1988 is regarded as having a crucial role, which brought those with a need for care into the social security scheme system. The reform indicated that health insurance has to provide an allowance or benefits for care service no matter how the care need occurres (Schulin, 1997). It was the first time that the concept of care need was provided with systematic allowance/ benefits in the German social insurance system.

Since 1995, due to increasing long- term care needs and the financial pressures on social insurance, Germany's statutory Long-term Care Insurance Act was phased in to create a sound and systematic system for long- term care need, which was designed to cover almost the whole population in Germany. It provided several patterns of long-term care service using three main care modes, which are home- based care, semi- resident care and institutional care. The benefits of Germany's Long- term Care Insurance Act, can be separated into the following parts of the above- mentioned three care modes: for home- base care: in kind service, cash allowance, care devices, social security of the care givers, measures for adapting and housing conditions; for semi- residential care: day care, night care and short- term care; for institutional care: around a clock care (all day care mode). After reform in 2008, Germany's Long- term Care Act substantially adjusted the benefits for the insured and their informal caregivers. It should also be noted that the benefits for Alzheimer's Disease sufferers and the recognition of the threat of Alzheimer's Disease is regarded as a huge impact factor on the need for care.

Germany's Long- term Care Insurance Act was implemented in three phases from 1995. The first phase, on 1st January, 1995, saw the statutory insured person required to pat the contribution for Germany's Long- term Care Insurance, three months later after accumulating enough preparation, on 1st April in 1995. For the last phase, the benefit for home- based care was conferred and the benefit for institutional care followed from 1st July 1996 (Schulte, 2002). The reason for postponing the benefit of the resident care mode was to encourage the community care mode and strengthen the concept of "ageing in place" which was launched by the World Health Organization (WHO) base on the principle of individual dignity for those with a disability.

The legislation for Germany's Long- term Care Insurance Act was not only simply to create a

long- term care social insurance, but it also had many additional consequences. To generalize Germany's Long- term Care Insurance Act (Social Code Book XI, SGB XI), the aim of the long- term care insurance was as follows: (1) Germany's long- term care policy emphasizes the concept of ageing in place and in order to prevent, reduce and overcome the need for long-term care. Therefore, Germany's Long- term Care Insurance Act emphasizes the principle of home- based care taking precedence over nursing home care; (2) Germany's Long- term Care Insurance supports care skill training, the inclusion of the pension system, replacement for 4 weeks leave and consultation for family members, relatives, neighbors and informal caregivers; (3) under the German Social Code Book XI (SGB XI), the creation of a satisfactory and top-quality care infrastructure, which was largely lacking until the introduction of the long-term care insurance (Naegele, 2010); (4) monitoring the quality of care giving to ensure the quality of care service and care status; (5) one background of creating Germany's Long- term Care Insurance was to reduce the financial pressure on social aid scheme and other social welfare policies in Germany. Since the long- term care insurance system was established and it is regarded as a independent pillar of German social security system and, therefore, the reduction of care- related welfare needs remains be an aim for Germany's Long- term Care Insurance. However, with respect to this, by the end of 2006, about one third of all residents who live in nursing home care still receive social aid subsidy (Rothgang, 2011; BMG, 2008); (6) the benefit limitation is designed for the financial system of Germany's Long- term Care Insurance, which provide a basic level of care, while the cost for the additional care service or other unnecessary service has to be paied by the insured person or assistance sought from the social aid scheme (Naegele, 2010).

In other words, Germany's Long- term Care Insurance Act planned to integrate three targets. First, Germany's Long- term Care Insurance provides comprehensive protection for people with a need for a long- term care service. Moreover, the expenditure of the care service

includes the public cost, which may emerge within the framework of a universal policy scheme. Third, it aims to build a family- supported ageing in place care pattern (Theobald, 2011).

6.4.1 The Evaluation Process for classifying the Care Level

According to Germany's Long- term Care Insurance Act and the Nursing Realignment Act (German: Pflege- Neuausrichtungsgesetz, PNG), the level of long-term care needs are classified according to the type of basic Activities of Daily Living (ADLs), Instrumental Activities Daily Living (IADLs) and the hours of care needed per day (Social Code Book XI Article 15).

Care Level- 0 (German: Pflegestufe 0) states that people who suffer from Alzheimer's Disease disease exist need care.

Care Level I (German: Pflegestufe I) refers to the moderate care need which require at least two ADLs help once a day and a need of care with IADLs more than once a week; besides, at least 90 minutes per day, with at least 45 minute for basic ADLs by family members or non-professional care workers;

Care Level II (German: Pflegestufe II) refers to severe care need which sees people require at least three ADLs help at different times of the day and need of care with IADLs more than once a week; besides, at least 180 minutes per day, with at least 120 minute for basic ADLs by family members or non- professional care workers;

Care Level III (German: Pflegestufe III) refers to the severest care need, whereby the ADLs help must be available around the clock and need of care with IADLs is more than once a week; besides, at least 300 minutes per day, in which with at least 240 minute for basic ADLs by family members or non- professional care workers. Besides, care service, which occurs between 10 p.m. in the evening and 06 a.m. in the morning, is regarded as night care. (Rothgang & Igl, 2007; German Social Code Book Article 15). (see *Table 6.4*)

Table 6.4 Classified Three Levels for Long- term Care Need

Degree of Disability	**Frequency of need for ADLs/ IADLs**	**The Time Require of ADLs/ IADLs**
Care Level 0	People who suffer from Alzheimer's Disease disease exist need for care	
Care Level I	ADLs: Once a Day IADLs: Several Times a Week	ADLs+ IADLs: 90 Minutes (in which 45 minutes for ADLs)
Care Level II	ADLs: Three Times a Day IADLs: Several Times a Week	ADLs+ IADLs: 180 Minutes (in which 120 minutes for ADLs)
Care Level III	ADLs: A Whole Day IADLs: Several Times a Week	ADLs+ IADLs: 300 Minutes (in which 240 minutes for ADLs)

Source: Rothgang, H. & Igl, G. (2007). Long- term Care in Germany, The Japanese Journal of Social Security Policy, Vol. 6, No.1;
derive from Germany's Social Code XI Article 15(Sozialgesetzbuch XI paragraph Article15) & The Nursing Realignment Act (Pflege- Neuausrichtungsgesetz, PNG).

According to the German Social Code Book XI (SGB XI) Article15, the level of long- term care need for children states that a child's care needs will be determined by comparing it with the needs of other healthy children (Social Code Book XI Article15). A child's evaluation

process should be organized by pediatric doctor or health- and childcare staff.

Moreover, with the fast growing number of people suffering from some of Alzheimer's Disease in Germany, currently 1.4 million, is predicted to exceed 2 million by 2040. According to the current care evaluation, the people who suffered from Alzheimer's Disease could not be included in the three aforementioned care levels; however, they do need some degree of long-term care, therefore, the Long- term Care Reform Act in 2008 added a level for these care receivers called care level 0 (Naegele, 2010; Focus, 2012).

In cooperation with the Federal Peak organization of the Long- term Care Insurer (German: Der Spitzenverband Bund der Pflegekassen), the Medical Review Board of the Statutory Health (German: Medizinischer Dienst der Krankenversicherung, MDK) shoulders responsibility for assessing those requiring social long- term care, while the Medic Proof Co., Ltd. (Medic Proof GmbH), a private company, carries out this duty for private long- term care insurance (Costa- Font, 2011; Social Code Book XI Article 18(1)).

The process of confirming long- term care needs was defined in the German Social Code Book XI (SGB XI) Article 18. The long- term care insurer works with the Medical Review Board of the Statutory Health to evaluate the care level of people in need of long- term care. The Medical Review Board of the Statutory Health has the rights to investigate in house of insured person. If not allow by the insured person, the long- term care insurer has the right to reject his/her benefits for long- term care. In the process of such an investigation, the Medical Review Board of the Statutory Health (German: Medizinischer Dienst der Krankenversicherung, MDK) can request his/ her family doctor to join the evaluation process.

For the evaluation of long- term care need, the Medical Review Board of the Statutory Health

(German: Medizinischer Dienst der Krankenversicherung, MDK) developed its own formula (German: Gutachtenformular der MDK) to classify care levels (Social Code Book XI Article 14, Article 15 & Article 18). The following Table 6.5 reveals the key points of that evaluation formula.

Table 6.5 The Evaluated Formula for Classifying Care Levels by the Medical Review Board

Formula (I)
Basic Information (Date of Evaluation)
1. Insured Person:
(Name) ☐Female ☐Male
2. Name of Insurer:
3. Location for Evaluation: ☐1. Home ☐2. Nursing Home ☐3. Others Address:
4. Examiner: ☐1. MDK Doctor ☐2. MDK Professional Care Staff ☐3. Both ☐4. others
5. The Mode of Care Service: ☐1. Home Care Service (☐Cash Benefit ☐In- Kind Benefit ☐Combination) ☐2. Residential Care ☐3. The Financial Subsidy for Disable Person
6. Current Care level: ☐1. Care Level I ☐2. Care Level II ☐3. Care Level III

Formula (II)
1. Demand and Current Situation
1.1 The Situation for Medical Treatment and Medicate _____
1.2 The situation for Rehabilitation _____
1.3 Use of Assistant Instrument _____
1.4 Mode of Care (☐Home- based Care ☐Semi- Residential Care ☐Residential Care)
1.5 Pattern for Living (☐Live Alone ☐Live with Spouse ☐Live with Child ☐Care Center ☐Nursing Home ☐Others)
2. Basic Information Related to the Care and Case History
2.1 Basic Information (Height, Weight, etc…) 2.2 Case History 2.3 The Result of Observation
3. Disease or the Pattern of Disability and the Effect to ADLs and IADLs 3.1 ☐The Barrier for Four Limbs The Effect to ADLs and IADLs: (☐0: No Functional Barrier ☐1: Act without Help but Take Long Time ☐2: Need Help ☐3: Unable to Act)

The Aspect of Effect: (□Mobility □Bathing/ Dressing □Feeding □Bowel/ Bladder)

3.2 □Inner Organ Disease or Barrier

The Effect to ADLs and IADLs: (□0: No Functional Barrier □1: Act without Help but Take Long Time □2: Need Help □3: Unable to Act)

The Aspect of Effect: (□Mobility □Bathing/ Dressing □Feeding □Bowel/ Bladder)

3.3 □Barrier in Sense Function

The Effect to ADLs and IADLs: (□0: No Functional Barrier □1: Act without Help but Take Long Time □2: Need Help □3: Unable to Act)

The Aspect of Effect: (□Mobility □Bathing/ Dressing □Feeding □Bowel/ Bladder)

3.4 □Neural System Function Barrier

□Orientation □Activity □Mood □Memory □Tempo for Day and Night Activity

□Ability of Thinking □Ability of Conversation □Ability of Conformation the Environment □Recognizable Degree for Social Surrounding

The Effect to ADLs and IADLs: (□0: No Functional Barrier □1: Act without Help but Take Long Time □2: Need Help □3: Unable to Act)

The Aspect of Effect: (□Mobility □Bathing/ Dressing □Feeding □Bowel/ Bladder)

4. Diagnosis (Summary 1- 3)

5. Need for Care

5.1 Aspect of Body

Items	Assistance Degree (□ Assistance □ Partial Proxy □Fully Proxy □care in one's side □Advice)	The Frequency of Assistance	The Period of Assistance
Sponge Bathing			
Showering			
Tub Bathing			
Teeth Brushing			
Hair Combing			
Shaving			
Bowel/ Bladder			

5.2 Aspect of Feeding

5.3 Aspect of Mobility: go to bed or get up, dressing and undressing, standing, walking, up and down stairs, house leaving and get in

5.4 Housekeeping: buying things, cocking food, house cleaning, laundry and heating in the house

6. Overall Evaluation:

□Don't Need Long- term Care

□Need for Long- term Care (Suggestion: □Level I □Level II □Level III)

(Suggestion: □Home Care □Institutional Care)

7. The Suggestion for Long- term Care Insurer
   Individual Case Plan
   7.1 Suggestion: ☐Gymnastics for Health Protection ☐Occupational Therapy
   ☐Physical Therapy ☐Speech Function Therapy ☐Others
   7.2 Assistant Instrument _____
   7.3 Technical Assistance _____
   7.4 The Improve of Care Environment
   ☐Care Pattern and Range _____
   ☐Suggestion for Caregiver _____
   ☐Suggestion for easing the burden _____

Source: Medizinischer Dienst des Spitzenverbandes Bund der Krankenkassen e.V., MDS (The Peak Organization of the Medical Review Board of the Statutory Health) & GKV-Spitzenverband (The Peak Organization for Health Insurance) (2009) Richtlinien des GKV-Spitzenverbandes zur Begutachtung von Pflegebedürftigkeit nach dem XI. Buch des Sozialgesetzbuches, Druckstudio GmbH.

After the first evaluation at home, the Medical Review Board of the Statutory Health (MDK) has to re- evaluate the patient each year until the care receiver discontinues the need for long- term care. Generally, the evaluations are made at home, however, for certain reasons the care receiver can request the council to evaluate them in hospital, an institutional care center or hospice care center.

6.4.2 The Benefit for Germany's Long- term Care Insurance

For Germany's Social Long- term Care Insurance, those eligible for benefits are all insured persons, irrespective of age, income or wealth (Schulz, 2010). Before the introduction of long-term care insurance, people with care needs had to pay using by their assets or depend on

informal caregivers from family members, relatives, neighbors or friends for long- term care. In addition, the means- tested social aid scheme could be regarded as a last defensive line for providing financial support. Until Germany's Long- term Care Insurance Act was implemented in 1995, the benefit for people with a need for long- term care (beneficiary) was paid on 1st January in 1995 for home- based care and institutional care in 1st July in 1996 .

The benefits of long- term care insurance are laid down by Social Code Book XI. Given the parallel system for Germany's long- term care insurance, the act emphasizes that social and private long- term care insurance are not allowed to have differences in the level of benefits, i.e. social and private insured are likewise entitled to the same benefits in the case of being in need of care (Naegele, 2010).

The main concept of Germany's Long- term Care Insurance is to ensure people with a need for long- term care. According to the Act, the benefits are paid for either home- based care, semi-institutional care and full- time institutional care with cash benefits, in- kind benefits and a combination of cash and in- kind benefits (Naegele, 2010). In 2008, the benefits of Germany's Long- term Care Insurance were reformed. The following description is based on the Long-term Care Further Development Act (German: Pflege- Weiterentwicklungsgesetz, PfWG), which was implemented on 1st July 2008 with three subsequent phases in 2008, 2010 and 2012. Further information about the reforms will be provided deeply in chapter 6. 5.

The selections of the benefits are:

Home- based care:

The benefit for home– based care includes in- kind benefit, cash benefit, respite care and short-term care. The in- kind benefit for home- based care refers to the professional care workers, which are regarded as a assistant for care receivers and their family members, and provide

personal hygiene, basic care, housekeeping and care- related consultation at home. Besides, the cash benefit is to awarded directly to the care receiver. The characteristic of the case benefits is that it can be used in any application, not only for the care- related use. Sometimes the cash benefit is regarded as a kind of additional income for the care receiver and for the family caregivers (Michaela Schunk & Carrol Estes, 2001). Therefore, according to the statistics from the Federal Ministry of Health, the selection of the cash benefit is much more popular than in-kind benefit. (see *Table 6.6*) if the expenditure of care for care receiver exceeds the benefit ceiling which is provided from the long- term care insurer, the expense has to be shouldered by the care receiver or an application made for assistance from the social aid scheme (Bundesministerium für Arbeit und Soziales, 2008).

Table 6.6 The Proportion of Cash Allowance and in- kind Outpatient Benefits, 1995- 2014

Annual average	Expenditure	Recipient
1995	82 : 18	88 : 12
1996	74 : 26	85 : 15
1997	71 : 29	84 : 16
1998	68 : 32	83 : 17
1999	67 : 33	81 : 19
2000	65 : 35	80 : 20
2001	64 : 36	80 : 20
2002	64 : 36	80 : 20
2003	63 : 37	80 : 20
2004	63 : 37	80 : 20
2005	63 : 37	80 : 20

2006	62 : 38	79 : 21
2007	62 : 38	79 : 21
2008	62 : 38	79 :21
2009	62 : 38	79 : 21
2010	62 : 38	78 : 22
2011	61 : 39	79 : 21
2012	62 : 38	80 : 20
2013	63 : 37	80 : 20
2014	63 : 37	80 : 20

Source: Selected Facts and Figures about Long-Term Care Insurance (03/15), from: <http://www.bmg.bund.de/fileadmin/dateien/Downloads/Statistiken/Pflegeversicherung/Zahlen_und_Fakten/Zahlen_und_Fakten_03-2015.pdf >

Since 2008, caregiver who provided at least six- months care service for a care receiver can ask for temporary leave, and the long- term care insurer will provide a maximum of four weeks respite care for the care receiver. In this period, the care receiver can determine who the caregiver is. Besides, if the care receiver temporarily cannot be cared for at home, the long-term care insurer has to provide a maximum of four weeks short- term care in institution.

Semi- institutional care:

The care receiver has the right to ask for the benefit of part- time institutional care, only when the home- based care is no longer enough for the care receiver. The care receiver can then choose the residential care service and organizations, which are contracted with the long- term care insurers. The benefit pattern for semi- institutional care refers to day or night care benefits.

Full- time institutional care

The care receiver has the right to ask for the benefit of part- time institutional care, only when the home- based care and semi- institutional care are no longer sufficient for the care receiver or due to a special situation. After evaluation by the Medical Review Board (German: Medizinischer Dienst der Krankenversicherung, MDK), the care receiver can obtain the benefits of full- time institutional care. Furthermore, the care receiver at the care level III can choose the full- time institutional care without the permission of the Medical Review Board.

Furthermore, the long- term care insurers and the federal government provide several benefits for informal caregivers. Such as:

Training course (for family members and volunteers)

The informal caregivers are composed of the family members, relatives, neighbors, friends and volunteers. In order to improve the quality of care for the care receiver, the long- term care insurers have to arrange training courses for such informal caregivers.

Leave of absence for working caregivers (German: Pflegezeit)

The leave of absence for working caregivers (Pflegezeit) refers to the fact that an employee can request maximum of six months non- paid leave to care for family members. The employer here refers to at least fifteen employees in for- benefit or non- benefit organizations. The employee can have ten days leave for urgent care needs with medical proof. Moreover, the federal government and long- term care insurer will provide the social insurance for the caregivers, i.e pension insurance, accident insurance, health/ long- term care insurance and unemployment insurance, only when the caregivers have provided at least six- months care service and fourteen hours per week for the care receiver. Otherwise, caregivers have to pay the contribution for health/ long- term care insurance and unemployment insurance themselves.

The above- mentioned benefits for care receivers and caregivers have been reformed since 2008 for the purpose of the continuing development of Germany's long- term care insurance. In order to offer an overview of these benefits *Table 6.7* outlines the benefits of Germany's Long- term Care Insurance in relation to care receivers.

Table 6.7 Entitlement to Benefits and Services for Person Insured under the German Long-term care Insurance Scheme at a Glance, in 2015 (unit: €)

		Care Level 0 *the insured who is not included in the care level however considerable need for long- term care service is required*	**Care Level I** *considerable need for long- term care*	**Care Level II** *severe need for long- term care*	**Care Level III** *extreme need for long- term care (in particularly severe cases)*
Home Care	**Benefit in kind**	0	468	1,144	1,612 (1,995)
	Benefit in cash	0	244	458	728
Stand- in (respite) care **- by near relatives** **- by other persons**		- 184.5 -1,612	- 366 - 1,612	- 687 - 1,612	- 1092 - 1,612
- Short- time care **- Part- time institutional care (day and night)**		-1,612 0	-1,612 -468	-1,612 -1,144	-1,612 -1,612
Supplementary benefits provided for long- term care patients with a considerable general need for care		2,496	2,496	2,496	2,496
Full-time institutional care		0	1,064	1,330	1,612 (1,995)
Care provided in full-time special support			10% of the fee for the institutional care, but not more than 256 Euro/ month.		

institutions for persons with disabilities				
Nursing aids intended for consumption	40 Euro			
Technical nursing aids and other nursing aids	100% of the costs, on certain conditions, however, a co-payment of 10%, amounting to a maximum of 25 Euro per item has to be granted. Technical nursing aids are made available for use mainly on free loan, i.e. free of charge and consequently without co-payment.			
Measures to improve the person's living environment	4,000 Euro per measure, considering a reasonable co-payment, up to total of 16,000 Euro.			
Payment of pension insurance contributions for informal carers (depending on the intensity of care-giving up to € a month (new Federal Laender))	0	141.37 Euro (120.43)	282.74 Euro (240.86)	424.12 Euro (361.28)
Payment of unemployment insurance contributions for carers during their periods of providing care for relatives	0	8.51 Euro (7.25)		
Premium subsidies for health insurance and long-term care insurance granted to carers for the period of care providing	0	137.97 Euro/ month (health insurance) 22.21 Euro/ month (long- term care insurance)		

Source: Selected Facts and Figures about Long-Term Care Insurance (03/15), from: <http://www.bmg.bund.de/fileadmin/dateien/Downloads/Statistiken/Pflegeversicherung/Pflegeversicherung_im_Ueberblick_2015.pdf>

An overview of the benefits of Germany's Long- term Care Insurance Act is that, the benefit

can be divided into three sectors, which include the benefit for care receivers (under the three levels of care), benefit for care level- 0 (usually referring to people suffering from Alzheimer's disease) and benefit for caregivers. (see *Table 6.8*) These benefits are provided and supported not only by the long- term care insurer, but also the German federal government.

Table 6.8 The Benefits of Germany's Long- term Care Insurance Act

For Care Receiver (Care I- III and special severe case)		**For Care Level- 0**	**For Caregivers**
Non- institutional Care **1. In- kind benefit** **2. Cash benefit** **3. Combination between cash and in- kind benefit** **4. Respite care** **5. Assistant instrument**	**Institutional Care** **1. Day/ night care** **2. Short- term care** **3. Full institutional care**	1. Additional Benefit (The Long- term Care Further Development Act (Pflege-weiterentwicklungs-gesetz, PfWG) 2. Benefit of Care Level 0 (The Nursing Realignment Act (Pflege-Neuausrichtungs-gesetz, PNG)	1. Benefit for Social Insurance 2. Leave of absence for working caregivers (Pflegezeit) 3. Training Course (for family members and volunteers)

Source: Derived: Germany's Long- term Care Insurnce Act & Germany's Nursing Realignment Act (Pflege- Neuausrichtungsgesetz, PNG); Jiang, C. C., Ke, M. C., Lin, K. Y. and Lin, C. C. (2009) A Study on the Related Laws of Long - term Care Insurance in Germany and Holland, Working Paper, National Development Council.

6.4.3 Management and Organization of Germany's Long- term Care Insurance

Germany's Long- term Care Insurance is regarded as a fifth pillar of the social security scheme in Germany. The parallel long- term care insurance system is composed of social long- term care insurance and mandatory private long- term care insurance, which is insured by the public health insurance and private health insurance. In order to compare this to the social insurance scheme in Taiwan, we will not focus on and discuss the system of private long- term care insurance.

Germany's long- term care insurers are administered by different long- term care insurance funds. In order to guarantee that the care service (benefits) can be provided, the funds have to be sure that the infrastructures of long- term care system are sufficiently available (Naegele, 2010). Based on the Social Code Book XI (SGB XI), in Germany, long-term care insurance funds are in charge of executing the long- term care insurer, which are affiliated to the health insurance funds. That means that, Germany's long- term care insurer does not set up an independent administration, but is secured under the roof of health insurance funds.

The concept of under the roof of health insurance (German: unter dem Dach der Krankenkassen) concerns not only saving administrative costs, but also creates an funded pathway between long- term care need and disease. Besides, the subswquent operational states are as follows (Bundesministerium für Arbeit und Soziales, 2012):

1. The long- term care insurance and health insurance share the same working employees and administration i.e. administrative committee and council (Social Code Book V Article 31, Article 43);

2. The long- term care insurance funds do not have an independent administration and medical review board, therefore, the evaluation of care will be the responsibility of the Medical Review Board for Statutory Health Insurance (MDK) (Social Code Book XI Article 18 (1));
3. The long- term care insurance has no administrative property (Social Code Book XI Article 62, Social Code Book V Article 259);
4. The long- term care insurance does not have unions at the level of the states and federation. Thies function will be replaced by the health insurance (Social Code Book XI Article 52, Article 53);
5. Health insurance and long- term care insurance can only be established, closed and merged with other health- and long- term care insurance together (Social Code Book XI Article 46(5));
6. Health insurance and long- term care insurance have the same official supervision (Social Code Book XI Article 46(6));
7. The insured number is complete or partial the same in between health insurance and long-term care insurance (Social Code Book XI Article 101);
8. The use of insured duty in health insurance is the same as the long- term care insurance (Social Code Book XI Article 96).

Besides, given the principle of "the long- term care insurance accompanying the health insurance", future reform of health insurance will also bring into play long- term care insurance.

6.4.4 General Contribution of Long- term Care Insurance

According to the social Code Book XI Article 54(1), the funding of Germany's Long- term Care Insurance is composed of the insurance premium and other revenue. The base for calculating the insurance premium is 7 days a week, 30 days a month and 360 days per year. Besides this, the so- called other revenue means the invested earnings from preparatory funding and operational property.

The financial system for German Social Long- term Care Insurance follows a pay- as- you-go- system. The contribution for the long- term care insurance is income- related but not risk-related (Rothgang, 2011). According to the Social Code Book Article 55(2), the income ceiling for long- term care insurance is the same as the health insurance reaching 4,125 Euro in 2015, which has to adjust its income ceiling every calendar year. Since 2015, the long- term care insurance premium has reached 2.35 per cent of gross income per month. The insurance premium cannot be increased without permission by the federal parliament.

For the contribution to long- term care insurance, generally, the employee and employer have to pay the contribution equally. However, several special cases exist. Since 2004, retired person have had to pay the whole amount by themselves. Furthermore, people with children will bear an added burden than childless people. Therefore, the Federal Constitutional Court adjudicated that insured persons without children who are aged 23 years or above had to pay an additional contribution of 0.25 per cent since 2005. Besides the relation of consanguinity, the concept also includes adoptive parents and stepparents However, the un- employed, firefighters, civilian public servants, who are aged 23 years and above can remit the additional contribution. Besides, employees working in the Federal State of Saxony (Sachen) work one day more than

other states. Therefore, the employers pay 0.675 per cent of the total contribution and the employees pay the excess 1.675 per cent in 2015. *Table 6.9* illustrates the burden of the long-term care contribution, which is defined by the Social Code Book XI Article 59.

Table 6.9 The Burden of the Long- term Care Contribution

	The Insured Person	**Employer or Other Social Insurance System**
Employee	1.175 %	1.175 %
Employer in federal state Saxony (Sachen)	1.675 %	0.675 %
Retired person	2.35 %	0
Un- employed	0	2.05 %
Sick allowance	1.025 %	1.025 %
Artist and refugee	0	2.05 %
Student who has part- time Job (the health insurance contribution exceeds 49.9 Euro per month)	1.175 %	0
Coverage of family dependants	0	0
Additional contribution for people without children	1.425 %	1.175 %
Voluntary insured people	2.35 %	0

Source: Derived: Germany's Long- term Care Insurnce Act & Germany's Long- term Care Stabilization Act (Pflegestärkungsgesetze)

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6.5 After the Reform Is Before the (Next) Reform

Since 1994, Germany's Long- term care Insurance was established and took effect in 1995, the need for long- term care was covered comprehensively by Germany's Social code Book XI. Until now, Germany's Long- term Care Insurance has proven to be a successful social scheme under the social security system in Germany.

After eighteen years of implementing the social long- term care insurance act, the number of insured persons reached 69.48 million by Social Long- term Care Insurance and 9.52 million by Private Long- term Care Insurance. The total number of beneficiaries is about 2.46 million, of which 1.70 million have home care and 0.76 million have institutional care. It covers almost 96 per cent of all the population in Germany. Moreover, one of the aims of Germany's Long-term Care Insurance is that home- based care takes precedence over institutional care. The number of people who live in a nursing home has been reduced from 80 per cent in 1994 to 30 per cent in 1998 (Rothgang, 1997).

However, policymaking has its meaning and special role at that time, after several years since being implemented in 1995, the policies might become outdated and not actually respond to the current situation. Thus, the policy could fail, and even harm society and its target groups.

After eighteen years of implementation of Germany's Long- term Care Insurance Act, its social status was changed. Under the circumstance of the surging demand for improvement and transparent quality evaluation, the increasing number of people suffering from Alzheimer's Disease, the additional role of the community and the benefits for care receivers and caregivers, Germany's Long- term Care Insurance was reformed and called the Long- term Care Further Development Act (Pflege- Weiterentwicklungsgesetz, PfWG). Then four years later, the Federal Ministry of Health again launched a reform of the Long- term Care Insurance Act, called the Realignment Act (Pflege- Neuausrichtungsgesetz). This part will discuss the above-mentioned reform of Germany's Long- term Care Insurance.

After permission from the Federal Parliament, the Long- term Care Further Development Act (German: Pflege- Weiterentwicklungsgesetz) took effect on 1st July 2008 and Germany's Long-term Care Stabilization Act was established in 2015. The main issues of the reform are: leave of absence for working caregivers (German: Pflegezeit); the stepwise adjustment in benefits; the long- term care support point (German: Pflegestützpunkte) and quality maintenance.

Leave of absence for working caregivers (Pflegezeit)

The leave of absence for working caregivers (Pflegezeit) refers to the fct that an employee can request maximum of six months non- paid leave to care for family members. The employer here refers to at least fifteen employees in for- benefit or non- benefit organizations. The employee can have ten days leave for urgent care need with medical proof. Moreover, the federal government and the long- term care insurer will provide the social insurance for the caregivers, i.e. pension insurance, accident insurance, health/ long- term care insurance and unemployment insurance, only when the caregivers have provided at least six- month care service and fourteen hours per week for the care receiver. Otherwise, the caregivers have to pay the contribution for health/ long- term care insurance and unemployment insurance by

themselves.

The stepwise adjustment in benefits

Further stepwise increases in benefits are scheduled at four times, which are in July 2008, January 2010, January 2012 and January 2015 respectively. The benefits of each Care Level are fixed by Germany's Long- term Care Act (SGB XI). According to the First Act to Strengthen Long-term Care (German: Pflegestärkungsgesetze) which was launched in 2015, on the adjustment, the in- kind benefit at home increase more benefits than in nursing home care, due to the principle of Germany's long- term care insurance: home- based care takes precedence over institutional care. (see *Table 6.10*)

Table 6.10 The Adjustment of Benefits Based on the Type of Care Patterns and Care Levels (in comparison with 2014 and 2015), in Euro

	Amount of benefits	
	2014	**2015**
Cash Benefit (Home- based Care)		
Care Level 0 (with Alzheimer's Disease)	120	123
Care Level I	235	244
Care Level I (with Alzheimer's Disease)	305	316
Care Level II	440	458
Care Level II (with Alzheimer's Disease)	525	545
Care Level III	700	728
Care Level III (with Alzheimer's Disease)	700	728
In- kind Benefit (Home- based Care)		
Care Level 0 (with Alzheimer's Disease)	225	231

Care Level I	450	468
Care Level I (with Alzheimer's Disease)	665	689
Care Level II	1,100	1,144
Care Level II (with Alzheimer's Disease)	1,250	1,298
Care Level III	1,550	1,612
Care Level III (with Alzheimer's Disease)	1,550	1,612
Hardship Case	1,918	1,995
Hardship Case (with Alzheimer's Disease)	1,918	1,995
Full Institutional Care		
Care Level 0 (with Alzheimer's Disease)	0	0
Care Level I	1,023	1,064
Care Level I (with Alzheimer's Disease)	1,023	1,064
Care Level II	1,279	1,330
Care Level II (with Alzheimer's Disease)	1,279	1,330
Care Level III	1,550	1,612
Care Level III (with Alzheimer's Disease)	1,550	1,612
Hardship Case	1,918	1,995
Hardship Case (with Alzheimer's Disease)	1,918	1,995
Partial Institutional Care		
Care Level 0 (with Alzheimer's Disease)	0	231
Care Level I	450	468
Care Level I (with Alzheimer's Disease)	450	689
Care Level II	1,100	1,144
Care Level II (with Alzheimer's Disease)	1,100	1,298
Care Level III	1,550	1,612

Care Level III (with Alzheimer's Disease)	1,550	1,612
Care Device		
Care Level 0 (with Alzheimer's Disease)	31	40
Care Level I, II, III	31	40
Caregiver (without blood relationship)		
Care Level 0 (with Alzheimer's Disease)	1,550 (up to 4 weeks)	1,612 (up to 6 weeks)
Care Level I, II, III	1,550 (up to 4 weeks)	1,612 (up to 6 weeks)
Home Modification Measures		
Care Level 0 (with Alzheimer's Disease)	2,557 (up to 10,228 Euro, when the care receiver live in the same house)	4,000 (up to 16,000 Euro, when the care receiver live in the same house)
Care Level I, II, III	2,557 (up to 10,228 Euro, when the care receiver live in the same house)	4,000 (up to 16,000 Euro, when the care receiver live in the same house)

Source: Pflegeleistungen nach Einführung des 1. Pflegestärkungsgesetzes (01/15), from: <http://www.bmg.bund.de/fileadmin/dateien/Downloads/P/Pflegestaerkungsgesetze/Tabellen_Plegeleistungen_BRat_071114.pdf>

The long- term care support point (Pflegestützpunkte)

The need for long- term care is not only related to obtaining the benefit from the long- term care insurance, but also concerns many aspects in the social environment. Besides, people with long- term care need or their families are difficult to collect and find the right resources, which suit their care arrangement while experiencing long- term care needs (Dräther, Kofahl, Lüdeck and Mnich, 2008). Therefore, the federal government put this into the reform of the long- term care insurance. The function and role of settled long- term care support point are that the care coordinator helps the case (care receivers or their family) to arrange and collect the individual care plan for care service and the social security scheme. Besides, the care manager (Pflegeberater) here is regarded as a consultant who provides the systematic analysis for the case.

Quality maintenance and improvement

In order to improve the quality of service in nursing home centers or institutional care centers, since 2008, the medical Review Board and long- term care insurer began to execute the evaluation of community and institutional care centers every year. The result of the assessment must be published with transparency.

The above- mentioned main issues of the Long- term Care Further Development Act indeed solved some of the problems at the time. However, in this reform, it is short of concerning on the target group- people, who suffer from Alzheimer's disease and other cognitive impairments. Besides, after this reform came a further reform related to those people with a need for long- term care.

Currently, about 1.4 million people suffer from Alzheimer's disease and other cognitive impairments in Germany (Focus, 2012). According to the current assessment standard for these

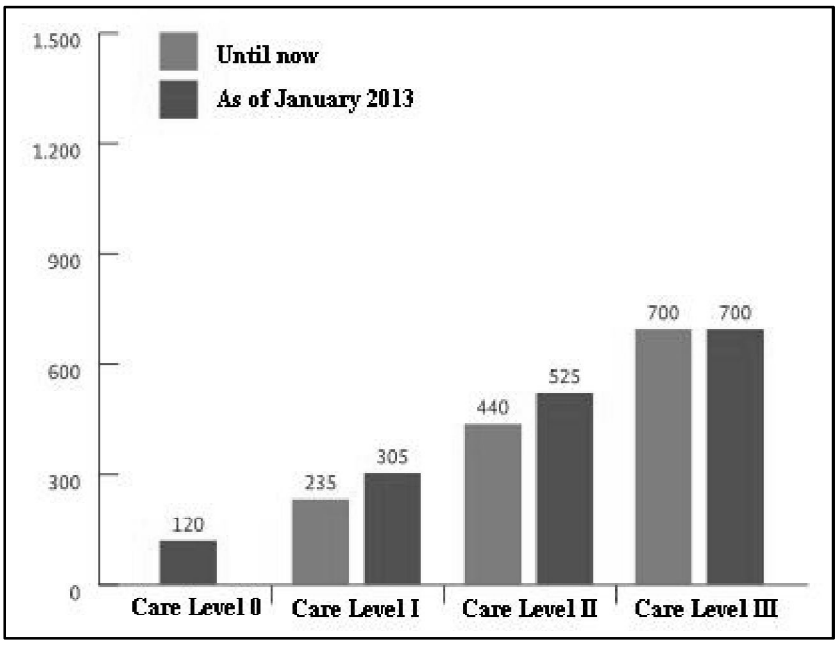
care needs, most of these sufferers could not be included in any of the care levels, despite,, in some degree, needing care. Therefore, the reform of Germany's long- term insurance was launched in 2015, and named the First Act to Strengthen Long- term Care (German: Pflegestärkungsgesetze).

The target of the Act was to provide for demand- oriented to the special needs of people with Alzheimer's Disease. It also had the goal of ensuring that people with Alzheimer's Disease had more opportunities for an independent and self-determined life and as far as possible could participate in society.

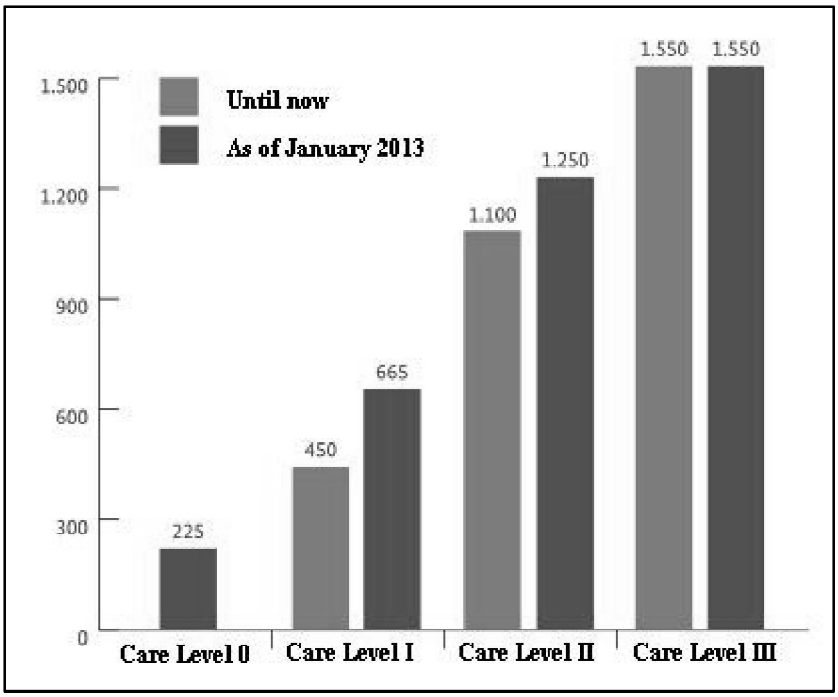
The main issues of this reform are: improvements for people suffering from Alzheimer's Disease; more support for caregivers; more possibility of care (realization of individual care); Strengthening of the principle of using rehabilitation services as a precedent and funding for Germany's Long- term Care Insurance (Federal Ministry of Health, 2012).

Improvements for people suffering from Alzheimer's Disease

Until now, care for people with Alzheimer's disease remains insufficient. The government is seeking other care patterns for them, such as additional benefits or in- kind service, i.e. besides basic care and housekeeping, home- based care will be increased to include, going for a walk and reading aloud to people with Alzheimer's disease. It provides a new concept of the need for care. People are only considered in care when they need assistance with physical care. Now, despite people with Alzheimer's disease acting for themselves they can, get some assistance from someone else. Since 2013, the benefit for people with Alzheimer's disease has increased. People who are not included in a care level (so- called Care Level 0) receive a monthly cash benefit of 123 Euro or in- kind service up to 231 Euro. (see *Figure 6.2*)



In- Kind Benefit



Source: Federal Minisrty of Health (2012). Das Pflege- Neu ausrichtungs-Gesetz Stand: nach der 3. Lesung im Bundestag. Bundesministerium für Gesundheit Kommunikationsstab (Referat Öffentlichkeitsarbeit), Berlin.

Figure 6.2 Supports for People with Alzheimer's Disease in Ambulant Care Cash Benefit

More support for caregiver

Until now, the caregivers of people with Alzheimer's disease cannot receive cash benefits (German: Pflegegeld) when for example the care receiver is in hospital. Since 2013, the caregiver has 1- 4 weeks of short- term leave but cannot exceed that 4 weeks per year, thus, the long- term care insurer will pay half of the original cash benefit for them. Moreover, if the caregiver needs rehabilitation, now, the care receiver can accompany the caregiver. The rehabilitative institution should provide suitable services and facilities to fit the circumstances.

Furthermore, before 2013, a caregiver would be included in the pension insurance system, when they deliver care for at least 14 hours a week for one care receiver, but now, the limitation will not focus on only one care receiver. The executive care period could be caculated from different care receivers (at least Care Level I).

More possibility for care (the realization of individual care)

People with care need and their families can have more choices in the design and compilation of the care service. In addition to performing contemporary performance- related complexes is the opportunity to decide on a certain volume over time. Care receivers and their families have to cooperate with the nursing service to decide which services are provided in this period.

Strengthening of the principle of taking rehabilitation as precedence

One of the aims of Germany's Long- term Care Insurance Act is to take rehabilitation as precedence. However, until now, the measure has not been clearly planned. The evaluation of the need for care only concerns the care level of the care receiver. Therefore, since 2015, the assessment will focus on not only the care level, but also the possibility before classification.

Funding for Germany's Long- term Care Insurance

By providing more benefits for people with Alzheimer's disease, the contribution of Germany's Long- term Care Insurance will increase 0.45 per cent from 1.95 per cent to 2.35 per cent in 2015.

The First Act to Strengthen Long- term Care (German: Pflegestärkungsgesetze) launched a new definition of the needs for long- term care. The amount of people with care need has been extended, and then, according to the current pay- as- you- go funding system of Germany's Long- term Care Insurance, the increasing funding must be happening in the future. With the unceasing increasing of the ageing population and people with Alzheimer's disease, the system indeed has to find a solution so it can be maintained.

Besides, based on the new definition of the need for long- term care, the assessment of the need for care has to be modified, especially for people with Alzheimer's disease. With the extended definition of the need for long- term care, the current assessment needs to be modified. Since 2006, the Federal Ministry of Health started to work on a new assessment, in which the actual status of the care level appear, and which will be included in the Second Act to Strengthen Long- term Care.

The care level will be divided into five different degrees: light, moderate, severe, severest and special cases with six models: 1. Mobility: body extension and mobility; 2. Recognition and connection: the ability of memory, feeling, thinking, judgment and connection; 3. Behavior and inner spirit: individual psychological status; 4. Self- care: personal hygiene, active daily living (ADLs); 5. The treatment under the disease and cure process: take medicine and personal medical treatment; 6. Social connection: time distribution and the maintenance of social relation (Jiang, 2009). Based on the criterion of the assessment, the new assessment stresses the evaluation of people with Alzheimer's disease and their connection with society.

6.6 Discussion and Conclusion

In response to the demand for long- term care needs, Germany formulated the Long- term Care Act in 1994 under the regime of social insurance. The first part of this chapter introduced the background and the reasons for establishing the act. Subsequently, the contain is surrounds Germany's long- term care insurance and its reform to clarify Germany's long- term care system.

With the rapid demographic changes since the 1980s, and to confront the urgent demand for receiving of care, the government began to establish the long- term care system in Germany. As a fifth pillar of social security system, long- term care insurance is the youngest social-insurance program in Germany. The characteristics of Germany's long- term care insurance is used to integrate three targets, and besides providing comprehensive protection for people with long- term care needs, the expenditure of the care service will include the public costs, which may emerge within the framework of the universal policy scheme. Moreover, it forces the establishment of a family- supported environment for the concept of ageing in place. In order to achieve this goal and avoid an outdated policy, the government in Germany had to reform the act to respond to the current situation appropriately, e.g. by passing the Long- term Care Further Development Act, the Nursing Realignment Act and First Act to Strengthen Long-term Care. These reforms concern an adjustment in benefits, quality maintenance, improvements for people suffering from Alzheimer's disease, more support for caregivers and funding for long-term care insurance.

Within the reform of the Long- term Care Insurance Act in Germany, the place of caring for people who suffer from Alzheimer's disease is gradually rising in importance. In this regard, in

January 2015, the First Act to Strengthen Long-term Care was launched to ensure quality of care for Alzheimer's disease sufferers. Besides giving support to people who suffered from Alzheimer's disease, the act provides improvements by combining respite care and day and night care within the short- term care provisions.

Unlike the long- term care policy in Germany, the financial resources of the Ten Year Long-term Care Program in Taiwan is not only based on the principle of social insurance, but also follows the model of social care by using the taxation system. From the governmental perspective, the role of the Ten Year Long- term Care Program is to create and construct the fundamental structure and base for the long- term care system in Taiwan. For the medium and long- term plan, in the near future, the government will establish long- term care insurance, which follows the principle of social insurance. In view of the long- term care policy in both Germany and Taiwan, the different backgrounds have driven a similar demand for long- term care. Despite the schemes not being the same, the aim of the respective policies has been to mitigate and defeat the social risks caused by long- term care needs.

Chapter 7.
A Suitable Model for Taiwan's Long- term Care Policy- Germany's Lessons

Based on the Constitution, social security models are designed by the social insurance scheme to protect the people in Taiwan (Chapter 4.2.1). From its Labor Insurance to the National Health Insurance System, Taiwan has gained lots of experience from the development of social insurance. This chapter, will be based on the premise that Taiwan's social insurance mechanism develops a suitable long- term care system that is derived from Germany's experience.

7.1 A Suitable Model for Taiwan's Long- term Care Policy- What We Can Learn from Germany

Since 2007 and 2015, the Ten Year Long- term Care Program and Long- term Care Service Act were launched one after another in Taiwan. Through the establishment of the Ten Year Long-term Care Program the aim was to respond to the rapidly increased need for long- term care. Another aim was to create a fundamental basis for the upcoming long- term care insurance scheme through the establishment of National Health Insurance.

As a generally acknowledged social welfare country in the world, Germany's complete social security nets have included Health Insurance (1883), Industrial Accident Insurance (1884), a Pension Insurance (1889), Unemployment Insurance (1927) and Long-term care Insurance. Each form of social insurance had its background of introduction, in which long-term care

insurance was the new social security act (1995) in Germany. Due to the growing ageing population, a reduced total fertility rate, the extended life expectancy, the financial status of former local or regional social assistance programs and the revolving door effect of health insurance, long-term care service and insurance were very strongly needed. Therefore, Germany's long-term care insurance was enacted under the foregoing circumstances. It has established itself as a comprehensive, through and renowned scheme of social insurance among the world and has become an example to other countries, such as Japan, the United States and as well Taiwan. Therefore, the following will illustrate what Taiwan can learn from Germany's model.

7.1.1 The Structure of Long- term Care Insurance

Long- term care in Taiwan is regarded as a social right, that is not just restricted to the elderly population although long- term care demand is higher among the elderly than other age levels. It does mean that there is not the demand for receiving long- term care service for the under 65s. As mentioned above, the design of the Long- term Care Insurance Program in Taiwan will follow the structure of the existing Nation Health Insurance (NHI), hence, who qualifies for insurance cannot be restricted by their age, gender or health status. According to the investigation in 2012 by the Department of Health, about 70 per cent of people aged under 40 years old support the government's establishments of the comprehensive Long- term Care Insurance Program. One important reason is that the program can lighten the economic strain and support families providing care service at home.

The demand for long- term care (German: Die Pflegebdürftigkeit) is one of the core concepts of Germany's Long- term Care Insurance Act. That means, the need for long- term care is a kind of social risk, that anyone of any age might face. Especially, as well, the Long- term Care Insurance falls under the roof of Sickness Insurance (SI), and consequently long- term care insurance in Germany covers the whole population. Based on the large numbers principle, the more insurance cover the higher the ability to share the risk.

Because long- term care is accompanied by the principle of health insurance, Germany's long-term care system is still maintained by multiple insurance systems (Jiang, 2009). Germany has implemented a health insurance system for more than 100 years. The spirit of the "Autonomy of the Insurer" has been well developed. By contrast, Taiwan's health insurance uses a single insurer, meaning that the government can easily intervene in the system. In the context of a single insurer system for its insurance scheme, whether the German system can serve as a reference point seems to have its limitations in relation to Taiwan. However, through the multi-insurer system, based on its supervisory position, the government cannot directly intervene in the system. The results of this diversification for the insurer means that not does it retain its own autonomy but also through competition among insurers it allows the quality of care to improve and provides a greater choice.

7.1.2 The Financial Planning and the Contribution

Regarding social insurance or tax- oriented schemes, these two kinds of funding system have been discussed in Taiwan for a long time, even before enacting the Long- term Care Insurance

in Germany.

In Taiwan, currently, the main two political parties have different stands on this issue. One is to extend the Ten Year Long- term Care Program, which is based on the taxation system. However, according to the current design, funding is derived from estate and gift taxes and also real estate transaction tax, In the case of the latter, real estate transaction tax is influenced strongly by fluctuations, i.e. the funding is not stable. In the current Ten Year Long- term Care Program, the biggest program is the lack of funds to cover costs, because the government now has no chance to raise the tax rate for the people who are under the strain of an economic downturn (Chapter 5).

Germany's long- term care system, under the roof of Health Insurance, is a combination of both. The regime of social insurance takes the form of risk sharing, as since long- term care is regarded as a social risk, the response needs to stand on the principle of solidarity. Furthermore, Taiwan has plentiful experience in implementing social insurance e.g. Labor Insurance and Health Insurance Program. Hence, in its design, the funding of the long- term care system will take the form of social insurance in Taiwan.

According to social Code Book XI Article 54(1), the funding of Germany's Long- term Care Insurance is composed of an insurance premium and other revenue, for which, the base for calculating the insurance premium is 7 days a week, 30 days a month and 360 days per year. Besides, so- called other revenue is derived from the investment of earnings from preparatory funding and operational property.

The financial system for German Social Long- term Care Insurance follows a pay- as- you- go- system. The contribution for the long- term care insurance is income- related but not risk-

related (Rothgang, 2011)

The funding of the National Health Insurance comes from contributions, governmental allowances and other revenue. Because of the contribution exists occupational different in Taiwan. According to the National Health Insurance Act, the insured person is divided into six categories and the government provides a different allowance for each category. The range is from 0 per cent to 30 per cent. Besides, revenue here means that which is derived from lottery and health tax, which comes from a tax on cigarettes.

Before implementing long- term care insurance, the funding system for health insurance first has to be modified as the current scheme is unfair. People can legally evade paying the high contribution, situation, which will undermine funding and lead to the collapse of the insurance system.

Besides, usually, people with children will bear an added burden compared to those who are childless. Therefore, in 2005 the Federal Constitutional Court adjudicated that insured persons without children who are aged 23 years or above had to pay an additional contribution of 0.25 per cent. Besides relationships of consanguinity, the concept also includes adoptive parents and stepparents, however, the un- employed, firefighters, civilian public servants aged 23 years and above can remit the additional contribution. As Taiwan is experiencing the status of depopulation and a low fertility rate, the Germany's model might be a solution for balancing the unfair phenomenon.

7.1.3 The Administration of Long- term Care Insurance

Due to the concept of under the roof of health insurance (unter dem Dach der Krankenkassen), the parallel long- term care insurance system is composed of social long- term care insurance and mandatory private long- term care insurance, insured by both public health insurance and private health insurance. This not only produces savings of administrative costs but also creates an affluent gangway between long- term care need and disease (Chapter 6.4).

Unlike Germany's model, the health insurance system in Taiwan only uses a single insurer called the Bureau of National Health Insurance (BNHI). The Bureau of National Health Insurance already has experience in health insurance affairs. Moreover, long- term care involves many nursing professions, and in order offer seamless care, long- term care and medical treatment should be integrated. Besides, the Ministry of Health plays the role of supervisor for the Bureau of National Health Insurance. When facing an important debate, the Ministry of Health has the rights to a final adjudication.

Following the introduction of National Health Insurance, the Ministry of Health should establish two organizations to consult regarding the related affairs of long- term care insurance in the bureau of National Health Insurance:

(1) Council of Long- term Care Insurance: the role of the council is composed of the insured person, an expert on long- term care and a representative of the government. According to the Long- term Care Insurance Act, it decides the contents of the benefits, and the ceiling for expenditure on long- term care and related affairs. Moreover, the members of the council shoulder the burden of overseeing the financial status of long- term care insurance.

(2) Council of deliberation on long- term care debate: the council is composed of an expert on

long- term care, jurisprudent and a fair-minded person to deliberate on the debates.

7.1.4 Care Management and its operation

In Taiwan, the service quality gap is very large between institutional care organizations. How to maintain and improve the quality will be an important issue while implementing the long-term care insurance. Currently, quality inspection is carried out by the Long- term Care Management Center. However, because of a lack of professional staff and the division of the authority running the management center like a paper tiger it has no power to ensure and improve quality.

In Germany, in order to improve the quality of service in nursing home or institutional care centers, since 2008 the medical Review Board and long- term care insurer began to carry out annual evaluations of community and institutional care centers. The results of these assessments must be published to reflect a policy of transparency.

In order to avoid the government being both a player and the referee, and also with respect to professional affairs, the statutory care insurance was entrusted to the Medical Review Board of the Statutory Health to identify care needs and ensure the quality of care. The Medical Services Division has a complete professional team, including nursing staff, rehabilitation staff and consultants. Besides, the Medical Services Division provides assistance in establishing care ratings and inspecting care quality and reporting the results of the examination to the care insurer. The results of the medical services review are published in a clear, open and

transparent manner by the care insurer. Thus, through symmetry of information, the insured can select among optimal choices (Chapter 6.4.1).

In Taiwan, since the Ten Year Long- term Care Program and Long- term Care Service Act was established, Care Management Centers were established in each city and county (Chapter 5.1.3). Their functions were to simplify the process of care integration, which includes case development, case selection, case assessment, plan drawing, service connection, service control, re-assessment, and case closing.

Based on the Ten Year Long- term Care Program and Long- term Care Service Act, the Medical Review Board of the Statutory Health no longer exists. However, in view of medical services in long- term care insurance, which played the professional and neutral role, a related organization is be needed.

7.1.5 The Benefits for Care Receiver and the Support for Caregivers

In Germany the benefits available to care receivers is classified into three types, i.e. cash, in-kind and a mixture of both. Based on actual demands, each case can choose a type that fits their status. In Taiwan, currently, the benefits in the Ten Year Long- term Care Insurance tend toward in- kind service as a priority and cash benefits as supplementary. It is not flexible to choose the care receiver based on demand (Chapter 6.4.2).

Despite the free choice of benefits in a model in Germany, there is one thing that it is necessary

to reconsider. When talking about the cash benefits in Germany's system, the purpose of consumption is not inspected, thus raising the question of how the quality of the care service can be ensured. We cannot say how most of the care receivers will use this cash benefit in another way, however, from the position of population policy, all benefits have to be used in the knife- edge when necessary.

Certainly, based on the free choice of benefits, the cash benefit option will be provided in Taiwan. However, we recommend establishing a standard process to check that the money is used for care.

Both Germany and Taiwan emphasize the principle of "ageing in place". With the human dignity in mind, care receivers would be better off receiving care service in a familiar place, through home- based care and community care. Therefore, the role of the informal caregiver will be very important regarding who actually shoulders the responsibility of care. Traditionally, the informal caregiver in Germany and Taiwan refers to daughters, female spouses, relatives, family members, friends, volunteers and neighbors.

According to Germany's Long- term Care Insurance Act, the Long- term Care Further Development Act and the Nursing Realignment Act, the current support for informal caregivers in Germany as follows:

Training course: In order to improve the quality of care for care receivers, the long- term care insurers have to arrange training courses for informal caregivers;

Respite Care: a caregiver who has provided at least six- months care service for the care receiver can ask for temporary leave, and the long- term care insurer will provide a maximum of four weeks respite care for the care receiver;

Leave for care: the employee can request for a maximum of six months non- paid leave to care for family members. The employer covers at least fifteen employees in for- benefit or non-benefit organizations. The employee can have ten days leave for urgent care supported by medical proof;

Social assurance: pension insurance, accident insurance, health/ long- term care insurance and unemployment insurance, as the caregivers have provided at least six- month care service and fourteen hours per week for the care receiver.

Since 2013, the caregivers to people with dementia have 1- 4 weeks short- term leave but cannot exceed that 4 weeks per year. Thus, the long- term care insurer will pay half of the original cash benefits for them. Moreover, if the caregiver needs rehabilitation, now the care receiver can accompany the caregiver. The rehabilitative institution should provide suitable service and facilities to fit the circumstances. Furthermore, before 2013, the caregiver would be included in the pension insurance system when they carry out care acts amounting to at least 14 hours a week for one care receiver. But now the limitation will not focus on only one care receiver. The executive care period can be summed from different care receivers (at least Care Level I).

In Taiwan, the support for the informal caregiver is insufficient. According to the Ten- year Long- term Care, support for the informal caregiver only providing respite care. Besides, according to the Project, the payment will be based on the means- test concept, whereby, the government will give a financial subsidy (≒ 25 Euro per day) for impoverished households or individual care receivers.

The long- term care policy emphasizes that the concept of "home- based care takes precedence" in both Germany and Taiwan. The concept of care in place and ageing in place is deeply rooted in both long- term care systems. Therefore, the support for the family caregiver is the main issue for long- term care insurance in both countries.

Germany's model provides several forms of support for the family of caregivers and includes them in the social security system, e.g. they are included in social insurance, respite care, cash benefits, training courses and leave of absence for working caregivers. That means that, support for the family of the caregiver is seen as essential and needs to be included in the Long- term Care Insurance Act to guarantee their rights.

In Taiwan, the support for the families of caregivers has been provided since the establishment of the Ten Year Long- term Care Program in 2007. However as mentioned above, the Program is relatively new and some integrative resources are not well connected. Support for the families caregivers has to be established as part of comprehensive social security nets (Chapter 5.1.4).

With the increasing number of Alzheimer's disease sufferers, Taiwan's long- term care system does not provide a comprehensive and regular care service for them. Currently, most non-profit organizations run before governmental policy, established "group homes", and the care park to provide an environment to care for sufferers (Chapter 2.1).

Compared with Germany's model, despite, Taiwan having already had experiences of Alzheimer's disease, since 2015, Germany's long- term care insurance has enacted the related legislation to support people with Alzheimer's disease. Thus, the support and benefits for caring for people with dementia exists on a legal basis. This process of formulation plays an

important role in the long- term care system (Chapter 6.4.1).

7.2 Conclusion

When reviewing the background of Germany's long- term care insurance policy, it is clearly to Taiwan's situation. A growing ageing population, low fertility rate and changes in family structure bring with them at heavy burden on the financial status of households in both countries (Chapter 1). Over the years, Germany has faced an aging population problem, but the long-term care insurance system still provides considerable assistance and effectiveness to all families. Germany established its Long- term Care Insurance based on the principle of social autonomy. Instead of standing as the provider of long- term care services, Germany chooses to collaborate with the private sector. Moreover, under the principle of the social state and the obligation of protecting citizens, the government plays the role of supervising controls over the quality of care for people who need long- term care services (Tsai, 2014). Therefore, it offers a valuable example for Taiwan.

Facing the rapid demand for a stable and comprehensive long- term care system, Taiwan established many programs to support and care for people who need long- term care services. However, until now, the whole system has been a patchwork, and so how to establish comprehensive long- term care systems, which combine successfully with other social welfare systems part of its social security nets will be an urgent issue for Taiwan.

Despite the different cultures and social welfare models in both Germany and Taiwan, we still

can find the same common point. Through its Bismarckian model, Germany has had experience with health insurance for over 100 years. The social welfare scheme in Germany follows and is designed by the social insurance scheme. In Taiwan, the Constitution states that the welfare scheme will follow social insurance to establish social security nets to protect its people.

The experience of Germany's model will be an important blueprint for Taiwan no matter what its advantages or shortcomings. It still has a long way to go, but hopefully this dissertation will provide some useful suggestions to Taiwan as it seeks to establish its own system.

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Appendix

Long- term Care Service Act

Long-Term Care Services Act

Published by Presidential Order Hua-Zhong-Yi-Yi-Zhi No. 10400064391 dated 3 June 2015

Chapter 1	General
Article 1	This Act is established in order to complete a long-term care service system providing long-term care services, to ensure the quality of care and support services, to develop universal, diversified and affordable services and to guarantee the dignity and the interest of the persons receiving the services and the care providers. In providing long-term care services, there shall be no discrimination that differentiates based on the gender, sexual orientation, gender identity , marriage, age, physical or mental disabilities, illness, social class, race, religious belief, nationality or place of residence of the persons receiving the services.
Article 2	The competent authority referred to in this Act is: the Ministry of Health and Welfare as the central competent authority, municipal governments for municipalities and county (city) governments for counties (cities) as local competent authorities.
Article 3	The terms in this Act are defined as follows: 1. Long-term care: Means the living support, assistance, social participation, care and relevant healthcare services in accordance with the needs of any individual whose mental or physical incapacity has lasted or is expected to last for six months or longer, or the needs of such an individual's care provider. 2. Person with physical or mental incapacity (the "disabled"): Means a person who has suffered partial or full loss of his physical or mental functions and who needs the assistance of others in his/her daily life. 3. Family caregiver: Means the main family member or household member who provides regular care to the disabled in the family. 4. Long-term care personnel: Means a person who is certified through training and certification in accordance with this Act to provide long-term care services. 5. Long-term care service institution: Means an institution established in accordance with this Act for the purpose of providing long-term care services or long-term care needs assessment of services. 6. Long-term care management center: Means an authority (institution) designated by the central competent authority for the purpose of providing assessment and linking services for long-term care needs. 7. Long-term care service system: Means the network composed of long-term care providers, long-term care institutions, financial and relevant resource development, management and referral mechanisms. 8. Individual care workers: Means a person hired on an individual basis to provide care at the homes of the disabled.
Article 4	The following matters shall be managed by the central competent authority: 1. Provision of long-term care services, establishment of national long-term care policies and regulations and planning, establishment and promotion of the long-term care service system. 2. Supervision and coordination of long-term care executed by municipalities and counties (cities). 3. Planning for the protection of the interest of long-term care service users. 4. Development of and rewards to long-term care institutions, as well as

	evaluations to be carried out by the central competent authority as provided under Paragraph 3, Article 39. 5. Cross-county/city assistance and supervision of long-term care institutions. 6. Planning for the management, incubation and training of long-term care providers. 7. Planning, raising, allocation and subsidies of funding for long-term care. 8. Research, development and monitoring of the information systems and service quality of long-term care. 9. Planning and promotion of international cooperation, exchange and innovative services of long-term care services. 10. Coordination of long-term care services in areas lacking resources. 11. Other planning and supervision of national long-term care services.
Article 5	The following matters shall be managed by the local competent authority: 1. Provision of long-term care services, establishment of long-term care policies under jurisdiction and planning, promotion and execution of the long-term care service system. 2. Execution of the long-term care service policies, regulations and relevant plans established by the central competent authority. 3. Performance of local long-term care service training. 4. Supervision and evaluation of long-term care institutions under jurisdiction and appraisal to be performed by the local competent authority in accordance with Paragraph 3, Article 39. 5. Planning, raising, allocation and subsidies of local sources of long-term care funding. 6. Rewards to long-term care institutions in areas of development difficulties or where resources are lacking. 7. Other long-term care services of a local nature.
Article 6	When the matters provided in this Act involve the duties of the central industry competent authorities, the duties shall be allocated as follows: 1. Educational competent authority: Long-term care education, Long-term care, human resources development and the sporting activities, locations, facilities and equipment for users of long-term care services. 2. Labor competent authority: Labor conditions, employment services and occupational safety and health for long-term care personnel and individual care workers, as well as the training and technical certification for long-term care providers without professional medical or social worker's certificates and individual care– workers. 3. Veterans competent authority: Long-term care for veterans. 4. Construction, building and fire safety competent authorities: Building and management of long-term care institutions, obstacle-free environments of public facilities and building and fire safety. 5. Indigenous peoples affairs competent authority: Coordination and contact for long-term care for indigenous peoples and assistance with the planning and promotion of relevant matters. 6. Technology research competent authority: Assistance with technical research and development, technical and research transfer and applications of long-term care services. 7. Other industry competent authorities: Long-term care related matters that are relevant to these authorities.
Article 7	The heads of the competent authorities shall serve as organizers to invite long-term

	care related scholars and experts, representatives from relevant private institutions and organizations, representatives of service users and representatives from each industry competent authority for the coordination, study, review and consultation of long-term care services, development of domestic long-term care human resources, fee payments and reimbursements, staff salaries, supervision and evaluation. Among the representatives as set forth in the previous paragraph, the relevant scholars, experts and the representatives from relevant private institutions, organizations and service users shall represent at least two-thirds of the participants. The service users and the representatives of either gender shall each represent at least one-third of the participants. There shall be at least one expert scholar who represents the indigenous people or who is familiar with indigenous peoples' culture.
Chapter 2	Long-Term Care Services and Long-Term Care Service System
Article 8	The central competent authority may publish the specific scope of long-term care services. Applications for the services as set forth in the previous paragraph shall be evaluated by the long-term care management center or the municipal or county (city) competent authority. The municipal or county (city) competent authority shall provide services based on the results of the – assessment. If long-term care services with healthcare is to be undertaken, an opinion must be issued by a physician and the long-term care management center or the municipal or county (city) competent authority should perform the assessment. The competent authority shall provide subsidies for services as set forth in the second paragraph in accordance with the level of disability and the economic status of the family. If any other legislation also allows for application for the same nature of service subsidiary, only one application shall be filed. The evaluation as set forth in the second and third paragraphs may be outsourced to a professional organization. The standard and method of evaluation, the qualification of staff and other relevant matters shall be published by the central competent authority. The amount or percentage of subsidy as set forth in the fourth paragraph shall be determined by the central competent authority.
Article 9	Long-term care services are divided into the following types based on the manner they are provided: 1. Home services: The services are provided at home. 2. Community-based services: A certain location and facilities are put in place in a community to provide day care, family care, temporary housing, group homes, small-size multi-function services and other integrated services, but excluding the services in Subparagraph 3. 3. Institutional services: The persons receiving care move into the long-term care institutions where full-time care or night care services are provided. 4. Family caregiver supportive services: Fixed-location and home supportive services provided to family caregivers. 5. Other manners of services published by the central competent authority. Long-term care institutions may provide integrated services listed in the previous paragraph. For the consolidated community services under Subparagraph 2, Paragraph 1, the municipal or county (city) competent authority may invite community representatives, representatives of long-term care providers and expert scholars for

	coordination, review and consultation on long-term care services and relevant plans, division of areas of consolidated community services, development of community human resources for community long-term care services, fee collections and reimbursements, staff salaries, scope of services and dispute coordination. The arrangements may be made together with the arrangements under Article 7.
Article 10	Long-term care services provided at home are defined as follows: 1. Physical care services 2. Daily life care services 3. Domestic chore services 4. Food and nutritional services 5. Auxiliary appliance services 6. Necessary home facility adjustment and improvement services 7. Psychological support services 8. Emergency rescue services 9. Healthcare services 10. Services for prevention of other or aggravated disability conditions. 11. Other long-term care related services that can be provided at home as determined by the central competent authority.
Article 11	Long-term care services provided in communities are defined as follows: 1. Physical care services 2. Daily life care services 3. Temporary housing services 4. Food and nutritional services 5. Auxiliary appliance services 6. Mental support services 7. Healthcare services 8. Transportation services 9. Social participation services 10. Services for prevention of other or aggravated disability conditions. 11. Other long-term care related services that are community-oriented as determined by the central competent authority.
Article 12	Institutional residential long-term care services are defined as follows: 1. Physical care services 2. Daily life care services 3. Food and nutritional services 4. Residential services 5. Healthcare services 6. Assistive device services 7. Psychological support services 8. Emergency rescue services 9. Family member education services 10. Social participation services 11. Services for prevention of other or aggravated disability conditions. 12. Other long-term care related services that can be provided through institutional residential care as determined by the central competent authority.

Article 13	The scope of supportive services provided by family caregivers are defined as follows: 1. Provision and referral of relevant information. 2. Long-term care knowledge and technical training. 3. Respite care services 4. Emotional support and referral of group services 5. Other services that help promote the capability of family caregivers and the life quality thereof. The application, assessment, provision and other matters of compliance in relation to the supportive services as set forth in the previous paragraph shall be determined by the central competent authority.
Article 14	The central competent authority shall conduct regular surveys on long-term care related resources and requirements and shall take into consideration the characteristics of diversified cultures. Long-term care services development plans shall be established and necessary rewards and assistance measures shall be undertaken for special circumstances in offshore and remote regions. The central competent authority shall consult with the Council of Indigenous Peoples for the long-term care service plans, long-term care service areas and the planning and promotion of human resources development in the indigenous peoples' regions. The central competent authority shall reward and assist research related to long-term care innovative services. The regulations about the scope and manner of rewards and assistance as set forth in the first and second paragraphs, the establishment of long-term care institutions or the restrictions on the expansion thereof, as well as the division of long-term care service regions and human resources development as set forth in the second paragraph shall be established by the central competent authority.
Article 15	To promote the development of long-term care related resources, improve service quality and efficiency and enrich and balance services and human resources, the central competent authority shall establish a long-term care service development fund. The amount of the fund as set forth in the previous paragraph shall be at least Twelve Billion NT Dollars and shall be budgeted over five years. The sources of the fund are as follows: 1. Government budget allocation 2. The Health and Welfare Surcharge contributions 3. Donations 4. Proceeds from the fund 5. Other income. The amount and sources of the fund shall be reviewed 2 years after the implementation of this Act.
Article 16	The central competent authority shall establish an information system for the care and management of service users, service workers management and the management of long-term care institutions and the service quality thereof as the basis for adjustment to long-term care policies. This system should be published in accordance with the law. The competent authorities and each long-term care institution shall provide the information required in the previous paragraph.

Article 17	When any non-for-profit long-term care institution needs to use any government real property that is not used for public purpose in accordance with national policy, it may file an application with the competent authority to approve a lease by the management authority of such real properties in accordance with the law. For rental standards, the annual rent shall be charged based on the land value tax and housing tax payable for such land and buildings for the current period in accordance with the law. If the purpose of land use must be changed for the land in the previous paragraph, the long-term care institution shall file an application with the competent authority for approval and forwarding to the relevant authority for further handling in accordance with the regulations. The application procedure, conditions and other compliance matters for the applications in the first paragraph shall be established by the central competent authority.
Chapter 3	Management of Long-Term Care Personnel.
Article 18	The specific scope of long-term care services published by the central competent authority shall be provided by long-term care personnel. The training, continuous education and on-the-job training programs for long-term care personnel shall take into account the differences among regions, ethnic groups, genders, specific illnesses and care experiences. Long-term care personnel shall accept continuous education and on-the-job training with certain accumulation of points. The regulations for the training, certification, continuous education program and determination of points, validity of certification and the renewal thereof for long-term care personnel shall be established by the central competent authority.
Article 19	No long-term care-personnel shall provide long-term care services unless he/she is enrolled with a long-term care institution, except healthcare providers and social workers who are registered in accordance with other applicable laws and have completed training and certification in accordance with Paragraph 4 of the previous Article and a filing has been done with and approved by the competent authorities. No long-term care institution shall house any person who is not long-term care personnel to provide the long-term care services in Paragraph 1 of the previous Article. Any change of registered matter in Paragraph 1 shall be filed for approval within 30 days from the date of change with the competent authority of the place where the long-term care institution is located. The registration conditions, procedure, location, scope of service, disqualification and cancellation, temporary support and other compliance matters as set forth in Paragraph 1 shall be determined by the central competent authority.
Article 20	No long-term care–personnel shall disclose any other person's confidential information learned or held due to professional activities unless it is in accordance with the law.
Chapter 4	Management of Long-Term Care Institutions
Article 21	Long-term care institutions are divided into the following categories based on the scope of their services: 1. Home services 2. Community services

	3. Institutional residential services 4. Integrated services 5. Other services published by the central competent authority.
Article 22	The long-term care institutions under Subparagraph 3 and the long-term care institutions under Subparagraphs 4 and 5 that provide institutional lodging services shall be established by judicial persons and judicial corporations (hereinafter collectively known as “long-term care corporate institutions”). The previous paragraph is not applicable to government long-term care institutions. The establishment, organization, management and other compliance matters for long-term care corporate institutions as set forth in the first paragraph shall be further established by law within one year from the date of implementation of this Act.
Article 23	The establishment, expansion and relation of long-term care institutions shall be subject to prior application with and approval by the competent authorities.
Article 24	The regulations concerning the conditions for application, standards for establishment, qualification of representatives, application procedure, review criteria and proof of establishment approval for the establishment, expansion and relocation of long-term care institutions shall be established by the central competent authority. The establishment of long-term care institutions in indigenous areas and the staff allocation shall be determined by the central competent authority in consultation with the Council of Indigenous Peoples.
Article 25	Any business suspension, business closure, business reinstatement or change of any matter registered in the approval certificate by any long-term care institution shall be filed with the competent authority for approval within 30 days from the date of occurrence of the event. The period of business suspension as set forth in the previous paragraph shall not exceed one year. If required, an extension of one year may be granted through application. After this period, business closure shall take place. Business closure shall take place within 30 days of the expiry date of the period of business suspension. If business closure is not carried out before such a deadline, the competent authority may cancel the approval of the establishment. The central competent authority shall establish the regulations concerning the application procedure and review as set forth in the first and second paragraphs.
Article 26	If a long-term care institution is established by a government authority (institution), the name of the government authority (institution) shall be included as the prefix of the long-term care institution’s name. If it is established by a private institution, the word “private” shall be included as a prefix of the institution’s name. The name of the long-term care institution shall be displayed in its location in conspicuous characters in accordance with the previous paragraph. The type of the institution and the scope of services should also be identified.
Article 27	The name “long-term care institution” shall not be used other than by a long-term care institution.
Article 28	The following names shall not be used by long-term care institutions: 1. The same name used by any long-term care institution whose permit for establishment has been cancelled or whose establishment has been approved by the competent authority in the same municipality or county (city). 2. Any name that may cause confusion with any government authority or other

	public-interest organization.
Article 29	No one other than long-term care institutions shall engage in any advertising for long-term care services. Advertising for long-term care institutions shall be limited to the following: 1. Name of the long-term care institution and specifications under Paragraph 2, Article 26, date of incorporation, approval certificate number, address, telephone number and traffic route. 2. Name, academic and professional background of the representative of the long-term care institution. 3. Professional and technical certificates of long-term care–personnel or number of justification document provided in this Act. 4. Manner and hours of services. 5. Business suspension, business closure, business reinstatement, relocation and the date thereof. 6. Fee schedules approved by the competent authority. 7. Other matters that may be displayed or broadcasted as published by the central competent authority.
Article 30	Long-term care institutions shall have one business representative to be responsible for the supervision of the business of the institution. The qualifications of the business representative in the previous paragraph shall be determined by the central competent authority.
Article 31	If the professional representative of any long-term care institution cannot perform his/her duties for any reason, he/she should designate a deputy who is qualified to serve as the business representative. If the period of designation exceeds 30 days, a report shall be filed with the competent authority of the place where the institution is located for approval. The period of designation as set forth in the previous paragraph shall not exceed one year.
Article 32	The central competent authority shall establish a linking mechanism among the long-term care service system, healthcare system and social benefit service system, providing the service users effective referral and consolidated services.
Article 33	Long-term care institutions providing residential services shall enter into healthcare service agreements with healthcare institutions that can accept timely referrals or that can provide the required healthcare services.
Article 34	Long-term care institutions providing residential services shall purchase public accident liability insurance to ensure the lives and safety of the users of long-term care services. The central competent authority shall determine the scope and amount of insurance to be purchased in consultation with the industry competent authority.
Article 35	The central competent authority shall assist local competent authorities to refer to local income levels, consumer price index and service quality and provide the long-term care institutions with fee charge reference information. The fee items and amounts charged by long-term care institutions shall be reported to the competent authority of the place where the services are provided for approval, including any change thereto.
Article 36	When the long-term care institution charges a fee, a receipt should be provided, stipulating the fee item and amount. No long-term care institution shall breach the fee charge rules under the previous Article, overcharge or create any fee items without authorization.
Article 37	Long-term care institutions shall display the certificate of establishment, fee

	schedules, service items and complaint channels put in place by the competent authority in a conspicuous location inside the institution.
Article 38	Long-term care institutions shall procure that their registered long-term care personnel prepare records of matters related to the provision of long-term care services. Records as set forth in the previous paragraph concerning healthcare shall, in addition to retention in accordance with healthcare legislations, be maintained by the long-term care institutions for at least seven years.
Article 39	The competent authority shall perform assistance, supervision, evaluation, inspection and review of long-term care institutions. The competent authority shall also ask the long-term care institutions to provide service related information as required. The long-term care institutions shall provide the required assistance and shall not avoid, interfere with or reject such requests. The evaluation results set forth in the previous paragraph shall be published. The target, contents, manner and other matters about the evaluation set forth in the first paragraph shall be determined by the central competent authority.
Article 40	The competent authority shall establish the standard of quality of long-term care services as follows: 1. User-oriented services and providing proper services 2. Public and transparent information 3. Participation by representatives of home care providers 4. Consideration of diversified cultures 5. Ensuring care and life quality.
Article 41	If any long-term care institution suspends or closes its business, the users of the long-term care services shall be property referred or placed. If referral or placement is not possible, the competent authority shall assist with the referral and placement and the long-term care institution shall provide cooperation. Any long-term care institution that fails to carry out referral or placement in accordance with the previous paragraph may be subject to enforcement by the competent authority. The long-term care institution to which the service users are referred shall cooperate with the competent authority to provide necessary assistance.
Chapter 5	Protection of Interest of Long-Term Care Service Receivers
Article 42	In providing long-term care services, the long-term care institutions shall enter into written contracts with the users of long-term care services, family members or fee payers. Concerning the format and contents of the contracts set forth in the previous paragraph, the central competent authority shall establish standard contract templates and the matters that must and must not be included.
Article 43	No video recording, audio recording or filming shall be allowed without the written consent of the users of long-term care services, nor shall their names, dates of birth, residences (domiciles) or other personally identifiable information be reported or specified. If the service user cannot give consent, the written consent shall be given by the legal representative or the closest family member who is the main care provider. To the extent required for the safety of the users of long-term care services, long-term care institutions may install monitoring equipment and shall not be restricted by the previous paragraph, provided that notice is given to the users of long-term care services, their legal representatives or closest family members who

	are the main care providers.
Article 44	Long-term care institutions and their personnel shall provide proper care and protection for the users of long-term care services and shall not abandon, physically or mentally abuse, discriminate, harm, restrict physical freedom or engage in any other matters that infringes upon their interests.
Article 45	The competent authority shall establish a petition, complaint and mediation mechanism to handle public complaint cases and disputes mandated by long-term care service departments.
Article 46	The local competent authority shall supervise, either alone or together with private organizations, the quality of long-term care services provided to users of institutional lodging long-term care services who are not dependents of any other person or who do not have any legal representative. The long-term care institutions shall not refuse to comply.
Chapter 6	Penalties
Article 47	Any long-term care institution that breaches Article 23, Paragraph 1, Article 41 or Article 44 shall be subject to a fine of not less than NT$60,000 and not more than NT$300,000. Any long-term care institution that breaches Article 23 shall, in addition to the fine set forth in the previous paragraph, remedy the breach before the deadline. Cumulative penalties may be imposed if the breach is not remedied before the deadline. Any one other than an established long-term care institution that provides long-term care services shall be subject to the penalties as set forth in the previous two paragraphs and shall also be ordered to close its business. The name of the institution and the name of the representative will be published. If a long-term care institution breaches Article 44, in addition to the penalty as set forth in the first paragraph, such institutions shall also be ordered to remedy the breach. If the breach is not remedied before the deadline, the institution shall be suspended for not less than one month and not more than one year. If the breach is still not remedied upon expiry of the suspension period, the permit for the establishment of the institution may be cancelled. Any long-term care institution that breaches Article 44 in a material manner may be subject to cancellation of the permit for its establishment.
Article 48	If a long-term care institution breaches the standards for establishment approval, an order shall be issued to seek a remedy. If the breach is not remedied by the deadline, a fine of not less than NT$60,000 and not more than NT$300,000 shall be imposed and the institution shall be ordered again to remedy the breach. If the breach is still not remedied by the deadline, the permit for its establishment may be cancelled.
Article 49	If a long-term care institution breaches Paragraph 2, Article 36, a fine of not less than NT$30,000 and not more than NT$150,000 shall be imposed. The institution shall also be ordered to reimburse any charges made without authorization.
Article 50	Any of the following events shall be subject to a fine of not less than NT$10,000 and not more than NT$50,000: 1. Breach of Paragraph 1, Article 18 by any long-term care provider, providing specific long-term care services published by the central competent authority. 2. Breach of Paragraph 2, Article 19 by any long-term care institution, lodging any person who is not long-term care–personnel to provide long-term care services.

	3. Breach of Article 27 by any entity that is not a long-term care institution, using the name of a long-term care institution.
Article 51	If a long-term care institution breaches Paragraph 1, Article 25 and displays or broadcasts any form of advertisement other than those listed under Paragraph 2, Article 29, or if any advertising content is false, a fine of not less than NT$10,000 and not more than NT$50,000 shall be imposed. An order shall also be issued to seek a remedy. If the breach is not remedied by the deadline, cumulative penalties may be imposed. If an entity that is not a long-term care institution breaches Paragraph 1, Article 29 and engages in any advertising for long-term care services, a fine of not less than NT$10,000 and not more than NT$50,000 shall be imposed.
Article 52	In providing long-term care services, if a long-term care institution fails to sign written contracts in accordance with Article 42, or if the provisions of the contract breach the matters that must be and must not be included as required by the central competent authority in accordance with Paragraph 2 of the same Article, the institution shall be ordered to remedy the breach. If the breach is not remedied by the deadline, a fine of not less than NT$10,000 and not more than NT$50,000 shall be imposed. Cumulative penalties may be imposed.
Article 53	Any long-term care institution with any of the following events shall be subject to a fine of not less than NT$6,000 and not more than NT$30,000: 1. Breach of Paragraph 3, Article 19 in failing to make a filing regarding a change of long-term care personnel in a long-term care institution with the competent authority of the place where the institution is located for approval before the deadline. 2. Breach of Paragraph 1, Article 31 in failing to designate a qualified deputy when the business representative cannot perform his/her duties for any reason or failing to make a filing with the competent authority of the place where the institution is located for approval within 30 days from the designation. 3. Breach of Article 33 in failing to sign a healthcare service contract with the healthcare institution that can accept timely referrals or that can provide the necessary healthcare services. 4. Breach of Article 38 by long-term care personnel in failing to prepare and maintain records in accordance with the law concerning the long-term care services provided. 5. Breach of Paragraph 1, Article 39 in avoiding, interfering with or rejecting the appraisal, assistance, supervision, evaluation, inspection by the competent authority or providing service related information. If a long-term care institution breaches Paragraph 1, Article 31, Article 33 or Article 38, in addition to the fine imposed in accordance with the previous paragraph, the institution shall also be ordered to remedy the breach. If the breach is not remedied by the deadline, the business shall be suspended for not less than one month and not more than one year. If a long-term care institution fails to pass appraisal in accordance with Paragraph 1, Article 39, the institution shall be ordered to remedy the failure. If the failure is not remedied by the deadline, a fine of not less than NT$60,000 and not more than NT$300,000 shall be imposed for long-term care institutions providing institutional lodging services. For long-term care institutions providing other types of services, the fine shall be imposed in accordance with Paragraph 1. If the failure is not remedied by the deadline, cumulative penalties may be imposed. In serious cases, the business may be suspended for not less than one month and

	not more than one year. If the failure is still not remedied upon expiry of the suspension period, the permit for the establishment may be cancelled.
Article 54	If long-term care personnel breaches Article 20, the business representative of a long-term care institution breaches Article 30 or a long-term care institution breaches Paragraph 1, Article 43, a fine of not less than NT$6,000 and not more than NT$30,000 shall be imposed and an order to remedy the breach shall be issued. If the breach is not remedied by the deadline and in serious cases, the business shall be suspended for not less than one month and not more than one year. If a long-term care institution breaches Paragraph 1, Article 19 by having its long-term care personnel provide long-term care services without filing with the local competent authority for approval, a fine of not less than NT$6,000 and not more than NT$30,000 shall be imposed.
Article 55	If a long-term care institution breaches Paragraph 1, Article 36 or Article 37, an order shall be issued to demand remedy of the breach. If the breach is not remedied by the deadline, a fine of not less than NT$6,000 and not more than NT$30,000 shall be imposed.
Article 56	Any long-term care personnel with any of the following events shall be subject to a fine of not less than NT$6,000 and not more than NT$30,000. Business suspension of not less than one month and not more than one year may also be ordered. In serious cases, the certificate may be cancelled. 1. Making false records in performing duties. 2. Allowing another person to use his/her long-term care personnel certificate. 3. Breach of Article 44.
Article 57	Any long-term care institution that hires any individual care worker that did not receive the training under Paragraph 1, Article 64 shall be subject to a fine of not less than NT$3,000 and not more than NT$15,000.
Article 58	Any of the following events shall be subject to a fine of not less than NT$3,000 and not more than NT$15,000: 1. Any long-term care personnel providing long-term care services without completing the enrollment procedure in accordance with Paragraph 1, Article 19. 2. Any long-term care personnel provides long-term care services without completing the renewal of an expired license
Article 59	Any long-term care institution with any of the following events may have its establishment approval cancelled: 1. Clear management negligence in serious cases, resulting in injury or death of any receiver of long-term care services. 2. Serious breach of this Act by any long-term care–personnel in providing long-term care services that is attributable to the institution. 3. Failure to suspend business pursuant to a suspension order. The determination of the events under Subparagraphs 1 and 2 of the previous paragraph shall be investigated by a dispute resolution committee organized by the competent authority. The invested party shall be given the opportunity to state its opinions. The composition of the dispute resolution committee shall be determined by the central competent authority.
Article 60	The penalties provided in this Act shall be imposed by the local competent authorities.
Chapter 7	Miscellaneous

Article 61	Any person providing the long-term care services defined in this Act in accordance with other laws before the implementation of this Act may continue to provide long-term care services for 2 years after the implementation of this Act and shall not be restricted by Paragraph 1, Article 18. The training program for the personnel as set forth in the previous paragraph, the consolidation of the program before the implementation of this Act and the conversion of titles and determination standards for existing certificates shall be determined by the central competent authority.
Article 62	Before the implementation of this Act, any authority (institution), corporation, organization, cooperative or firm that provides long-term care services in accordance with other laws before the implementation of this Act (hereinafter "long-term care related institutions") shall complete the application for the establishment of long-term care institutions or complete conversion and issuance/replacement of approval documents for the establishment of long-term care institutions in accordance with the provisions of this Act within 5 years from the implementation of the Act. If the approval is not acquired or if the license is not issued/replaced before the deadline, no long-term care services shall be provided. Any long-term care related institution as set forth in the previous paragraph providing residential services as a private institution shall not be restricted by Paragraph 1, Article 22. The conversion and the issuance/replacement of approval documents for establishment as set forth in the previous paragraph may be completed by using the original name of the long-term care institution providing lodging services as a private institution. However, the representative thereof or the expansion, reduction, relocation or change of name of the long-term care institution shall remain subject to Paragraph 1, Article 22. In relation to the management of long-term care related institutions, within the deadline as set forth in the first paragraph and before the establishment approval of completion of conversion, in addition to other applicable laws, Articles 18, 19, 23, 39 to 45 and the previous article shall apply mutatis mutandis. Any breach shall be subject to penalties in accordance with applicable provisions. The application for conversion, procedure and other compliance matters as set forth in the first paragraph shall be determined by the central competent authority.
Article 63	Veteran homes established in accordance with the ROC Veterans Assistance Act as long-term care institutions providing exclusively long-term care services to veterans and the placement of their family members shall be subject to the provisions of this Act concerning the standards of establishment, qualifications of professional representatives and training, certification standards and appraisal of long-term care personnel, excluding the application of Articles 23, 25 and 35 concerning the establishment and approval procedure. However, a filing shall be made with the local competent authority for reference within 30 days from approval by the superior competent authority. Article 14 is not applicable to the long-term care institutions as set forth in the previous paragraph.
Article 64	Individual care workers shall receive designated training published by the central competent authority. For any foreign national that enters the Republic of China for the first time after the implementation of this Act and is hired by a family of the disabled to perform individual care work, the employer may file an application for such a care provider to receive supplemental training determined by the central competent authority.

	The program, fee rate, application procedure and other compliance matters for the supplemental training as set forth in the previous paragraph shall be determined by the central competent authority.
Article 65	The enforcement rules of the Act shall be established by the central competent authority.
Article 66	This Act shall be implemented 2 years after its publication.