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**Partnership Working in the Long-term Care
System for Older People:
Cross-national Learning from England, the Netherlands and Taiwan**

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ABSTRACT

This paper based on qualitative cross-national research at national, municipal and local level in England, the Netherlands and Taiwan explores whether relevant actors were sharing the same goals, whether they communicated well with each other and whether they were working together with the service users. Through horizontal and vertical partnership analysis, the study found the care actors from top to bottom were not always sharing the same goals and priorities about how long-term care should be delivered. The split between health and social care in the care system has constituted a great challenge in working in partnership in English and Taiwanese practice. Whereas having a strong culture and ideology of solidarity and consultation embedded in the care system has helped the Dutch care actors to have a more equal working partnership. Most importantly, the involvement of all the care actors in policy and practice planning and decision-making is crucial if a better joint-working structure to fulfil the policy intention of providing a seamless long-term care service in practice is to be achieved.

< Key-words >

partnership, long-term care, older people, England, the Netherlands, Taiwan

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I. Background

Due to the complex care needs of older people and higher life expectancy, no one is any longer able to meet such demands alone. One way to strengthen the care support of older people is to improve partnership working within the care system. The aim of such an approach is to harness the energy, skills and resources of the key players who develop, implement or use long-term care services. This is especially important to fulfil the multiple care needs of the chronically ill (Bień et al., 2013; Leichsenrig, 2004).

Policy initiatives from all three long-term care systems researched here have reflected the intention to move from working in isolation to integration and joint-working. In England where there is strongly decentralised care responsibility and a privatised care market, partnership working has been a key component of the government's modernisation agenda in the last 40 years, particularly in the health field. The NHS Plan for England (DH, 2000) and Care Act 2014 require a 'duty of partnership' between the NHS, local authorities and local service providers. Equally, in the Netherlands, which has a strong state caring responsibility, social insurance funding system and predominately non-profit care market, the Exceptional Medical Expenses Act (AWBZ) (1968), the Social Support Act (WMO) (2007) and the Long-term Care Act (WLZ) (2015) regulate participation between clients, central government, regional care offices, local authorities and insurers. In Taiwan, where there is a strong familial society with a mixed non-profit and for-profit care market and the state responsibility is increasing, the National Health Promotion Plan and the Rehabilitative Care and Long-term Care Plan were implemented in 1991 (DH, 1997; Juan, 1999). These were reinforced in 1998 by Long-Term Care of Older People – a three year plan, to integrate and merge social, health and retirement military care into a holistic, long-term, care network (LTC Association, 2003). This was followed by the Long-term Care Service Act 2015 which should take effect from 2017 to further integrate scarce resources and to meet the increasing cost of care (Chou et al., 2014).

Although the care policies of the three countries have been actively developing partnership, joint working and service integration; four sets of questions have been raised about the potential extent of collaboration between relevant care actors in the long-term care systems. Firstly, there is an unequal power between the Department of Health and local government; and between local authority public services and voluntary and private organisations in England. As a result, in each case, the latter has the least power and incurs a larger burden of costs (Care Quality Commission, 2016; Means et al., 2002; Glendinning et al., 2001). Considerable interagency variations in the take-up of long-term care responsibilities in Taiwan seem to result, to some extent, in difficulties in policy-making and the organization and administration of aged care services (Lin et al.,

2013). Secondly, reluctance to fund shared and joint-service delivery - caused by different lines of accountability and lack of role clarity between each partner, such as the financial split between health and social care as well as between public, private and voluntary sectors in England and Taiwan - has hindered integrated care development and delivery in the countries studied. Thirdly, culture clashes can often be expected between people who come from different levels and organisations and who need to find ways of working together. Social- and health-care staff may have different perspectives on tackling joint issues, as seen in the English experience where the 'Berlin Wall' between health and social care professionals has been well documented (Hudson, 1999 and 2009; Balloch and Taylor, 2002; Mangan et al., 2015). In order to overcome this, the Care Act 2014 was introduced to further emphasise the importance of partnership working in the English care system. Fourthly, structural factors that cover different geographical areas and ICT systems, can make it difficult for parties or individuals to link with their opposite numbers (Cameron et al., 2014; Llug and Abadie, 2013). Any of these barriers can contribute to distrust.

While the principle of partnership is now quite widely accepted nationally and internationally to reinforce the traditional value of service provision and help to keep 'quality in care' a unifying concept, there is too little acknowledgement of how the best examples can demonstrate a lasting impact on the life quality of older people who need care on a broad and multidimensional basis (Janse et al., 2016; Cameron et al., 2014; Kümpers et al., 2002). The value added by partners and the associated impact attributed to them need to be better measured (Glendinning, 2002; Newman et al., 2008). A degree of consensus between academics and policy makers exists on the key measurement criteria of successful partnership. Outcomes such as accessibility, acceptability, accountability, effectiveness, efficiency, equity, implementation and responsiveness appear to be common across studies (Petch et al., 2013; Dowling et al., 2004, Glendinning, 2003). However, there has been little cross-national and cross-level assessment. More evidence is required on the evaluation of different models and structures of partnerships, about the outcomes for different partners and stakeholders, including those directly involved (i.e. service users, carers, professionals and service providers) and those with a wider interest in the success of initiatives (i.e. civil servants at national level and local administrators). While there has been a number of practice-based studies, research tends to focus on a specific project (i.e. Janse et al., 2016; Kassianos et al., 2015) or a particular level of the care system or form of collaboration (i.e. Humphries, et al., 2016; Bennett et al., 2015; Stuart and Weinrich, 2001). I would argue, firstly, that we need to examine whether partnerships in practice fulfil policy intentions. Secondly, we need to ensure that contributions from all organisations range across specialisms and can be integrated to achieve a more coordinated service for users and better joint-working structures for care contributors. Holistic research is needed to gather an overview of partnership working in the whole care system.

This paper, therefore, outlines the approaches that each care system has adopted and the difficulties that they were facing. The article is structured as follows. First, the concept of partnership adopted in this study is defined. Second, the research data are described and the methodology explained. Third, the results are discussed and the conclusions set out.

The concept of partnership

Partnership is not an entirely new phenomenon (for English examples see: Balloch and Taylor, 2001; Leathard, 2003; for Dutch examples see Mur-Veeman et al., 2003 and 2008; for Taiwanese examples see Kuan, 2000; Lai, 2002). Nevertheless, some commentators have noted that there is no single definition or model of this particular concept (Wilson and Charlton, 1997; Balloch and Taylor, 2001; Glendinning, 2003). It is often associated with many other labels, such as collaboration, co-ordination, co-operation, joint working, interagency working and networking (for example Huxham, 1996; Powell and Exworthy, 2002). All of these terms are concerned with “relationships” between relevant authorities, organisations and participants in the care system. People involved in partnerships have been defined at different levels:

- (1) Macro-level: the financing and policy context of the care system within a national or state ministry or on a country level;
- (2) Meso-level: the organisational context of the local level; and
- (3) Micro-level: individual service users (Glendinning, 2003).

Collaborative activities can be divided into two levels:

- (1) Strategic level: at which strategic decision-making concerning resource allocation and investment is coordinated; and
- (2) Operational level: at which service delivery is coordinated across people and functions.

Ideally, there should be both a horizontal (i.e. strategic and operational level) and a vertical (i.e. between macro, meso and micro level) link of decision-making, resulting in actions to improve the quality of care (Challis, 1998; Leichsenring, 2004). In reality, this ideal is difficult to put into practice. Cross-national research on integration by Kümpers et al. (2002) and Leichsenring (2004) suggest that different macro-institutional frameworks, and, particularly, different funding sources can have a different impact on the possibility of integrated care development. The Dutch Bismarckian insurance-based system comprises a public-private dimension which includes short- and long-term care provision with elements of the public, self-regulatory and the market competition model (Hardy et al., 1999). The English situation is more formal and complex. Based on the

tax-funded Beveridge system, this includes national healthcare and social services which are predominantly publicly funded but delivered by a mix of statutory, voluntary and private agencies. In Taiwan, two national departments and two sets of agencies for social and health care, combined with an individual and family funded system, result in difficulties in the organisation and administration of care services (Lee, 2002). There are, however, cultural and historical factors involved. For instance, Dutch values of solidarity, equality and needs-led services promote a more negotiated and self-governing system with a client-centred approach (Ex et al., 2004). The English network can be conceived of as operating within a relatively more hierarchical model of governance (Kümpers et al., 2002). In Taiwan on the other hand, the predominant NGO welfare tradition is more focused on flexibility, co-ordination and networking between different types of providers (Kuan, 2000).

II. Data and Methodology

The substantial focus of the study was to explore what constitutes good partnership working in long-term care systems. Evidence of the capacity within each care system was sought to discover: why were some societies able to promote partnership more than others? What successes and difficulties did each society experience in promoting partnership in long-term care? And how can countries learn from one another in their search for solutions? This study attempts to address those questions by centring on the views and experiences of older people and radiating out to their carers, professionals, local administrators, service providers, civil servants and voluntary agency officials holding care provision responsibilities. To minimise variation in the comparative research, the service users were female, aged over 60, from the majority ethnic group, and receiving formal care support. Women were chosen partly because of their propensity to live longer than men and thus their increased likelihood of needing long-term care. To maximise the range of service users in this research, five in each country received community care; two in each country received nursing care; and two received residential care in England and Taiwan. Additionally, three (including the one resident in the care hotel) received residential care in the Netherlands. As a result, out of a total of 143 interviewees (48, 43 and 52 in England, the Netherlands and Taiwan respectively), 28 older people were involved in this study as Table 1 shows.

<Table 1> Numbers of interviewees in this research

Interviewees	Number of interviews			
	England	The Netherlands	Taiwan	Total
Service users	9	10	9	28
Informal carers	6	1	3	10
Formal carers	5	9	9	23
Assessors	11	8	11	30
Service providers	10	7	8	25
Local administrators	4	4	6	14
National civil servants and voluntary agency officials	3	4	6	13
Total	48	43	52	143

III. Findings

What this section hopes to achieve is to outline the approaches that each country has adopted and the difficulties that they are facing. Partnership in this study is used in the sense of “cooperation”, to see whether relevant actors were sharing the same goals, whether they communicated well with each other and whether they were working together with the service users. To begin with, within each country there must be shared understandings of goals and expectations of the priority of care for partnership to work. This section first explores these goals at the policy level and then moves on to examine partnership horizontally (strategically and operationally) and vertically. Through horizontal and vertical analysis, we will be able to see how and whether partnership in each country studied can achieve better joint-working structures to fulfil the policy intention of providing a seamless, long-term, care service.

Expectations and goals

Common goals of long-term care across relevant care actors are crucial in the context of working in partnership. Goals can be objective (e.g. working towards standards of quality, efficiency and effectiveness), or subjective (e.g. aims, motives and purposes). From the grass-roots level, we have already seen in Chen (2007, 2014) that many older people and their families in the three countries studied emphasised the importance of care provision to meet the care needs of older people. In England, the reliability of the care services is a serious concern.

According to many national participants (8/13) across the countries, looking after older people in their own home for as long as possible is an important policy goal. Whenever possible this has been reinforced by increasing service innovation - such as housing renovation in England and the Netherlands - and technological innovations such as alarm systems and computing systems, in England, Taiwan and especially in the Netherlands.

Although empowerment and a client-centred approach are also clear goals in the three countries studied, there are a number of other goals within England and Taiwan which undoubtedly exacerbate the vulnerability of some older people in long-term care. For example, two out of three national participants in England were clear that the goal of trying to guard the basic safety of older people competed with their independence.

We'd look to provide a safe system from the worst of abuses and exploitation but not a safe system that therefore removes all the independence. Actually, we all take risks, so it's about getting the balance right (Civil servant, Department of Health, England).

In Taiwan, one of the goals of the national government is to develop an economic-oriented, long-term care system. It means reducing the national unemployment rate through increasing employment in the care sectors. Nevertheless, many of the national participants interviewed in Taiwan (4/6) and all in the Netherlands but none in England acknowledged that 'normalisation' is one of the goals in the long-term care of older people. We have already seen that in the Netherlands and to some degree in Taiwan, older people are socially included and that the care they receive is imaginative in meeting individual needs (for further discussion, see Chen, 2009). One of the important issues raised was that, at the time that this study was undertaken, social care priorities in English national policy were subordinated to the needs of healthcare or care for children in need:

Sometimes the only way we can make our argument about older people and social care is to demonstrate how it benefits the NHS, it drives us potty (Civil servant, Department of Health, England).

One of the things that is happening more frequently now is that money is not ring-fencedYou will find most of the money disappears to children. It's the way the whole of the money is allocated to Social Services ...There is always a bigger budget going to the NHS. You're worried about how much of that is actually being spent on older people (Senior official in Age Concern, England).

Implementation of the goals of national policy, by and large, depends on co-operation between local authorities and service providers. Nearly all of the participants at the meso-level in all three countries addressed the importance of promoting improvements in community care services. There were, nonetheless, some differences. In England and the Netherlands, the interview data suggested service integration was an important goal. English local administrators were focused on service integration for older people with intensive care needs in the new type of care homes (e.g. extra care housing). However, Dutch local administrators were focused more on the social well-being of older people - whether they lived in their own homes or care homes. This was one of the reasons which stimulated joint working with wider local authority departments and relevant agencies in the Netherlands:

We have to focus on all the issues. We need to make a happy life for older people ... it's not only about the stones for the house, you have to organise healthcare, education and travelling so that they have some meaning in their day and that they are doing something. They may think they have care problems but they can still do something for the community. All support is about the social integration (Project manager of Housing Association, the Netherlands).

In Taiwan, most of the local administrator respondents (4 out of 6) stated that an important goal for the local authority was a need to expand accessibility to local services such as day care and home care. However, from the local administrators' perspective, there were difficulties in priorities between the national and local levels. Such difficulties were partly the result of difficulties in the implementation of community care and social care locally. In spite of community care and ageing in the person's own home being clearly stated as a policy goal in all three countries, the interviews with local administrators suggest in practice that their national governments had other priorities. The local administrators interviewed in all three countries thought healthcare were the principal priority on the national care agenda and there is a need for more social care support:

... most of the government's focus has been on hospitals and on waits for going into hospital and so on, so government can, in effect, set priorities and provide performance targets which may be against some of its other statements and some for the things that locally you want to develop (Service Director of Social Services, England).

... the government has other priorities than we would like them to have ... for instance, projects which are short-term, should be long-term but because they have other priorities... they are busy with care about illness (Senior official, CSO, the

Netherlands).

The rapid increase in various service resources and choices were positive signs in Taiwanese care development at the moment but that an important goal for the future would be the need to focus on the expansion of mental and social support if the quality of the care was to be improved (Local government administrator, Taiwan).

Furthermore, although nearly all of the Dutch interviewees from top to bottom were satisfied with current standards of long-term care based on older people receiving generous and consistent care support; they were, nevertheless, concerned at maintaining individual normalisation, autonomy and social inclusion. Staff shortages - which might adversely affect the future of staff quality - were also a problem mentioned by all of the Dutch participants. According to the interviewees, technological innovation was one way of filling the gap in future staff shortages. In addition, maintaining the stability of care staff was another way of preventing increasing care pressures on families.

There were differences in the expectations and goals among different sectors of service providers (e.g. statutory, private and voluntary sectors) in the countries, which may link with their funding resources and the welfare ideology in their country. All of the Dutch voluntary sector interviewees who rely on state funding thought the responsibility for care, regulating policy and funding, should be shared between central government, service providers and families, which reflects the strong Dutch solidarity tradition. In England, most of the providers (8 out of 10) who rely on government funding stated that national government should regulate the local authority's responsibility for assessment and accountability; service providers should provide care according to the outcome of the assessment; and families should take the majority of the responsibility before services came into place. In Taiwan, however, all of the service provider participants agreed that the responsibility for care should be divided between the government (providing carer training, policy regulation and subsidies); service providers (being responsible for providing the service); with decision-making remaining with the families who provided funding and support for older people. Moreover, all of the Taiwanese and Dutch private for-profit service providers interviewed whose funding source is not from the state emphasised that they did not want to have the state interfering in their care provision and wanted to have autonomy.

I think we will never get anything from the government, because we are private ... I prefer also not to get anything from the government, because then the government is in a position to make rules and protocol and things, and, that's what we really don't want. We want to care in our very own way (Home care manager, the Netherlands).

We would like the government to interfere less with what we do and to keep the market free. It is not appropriate for the government to aim for a free market but interfere with prices at the same time. You won't find it in other industries ... (Foreign care agency manager, Taiwan).

The assessors in all three countries interviewed shared similar views regarding their care systems. Firstly, they felt that governments should stop emphasising saving money but focus on improving the quality of care. The Dutch assessors thought there should be more investment in updating care services, for instance, providing smaller scale service units within an institutional setting. They also thought the Dutch government should consider increasing services for older people and put less expectation on the families because there would not be so many family members available for their older people in the future. English assessor participants would like the government to put much more investment into the improvement of service resources. Service criteria could then be more generous and support more older people who need care. Similar views were expressed by Taiwanese assessor interviewees who emphasised the need for the Taiwanese government to review their funding criteria and processes, so that older people could access funding and care support appropriately.

Secondly, there were concerns about service accessibility. The English assessors stated that problems were closely related to resources. The Dutch assessors interviewed felt there was a great need for government to de-centralise the assessment process, to allow professionals to perform their professional skills of personal contact and advising the older people. In Taiwan, it was felt that more information should be made available to the public to help older people and their families be aware of their rights, to know what was available for them; and to reduce the cultural barrier of reluctance in asking for help. Moreover, the Taiwanese National Health Insurance should not restrict the range of healthcare delivered to older people's own homes and communities.

Finally, but most importantly for most English and Dutch assessors in this study, it was felt that bureaucracy limited front-line interaction and prevented adequate partnership working take place:

...if you have social interaction then you have mutual benefits from the work you do it's all theory to say this is what professionals should do and put everything in boxes, ... but in practice you need to see each other, you need to meet each other, you need to make this whole thing work together (Assessor, social worker of Ms Bowman, the Netherlands).

Overall, this section has evidenced some similarities and differences of expectation and goals between different levels of the care actors in the three countries. The question raised here is that if actors in the long-term care system do not always have similar goals and expectations, how can they cooperate and deliver appropriate care services and support to promote successful ageing in long-term care.

Horizontal partnership

With the above expectations and goals from the various actors interviewed in mind, we now examine horizontal partnership across the board. Horizontal partnership can be divided into two levels:

- Firstly, partnership at the strategic level in which the emphasis is on how the policies, resources and investment decisions are made between national and local administrators and relevant actors.
- Secondly, partnership at the operational level which reflects on everyday life of caring for older people and how the care has been identified and provided in practice.

To examine the strengths and weaknesses of partnership in a whole system, the analytical framework used will follow the elements of: the balance of power and resources between actors, namely, fund sharing, joint service delivery and different working cultures.

Partnership at the strategic level

The process of policy-making and legislation in the area of long-term care is complex. One reason is because the long-term care of older people involves various issues such as housing, transportation, benefits, health and social care and no individual department can work alone. Moreover, all three countries have shared the similar challenge of government departments and NGOs at the central level working together with their different interests:

...Sometimes very difficult, because we often have a different agenda. Different ideas about how to arrange things ... (Civil servant, Ministry of Welfare and Sport, the Netherlands).

All those government departments are working with us on our Green Paper. I think its strength would be, overall, I think, you would probably get a shared view of the policy intentions for older people....and a shared understanding of what that would look like... [such as] independence, choice and control going across the government agenda. In terms of weakness, I think we probably still have too many different

initiatives going on at the same time, and there would have been quite a lot of mileage in working together (Civil servant, Department of Health, England).

There is some diversity between [authorities]. Each of them has their own database to store clients' information. Each of them has their own system to develop long-term care (Senior officials, Association of Welfare of Older People, Taiwan).

Conversely, there are different models and structures at the strategic level within the countries. This has resulted in different outcomes in policy-making and strategy. The Dutch strategic working framework was evidently involved with a wide range of care contributors from the system at both the national and local levels - not only central government but also insurance organisations, older people and service providers. At the national and local levels, the participants interviewed indicated there was frequent consultation and active participation in policy making. As a result, nearly all of the Dutch interviewees at national and local level stated that their work was based on shared policies/agreements:

... there is a lot of debate, a lot of contact... a lot of convincing them, they are convincing us, talking, debating and looking for solutions ... both parties are happy with ... At the moment when you make a deal, based on law, you have to do your part of the share of the deal (Civil servant, Ministry of Health, Welfare and Sport, the Netherlands).

However, historically, there has not been a strong partnership between central and local government in the Netherlands regarding the long-term care of older people. This was because care had been the main responsibility of central government until 2006. Nonetheless, the interview with a local policy officer did find that consultation had taken place between central and local government in the policy making process:

We have local government representatives who have lots of talks with central government about the new laws [WMO] and about how much money will come from the centre to us and what tasks we [local government] are able to provide locally. Everything will be done in the discussions and everyone has to agree with it (Local authority policy officer, the Netherlands).

This indicated that the Dutch strategy-making process reflected a balance of equal power and involvement within and between national and local actors, as well as clear macro-institutional responsibilities. Indeed, all of the Dutch participants involved with strategy stated that such joint work was effective in ensuring all the parties had an equal

say and that their views were taken into account in setting policy objectives and deciding the future financing of care. Nevertheless, the Dutch civil servant interviewed pointed out that a great deal of talking and negotiation could not be avoided in the policy-making process. The Dutch experience showed the significance of consultation in partnership working. Time and effort are crucial if a common goal is to be established between actors who have different care ideologies and organisational interests.

Consultation, negotiation and wider care actors' participations in policy-making were dominant themes in the Dutch interviews. There was some evidence of this in Taiwan but in England it was rarely mentioned. The English actors' framework at the strategic level reflected a hierarchical partnership. In England, local authorities and Primary Care Trusts created a local care strategy in line with national policy made by the Department of Health. According to a senior official at national level, policy-making sometimes had to be done without agreement between local and national levels. The funding split between the Department of Health and the local authority; and the different responsibilities of departments in local government (such as Social Services, Benefits and Transport) also showed some difficulties in partnership and service integration at the local strategic level. The Service Director of Social Services in England interviewed explained:

... different organisations ... have often got different boundaries and so they've got different sorts of governments and control so you can get people working well together but you can't guarantee it and sometimes authorities, well every organisation, will worry about their own budget, their own priorities rather than working together (Service Director of Social Service, England).

Similarly, an unequal budget restricted partnership working at the Taiwanese strategic level. However, unlike in England, where one department was responsible for the long-term care of older people at the national level, in Taiwan, national long-term care strategy was further complicated by the involvement of at least four national departments under Executive Yean. Different financial interests between the departments have caused difficulties in joint working at the strategic level within the Taiwanese central government. The Council for Economic Planning and Development was appointed to strengthen partnership at the national level. However, all of the civil servants interviewed found joint working between departments especially difficult as the Council did not have a leading role and financial resources were controlled by the Department of Social Affairs and the Department of Health. Nonetheless, there was some evidence of consultation between various departments at the central level in Taiwan:

We are consulting and keeping other departments informed of what we do at the central level through regular meetings but we do not interfere and pay respect to what other departments do... (Civil Servant, Council of Labour Affairs, Taiwan).

It is to be argued that the Taiwanese partnership model at the national level seems to provide each national department with autonomy and respect. However, such an arrangement could be seen as passive, restricting a closer working relationship within the Taiwanese national government. This could cause difficulties in making consistent national policy.

Furthermore, this study found the partnership between the central and local levels in Taiwan was probably poorer than in England due to a lack of clear central legislation and a shortage of funds and human resources locally:

There are difficulties in implementing policy at a local level. It is because funding and human resources come through either the Ministry of the Interior or local government itself, which leaves us with no power to negotiate or assist local government when they complain that they have not enough money or human resources to operate a policy (Civil servant, Council for Economic Planning and Development, Taiwan).

Partnership at the operational level

Partnership at the operational level involves older people, their assessors, their service providers and their formal and informal carers. This study found none of the local administrators in the three countries had a strong association with informal care at the local level, although a small degree of such partnerships was evident in the English interviews. This lack of evidence indicates that informal carers carry out a massive care responsibility but with no or limited participation and influence at the local level.

When it comes to working with other assessors, the Dutch and Taiwanese assessors interviewed had similar working environments and organisational structures. For instance, evidence of multi-disciplinary teamwork can be found in care settings in both countries. Most of the Dutch and Taiwanese assessors indicated that different professionals working in the same building and same organisation did encourage: (a) a more cooperative working relationship and (b) working towards the same goals and expectations. Conflict between those with different professional backgrounds was rarely mentioned in the interviews with assessors in the Netherlands and Taiwan. Furthermore, in Taiwan, there was some interaction between specialist professionals and service providers concerning their professional practices:

I also meet nutritionists from other care homes to share our working experience. *The Foundation of Long-term Care* also has regular conferences where we can meet professionals from other providers to share our experiences (Assessor nutritionist, Taiwan).

Professional partnership in England was more complicated than in the other two countries because the various assessors were spread throughout different funding bodies – the Primary Care Trust and local authority Social Services Departments. Much consultation and negotiation was required in the process of assessment and commissioning services. This caused operational difficulties in the English system from the point of view of the professionals. The government has introduced a Single Assessment Process to strengthen professional cooperation. However, the difficulties involved in staff working for different agencies and in different buildings – as well as having extensive differences in working culture - limited the possibility of good communication:

It's all very well people in high management talking to each other and making policies but it's people on the front line that actually bridge the gap between the service users and the organisation, and if you don't take all those people with you, with your policies, then, you're going to have a hard job creating the change that's needed ... but until we're actually based together in one office, I don't think we're sort of going to move the whole way ... the essence of our job is communication and yet our own department doesn't seem to understand how important communication is within the organisation ... things like email and that sort of thing, are good on one level but they can be abused because it's like a quick way of communicating something which actually should take a bit longer (Assessor social worker, England).

Furthermore, England was the only county in the three, where due to the professional care culture and status, almost none of the multi-disciplinary assessors and professionals worked in a care provision setting (e.g. homecare, care homes, day centre, etc.). This was probably one of the factors that restricted the quality of continuous care monitoring of individual care needs.

There was clear evidence of partnership between service providers and older people in Taiwan and the Netherlands, unlike England. Nearly half of the Dutch providers (3 out of 7) saw the relationship between service providers and clients as: (a) the clients having full autonomy in decision-making and (b) the providers having the role of offering professional advice and acting on what their clients wanted.

I stay informed. And every so often we have residents' consultation ... [we] explain what has been going on within the nursing home, what developments there are ... So you enter into discussion with the residents. Not so long ago, one of the residents came to me to complain that the toilet paper here was much too hard. You take that on board. You ask yourself what could be done about that. I suggested that when she goes to the toilet, she should ask the nurse to use a flannel instead of toilet paper, especially if they have had a bowel movement. So you encourage the residents to ask us if they have any problems (Nursing home manager, the Netherlands).

In the case of England, a few (2 out of 10) providers stated they had involved the client indirectly by sending out a service evaluation questionnaire or by carrying out a care review. This did not really engage older people as true partnership would do.

In Taiwan, the strong ideology of familial society influenced the familial partnership between older people and service providers:

We see our residents like families and we play the role of their children or grandchildren as well as their carers. We try to make them feel they are not alone in their later life ... (Nursing home manager, Taiwan).

Similarly, interviews show Taiwanese service providers working closely with the family. Most of the providers (7 out of 8) said they had regular contact and full involvement with the families in decision-making.

Some Dutch providers (3 out of 7) believed clients had a primary participant role and that their opinion should be more highly considered than their families' unless they were mentally incapable of making a decision. However, when they worked with families, their needs were considered. Some Dutch providers interacted well by consulting with the family and reacting to the result of the discussion immediately.

... I offer a listening ear ... And I listen straight away if possible, I don't tell them it will have to wait until tomorrow ... Because it's quite a tall order, having to leave your partner behind here and go into a home alone. You have to notice and appreciate that; it's not nothing (Nursing home manager, the Netherlands).

Half of the English respondents (5 out of 10) thought partnership between the providers and the families was good. However, some participants (4 out of 10) said that the interaction with the family occurred mainly when there was a concern about the older person. Participation was in the form of decision-making regarding the needs of the older people following such concerns. Even when participation took place in formal

decision-making, there was little evidence of continuing engagement and monitoring of older person's care unless there was a crisis.

While service integration and collaboration is on the top policy agenda in the three countries, nearly all of the service providers in England (9 out of 10) and most in the Netherlands (5 out of 7) stated they had little contact with other agencies in the provision of care. In contrast, the Taiwanese care system delivered much greater partnership between the providers and other agencies. Taiwanese providers worked jointly with other providers in sharing practical experiences and staff training resources. Similarly, the migrant carer agencies interviewed stated they had a mutual relationship with the carer agencies in the countries that provided the carers.

The relationship with our partner agencies in foreign countries is good. We rely on each other. We need them to provide and train the carers for us. They need us to import their carers to Taiwan. Normally, when we ask for one carer they would provide CVs of a few candidates for us to choose (Migrant carer agency manager, Taiwan).

Vertical partnership

We have demonstrated how in each country partnership has worked at strategic and operational levels horizontally. In this section, we will further examine how partnership works vertically i.e. between different levels.

Social- and health-care barriers in England and Taiwan

Until 2006, government responsibility for health and social care was centralised in a single department in the Netherlands. Although change is now taking place, at the time of my fieldwork, this was the case. Consequently, there were few problems. However, the partnership between Social and Health Departments had been problematic in both England and Taiwan. As a result, there were difficulties in strategic policy-making as well as the provision of care. Most of the interviewees from Social and Health Departments at the local level in both countries found that a number of operational difficulties were caused by national policy inconsistencies. In both countries, the national partnership strategy - because of different departmental interests - led to different priorities between social- and health-care:

Different organisations have often got different boundaries and they have got different sorts of governance. So, you can get people working well together for a bit, but you can't guarantee it and sometimes authorities, well every organisation, will worry about their own budget, their own priorities rather than working together (Service Director of Social Services, England).

There are operational difficulties and confusion across the departments between social- and health-care, which is related with there being no clear recognition between Social and Health Departments at the central level (Long-term care co-ordinator, Taiwan).

The dependency of older people in residential and nursing care was not clearly defined in any of the three countries (Chen, 2010). In the case of Taiwan, the mixture of residents within a care home was partly caused by ambiguous policies between social and health departments. Most Taiwanese interviewees at the local level across social- and health-care (5 out of 6) pointed out that an unclear responsibility boundary between the two had resulted in a duplication of services in practice:

The responsibility between social and health is ambiguous. Sometimes the services provided by both departments are duplicated. Although the Health Department is responsible for healthcare, it is very difficult to define what healthcare is and what social care is. All of the residential homes have fewer nurses in charge, but they also provide nursing care to some of the residents (Head of Social Affairs Bureau, Taiwan).

The barrier between Social and Health Departments also meant there was a barrier to sharing information and resources between assessors from different professional disciplines. Taiwanese local administrators pointed out that currently the primary connection between the two departments was simply through referring a case without further consultation. A lack of information sharing - as well as a lack of recognition of each other's professional expertise - restricted cooperation between them and prevented a holistic approach to the long-term care needs of older people:

There are operational difficulties and confusion across the local department between social- and health-care, which are related to there being no clear recognition between the two organisations at the central level. Each department has its own criteria and understanding of care. We only can refer the case but there is not much consultation. Our assessments are not recognised by the Social Department and they will carry out their own assessment after we refer a case to them (Long-term care co-ordinator, Local Department of Health, Taiwan).

Similar barriers between health and social care exist in England. According to most local administrators (3 out of 4), the difficulties of joint working were information sharing and the responsibility for, and understanding of, holistic caring:

... We do have a kind of protocol for working with them but at the moment we're having to revise that because of the Data Protection Act. They're saying there's a lot of information they can't give us – about individuals. All we can get now is sort of general information from them, if there's a problem in a home ... Health is a bit of a mystery in the way we work ... (Homecare contractor, England).

Decisions at strategic levels about how tasks should be allocated between health and social care actors may be the product of extensive consultation. Nevertheless, on the ground, these were still sometimes perceived as arbitrary by those who participated in this study. Such views were reflected in statements from a number of the English service providers (3 out of 10).

District nurses at the moment do things that homecare staff can't do, but sometimes they think we should be doing them. But, until it's been discussed and negotiated at higher level, our staff can't do it, you know, district nurses will go in and they used to give ear-drops which our staff couldn't do, but they used to say, oh, it's easy, just do it. Well, we couldn't (Homecare manager, England).

Furthermore, the unclear boundary between the two organisations not only affected care practice but also produced confusion and unrealistic expectations among the public:

I think people's perception of what Health should provide and what Social Care should provide is sometimes a bit unrealistic ... relatives with older people often think that somebody should pick this up and not the family ... they feel that their older people or older relatives need healthcare as opposed to social care (Long-term care co-ordinator, Primary Care Trust, England).

Nevertheless, England appears to be further ahead than Taiwan in improving its joint working between Social and Health Departments. Co-ordination has been stimulated by several national policies, such as the Single Assessment Act and the National Service Framework for Older People. These emphasised the importance of enforcing local joined-up services. Intermediate care was a prime example of service integration and joint funding between Social and Health. It provided short-term care or rehabilitation for older people who had just been discharged from hospital. The main aim was to help older people recover from their ill health in order to return home and prevent further hospitalisation. The English Service Director of Social Services said there had been intensive negotiation between healthcare and social care at the local level, in order to achieve the current level of cooperation. Furthermore, clear guidelines and protocols from the central level - to identify expectations and to help those at local level to know how things could work effectively to reach national targets - were in progress:

I do know we've had a new medication policy come out recently, it's still in draft form ... there has been a lot of discussion with the health side, over the last year or so, because of the problem that we have to call nurses in to do certain tasks, and I think it will get better (Homecare manager, England).

A policy of healthcare and social care integration has also been introduced at the local level in Taiwan. For example, the local area is required to have a local drop-in long-term care centre for Taiwanese older people where both health and social professionals work alongside each other to take referrals. However, in the Taiwanese local area studied, there were only staff from the local department of health. This was because there was, as yet, no general commitment or resources between the two local government departments:

Both departments need to set up a drop-in centre. However, the best for the public is a one-window access to meet their needs. The system has become more complicated... there is no general common agreement at the local level between Social Care and Health Departments. The Social Affairs Bureau was reluctant to have their staff based in the drop-in centre because they claimed they don't have staff available (Long-term care co-ordinator, Local Department of Health, Taiwan).

A lack of clear and consistent guidelines between social- and health-care was clearly evident in the restricted partnership working in the Taiwanese long-term care system. The Taiwanese local administrator from the Health Department further argued that partnership could not operate without either clear guidelines or a balance of power between the two government bodies at the local level.

Policy implementation

The case of Taiwan mentioned above has raised the issue of putting policy into practice which requires cooperation between central and local levels. Similar difficulties were also found in the other two countries studied. As mentioned earlier in the paper, much research into partnership has emphasised the importance of the power balance between actors. It can be argued that sometimes a hierarchical structure is unavoidable. This issue will be examined further by looking at how the actors at the strategic level work with those at the operational level to implement and improve long-term care.

None of the three countries has strong sanctions to insist either that service providers or local authorities provide appropriate care. Central government tends to use incentives and budget control to implement policies and to improve care services, but closing down poor-quality services was done reluctantly.

Both the Dutch and Taiwanese governments had adopted a “subsidy” approach in order to implement a policy or stimulate creative care services. In the Netherlands, for example, the subsidy was provided by central government to service providers. In Taiwan, local government and service providers received subsidies from central government to implement policies. The difference between the two is that the Dutch government provided a large, stable budget to service providers in combination with subsidies and law enforcement. In Taiwan, most of the funding consisted of subsidies to local authorities and service providers. One of the disadvantages of subsidies was their short-term nature. Some Dutch participants and most Taiwanese participants claimed the weakness of the grant was that most of the providers were not willing to continue the service once the financial support ended or were reluctant to co-operate when funding was not constant. The consequence was that some services were comparatively unstable, especially in Taiwan:

A lot of care providers say that when the subsidy is ended; they won't do it any more. That's a weakness of our system... We use a combination of law, of subsidies, of financial incentives and management by speech... we talk a lot in the Netherlands as you probably know. So often it's a combination of more implementation ... (Civil servant, Ministry of Health, Welfare and Sport, the Netherlands).

Central government is willing to invest a lot of money to support a subsidy project, but after the project ends it is the responsibility of the local government to arrange the services from their local budget. Most of the local authorities possibly do not want to carry out the project after the funding has ended from the central government ... it [is] simply because there is not enough money locally (Senior official in Disability Welfare Alliance, Taiwan).

Conversely, all English participants (3 out of 3) at the national level drew attention to the so-called “carrot and stick” approach whereby there was a small degree of subsidy to implement a policy and improve long-term care services. This was based on star-ratings of service providers and the local authority. The service provider that had been inspected and judged to be of a higher quality would have a higher star rating. Those rated as having poor care quality would receive advice from the inspection unit or be forced to close down the service. If a local authority received a high star rating it would have more funding through central government and more freedom and autonomy. For the lower star-rated local authority there was less central funding together with close monitoring by central government and quasi-independent inspection units, such as CSCI and the Social Care Institute of Residents (SCI). There was a divergence of views on English strategy between the senior official from Commission of Social Care Inspection

and the civil servants from the Department of Health. Nevertheless, the strategy has been in place for less than a decade and it remains to be seen which of these is the more accurate view.

... I just get very frustrated because it feels like all of that going on, it really feels very hard to get a real change often, in what the older person gets (Civil servant, Department of Health, England).

In spite of the debate mentioned above, it could be argued that it seems contradictory to promote partnership which includes a more equal balance of power on the one hand, with a punitive strategy which implies an unequal power balance on the other. The punitive strategy is probably the way forward to monitor and ensure the quality of care. However, a more equal partnership might be needed to emphasise joint-working to help those poor providers and professionals searching for ways of improving their care service delivery.

IV. Discussion and conclusions

Partnership across the long-term care system is one of the means whereby successful ageing of older people who need care support can be achieved. The study showed that coordination, integration and consultation were very important in implementing partnership. It found clear evidence of a cultural difference between the care systems, in which the Dutch benefited from closer joint-working with clear responsibilities between actors more than the other two countries. The English system reflected difficulties in the healthcare funding system and in partnership arrangements. The empirical findings confirmed that a 'Berlin Wall' (Hudson, 1999) separated two primary care systems (social- and health-care) in conflict with one another. However, examples of service integration, suggesting that partnership in the English care system was improving were well evidenced. Although in some ways the Taiwanese had a more private and family care system, this study provided some evidence to suggest that there was a sound partnership between the various actors. England was the only country which had a strong policy implementation mechanism in this field. In the Netherlands each actor had more or less equal power and autonomy.

For partnership to occur, some work has to be done to recognise that people have different priorities. Therefore, England and Taiwan could learn from the Netherlands institutionally and through policies to ensure relevant actors have similar goals. This would help to achieve successful ageing in long-term care. The unclear boundary between social- and health-care at the national level has brought about difficulties in policy implementation at the local level in England and, especially, in Taiwan. England has

shown some positive action in joint working to improve the situation. This might be a good example for Taiwan. The strong message from the local to the central level in both England and Taiwan was a need for consistent policy and guidelines as well as appropriate funding. The barriers to working in partnership between assessors were clearly demonstrated by English interviewees. From the Netherlands and Taiwan, we learnt that working in a multi-disciplinary team under organisations with the same funding, in the same buildings and working under the same agencies helped assessors from different professional backgrounds to share goals. English structures for assessors and professionals could take the Dutch and Taiwanese experience into account to extend such multi-disciplinary practice not only through the public funding mechanism but also in the care setting. The Dutch themselves have recently shifted some social care responsibility to the local authority. It could be argued that the Netherlands should learn from England and Taiwan that there are huge difficulties for local organisations to implement care when there is a shortage of resources or when there are many policies introduced by different authorities on different levels. This suggests a unified policy in social- and health-care is vital and that good partnerships across various actors are crucial.

As other research (such as Kümpers et al., 2002) has already shown, this study concluded that it was difficult to identify which model of partnership was more desirable than the others as each of them had their own strengths to meet their own care system requirements. Nonetheless, the lack of involvement of formal carers in decision-making had resulted in weaknesses in participation in all three countries.

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