Abstract

The population is aging rapidly in China as a result of the baby boom, the One-Child Policy and a declining mortality rate in the past decades. The government has proposed “Aging at home” and “Societalization of elder care” as the basic strategies for the older population. Beijing is a typical case to study for emerging social programs and services as the capital city. In the human geography literature, experiences of aging and care at home and at the community level have been barely studied in a Chinese context.

Methodologically, a “new division” is taking place between quantitative and qualitative researchers in health geography. (Rosenberg, 2015) This dissertation seeks to contribute to the current literature by providing a non-Western lens and combining quantitative and qualitative methods in understanding old age, place and care.

There are two broad research objectives in the dissertation: first, to understand the experiences of aging in place and older people’s negotiations with changing environments in old age; and second, to understand access to home and community-based services and the experience of care. The above research goals are achieved by using both quantitative and qualitative methods. Four hundreds and fifty-one valid questionnaires were collected for quantitative analysis. Forty-seven older people and 21 caregivers were interviewed for qualitative analysis. It is found that the current physical, built and social environments inform the meanings of place and challenge the identities older people that have been established throughout the life course. The representation of the socialist past among older people is circumscribed by their economic conditions and environmental situation. Home and community-based care is largely provided by informal caregivers while their roles are decreasing. Access to care is varied by individual socioeconomic
characteristics and place. The public sector’s role in providing care is still small and conflicts are common between older care recipients and private sector providers. By adopting mixed methods, they complement each other to provide a more complete story and bring different foci to the fore in understanding the issues. The dissertation sheds light on the government’s planning and policy making in China.
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Chapter 1

Introduction

1.1 Research Context

The population is aging rapidly in China as a result of the baby boom, the One-Child Policy and a declining mortality rate in the past decades. It is estimated that by 2030 Beijing will have 35 percent of its population over 65 years old. (Bureau of Civil Affairs, Beijing) The demographic structure of urban China is gradually turning into a “4-2-1” formula, meaning the typical couple from a one child family will have four parents and at least one child to look after. The state has written aging and health into the National Strategic Plan for the next five years (Twelfth Five-Year Guideline of People’s Republic of China, 2010). The government and the rest of the society are facing the task of satisfying the care needs, both physical and emotional, of the elderly.

Deeply rooted in Chinese Confucian culture, filial piety (Chinese: 孝) is one of the virtues valued above all else, which means that sending parents to a long-term care facility symbolizes abandonment by the family. That children should take responsibility in caring for their elderly parents was also written into law in 1996 (Wu et al., 2005). The elderly see emotional care as important as physical care. The majority of older Chinese prefer aging at home; institutional care is the last resort for those who have no family around, who need special care or so much help that their relatives cannot cope (Wu et al., 2005).
At the same time, development and globalization bring changes to family patterns and people’s ideas. An increasing number of elderly parents have their only child working under intense pressure or living in other places. Some of the older population is now more open to the idea of institutional care depending on the family situation.

However, China’s aging pattern is unique as the country is “getting old before getting rich” or “getting old while getting rich”. The public pension system does not apply universally to older citizens and the gap between rich and poor still exists. The “One-child generation” faces intense competition at work and has to take more family responsibility at the same time. The elderly who have only one child are more likely to suffer from loneliness. The Chinese government has proposed “Aging in community” and “societalization of elderly care” as the basic strategies for the older population, which means the government is trying to keep the elderly at home, providing care at the community level and making care the responsibility of the whole society (Chen, 2012).

The State Council of the People’s Republic of China printed “Notice of 12th 5-years plan on Chinese Aging Development Planning” in 2011 and “Notice of Accelerating the Development of Services for Elderly by the State Council” in 2013. Both documents conveyed the message that a system “based on family care, supported by community services and supplemented by institutional services for seniors” need to be built. As directed by the policy makers, home and community are going to be the main settings for older people to age in China. Currently, the responsibility of taking care of a senior at

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1 In official Chinese documents, the term community is consistently used to mean small geographic areas within cities where street offices and residence committees are the legal entities for organizing the communities. The closest equivalent in the geographic literature is neighbourhoods. Throughout the remainder of the thesis, when citing government documents, the term community is used; otherwise, the term neighbourhood is used.
home relies heavily on family members and the market. The rise of neoliberalism has had a profound influence on community-based care\(^2\) and the health care system as a whole. Facing the rapid aging of Chinese society, the state is taking a more active role in service provision and public policy development.

Beijing is one of the most populous cities in the world, with a population of around 20 million in 2010. It is estimated that by 2030, it will have 30 percent of its population over 60 years old\(^3\). (China Development Research Foundation, 2012) As an emerging global city, Beijing is experiencing a pressing aging issue along with other development issues such as pollution, the income gap, uneven resource distribution, etc. Social stability is highly determined by how a society reacts to changes in its population structure. New policy and ideas often are developed in Beijing and then diffuse throughout China. Therefore Beijing is an importance case to study aging and aged care.

As Beijing expands, aging and caregiving become increasingly complex issues. The current elderly care policy in Beijing is directed by state-level planning and policies which operate differently among various levels of government. Also the elderly care sectors contain various stakeholder groups – government bodies, public and private care providers, frontline caregivers, the older population and their social networks, paying institutions, non-profit organizations, etc. In 2008, the city of Beijing had proposed the “9064” elder care development strategy. It means, by 2020, the goal is for 90 percent of the elderly to age at home, 6 percent to age in place with government support and 4 percent to age in institutions. The community plays an important role in supporting the

\(^2\) Community-based care which includes any service received outside of a hospital or doctor’s office. Examples are: home nursing care, home-based counselling or therapy, personal care, community walk-in clinics, day care services and community meal services.

\(^3\) In China, people who are 60 years old and over are considered the elderly by Chinese law.
elderly aging in place. As the government is promoting “societalization of elderly care”, this large and unregulated system needs close study.

In English-speaking countries, many of studies have been done to understand place, space, health and care. (Gesler and Kearns, 2002; Parr, 2003, Dyck et al., 2005; Rosenberg and Wilson, 2005) There has, however, been little research examining how the various theories fit into the Chinese context and what is unique about aging in China. More specifically, what are the socioeconomic and spatial factors that influence the way people are aging in China and culturally what distinct patterns can be found. It would be useful from both theoretical and practical perspectives to test different models of health geography of the aging population and geography of care in the Chinese context.

1.2 Research Goal and Research Question

The general research goal of my Ph.D. thesis is to examine whether place matters in the geographic patterns of aging and care experience of those who age at home in the case of Beijing. To be more specific, the changing meaning of place to older people and whether place matters when it comes to older people’s decision making, accessibility to care, care needs, care provider’s availability and care experience in general. Therefore, I want to analyze the relationship between older people and place, the factors behind the choice of place of aging, availability and accessibility of elder care on the home and community level for those aging at home in urban China, where care includes both physical and emotional care.
There are two hypotheses I would like to test. First, I want to test the relationship between older people and their changing environment in different places. Beijing has experienced many facets of urban transformation since economic reform in 1978 and is still undergoing rapid urbanization. I want to know if the changes in time and space influence older people’s perception of the environment, place identity and thus how they negotiate aging in place experiences in the urban Chinese context. The examination of these relationships also speaks to the discussion of home versus institution and the aged care model. Second, I want to see if the experience of utilization and provision of home and community-based care vary in different places and the spatial implications of caring relationships. Since the destruction of the work-unit system and the opening up of the market, local level governments have had to mobilize revenue as part of neoliberal economic strategies while the strategy of “community building,” symbolized by the state’s determination that social functions cannot be weakened by entrepreneurial behaviors, is also operating simultaneously. As societalization of elder care has been pushed by the government, there is a great need to study the system under construction.

To reach the research goals, there are three sets of research questions I will answer:

1) How do older people perceive their physical, built and social environment? What is the experience of aging at home and how do older people negotiate aging in place? How does aging in place experience speak to the intention of relocating to a residential care facility (RCF)?

2) What kinds of care needs do older people have and where do they get the services? Who are the caregivers for the older people living at home and what are
the available services for them? What are the utilization and provision patterns of home and community-based service?

3) What is the care experience of both care recipients and caregivers at home and in community settings?

To answer these questions, I analyze databases based on questionnaires and semi-structured in-depth interviews. Questionnaires identify the social-economic characteristics of the older population living in different places, their general experience of aging in place, their care needs and who are the caregivers. The database based on the questionnaires therefore answers the questions of environment and aging experience, care utilization patterns, accessibility of elder care, the share of different parties in care provision, spatial relations and reasons for unmet care. Semi-structured interviewees include older people and caregivers (formal and informal). Interviews help me understand environmental challenges, place meanings of older people, care experiences of both care recipients and caregivers, their perception of caring space, and the further analysis of the mechanisms behind elder care patterns. Since the elder care system has largely not been formalized in China and society is changing fast in various ways, it is essential to develop a more comprehensive story by using in-depth interviews.
1.3 Theoretical and Empirical Contributions

1.3.1 Theoretical Gap and Perspective

Chinese geography has seen great advancements in the past decades in terms of both quantity and quality, especially research has started to encompass “concepts, models, and contextually sensitive theories”. (Fan et al., 2002) However, as an area that mainly developed in the west, theories are strongly rooted in western philosophic traditions. It is important to discuss theoretical gaps and context-specific research. Both the development path and aging patterns have unique Chinese characteristics. Moreover, the politics of care is largely related to social and economic reforms. This particular research will pay close attention to the changing demography, family structure, ideas, culture, policies and geographic discourse in China.

As Yeung and Zhou (1991, p. 373) noted human geography has “undergone a tortuous path of development in China”, and this reflects the political economic trends, rapid material change of the country and the discursive practises in the discipline of geography (Lin, 2002).

Different scholars have tried to identify the development stage of human geography in China. According to Yeung and Zhou (1991), it was infant growth under western influence prior to 1949, unbalanced development under the influence of the USSR between 1949-1966, stagnation during the Cultural Revolution until 1976, and resurgence in human geography since the 1978 economic reform and open door policy. Lin (2002) sees the development of human geography in China from a discourse formation perspective. From the Chinese city as the center of change in the 1970s, the uniqueness of Chinese urbanism in the
1980s, regional development in the 1990s to the new era use of notions of space, place, and transnationalism to construct the Chinese diaspora as a geographic system. During the years of development, some areas have seen great achievement and breakthrough more than the others, especially in economic, urban, and tourism geography and the geography of population. (Yeung and Zhou, 1991; Yeung and Lin, 2003) The focus has seen a shift away from natural environment studies to “ongoing transformation of the political economy, its human consequences, and spatial manifestations” (Lin, 2002, p. 1816).

Despite the development and changes, gaps in terms of theory and research areas still exist. Several scholars have stated their views on where human geography research on China should stand within the broader academy. They recognize the inevitable trend of “the globalization of knowledge and theories” (Yeung and Lin, 2003) while selectively and critically learning from the western context are required (Yeung and Zhou, 1991). Lin (2002) maintains that China geographers need to move beyond the circle of empirical studies and become more engaged with major theoretical debates. Yeung and Lin (2003) argue that certain geographical processes in Asia may require a fundamental new approach to theorization, and development of original theoretical insights from grounded studies of the Asian experience is largely needed. In all, given the importance of Chinese culture, restructured socialist institutional settings (Yeung and Lin, 2003), the changing demographics, and Chinese space economy reform, it is important to bring the Chinese case into theory development.

As for geographic research on aging and care in China, it is equally important to bring Chinese studies into theoretical realms. Current studies on aging and elderly care in
China are mostly from sociology, public health perspectives and are mainly empirical (Xian, Liang and Gu, 1995; Liu, Liang and Gu, 1995; Neal, Liang and Gu, 1998; Chen and Silverstein, 2000; Chi and Chou, 2001; Lai, 2001; Ng, Phillips and Lee, 2002; Chou and Chi, 2005; Lee, Ruan and Lai, 2005). More social gerontology and geographic studies on aging and care have been done in Hong Kong, Taiwan and Singapore than in Mainland China (Phillips, 2000; Phillips and Chan, 2002; Phillips et al., 2004; Phillips, 2005). There is a group of studies from the 1990s on aging and elderly care in China (Olson, 1993; Bartlett, 1994; Bartlett and Phillips, 1997; Joseph and Phillips, 1999). Lately, there have been a series of geographical studies on residential care in China (Yang et al., 2011, 2012) but more recent research focusing on home and community experience is needed.

In all, this particular research exams the existing theories and potential theoretical gaps. It takes a contextual-sensitive approach.

1.3.2 Policy Implication and Empirical Contribution

This study potentially contributes to the understanding of aging, care and related policy on different scales. Current studies on home and community-based experience of aging and care in China are limited to population level analysis using mostly quantitative methods. This study is one of the first to combine qualitative and quantitative methods and covers communities of the six urban districts in Beijing. It aims to give voice to older people who are experiencing aging and care in their everyday lives and to shed light on the current aging policies in Beijing and the rest of China.
This particular study focuses on the experience of aging and care home and community level. Beijing, like other large Chinese cities, has shown diverse patterns in urban geography. The complexities embedded in different types of communities and individual experiences need to be deconstructed when discussing aging in place in the changing urban landscape. Community-focused research, rather than a population level analysis, is essential in this context.

At the municipal level, the government of Beijing has been promoting aging at home and community as the basic strategy toward the fast aging society. Planning documents and policies (e.g., the 9064 strategy) have been announced to encourage older people to age in place. The findings will have strong policy implications in terms of the effective ways of reaching the political goal of aging in place and institutional care facility planning.

The study of Beijing also contributes to planning strategies on a national level. As the capital city of China, Beijing shares similarities and differences with other Chinese cities in its development path and urban structure. It is also where emerging social policy makers “test the waters.” Due to the geographic proximity to the central government, a study of Beijing will also contribute to policy making at the national level.

Lastly, China has developed strong political and economic influences in the globalized world. Aging in China is both local and a global issue. The results could potentially contribute to the conversation about aging as a global issue and be used as case for an international comparative study in the future.
1.4 Thesis Outline

In chapter one, I have introduced the research context in terms of population aging, demographic trends, population policy, cultural-specific ideology on aging and the uniqueness of the aging society in China. Then elderly care and aging policies at the national level were briefly introduced. Background information on Beijing’s demographic and aging policy was given. Following the discussion of the research context, the research objective and questions were presented. As a discipline with a long history of development in Western society, the theoretical gap and potential theoretical contribution of this study were discussed based on current human geography research and discourses on China. Finally, this chapter talked about potential empirical contribution.

In chapter two, current literature concerning the themes of geography of aging and geography of care on home and community levels are reviewed. More specifically, studies on population level analysis of geographic aging patterns and individual level experience of aging and place are reviewed. Then research on utilization and access to home and community-based elder care service is discussed. This group of studies focuses on the patterns of service uses and needs, and the barriers to access. Finally, studies on experiences of using services, receiving and giving care are discussed. Research from both Western and non-Western contexts are included. The review focuses on studies that are of interest because of their findings and/or methods. This chapter provides important conceptual and empirical knowledge of the topic.

In chapter three, the research design and methods are detailed. Mixed methods as an approach is adopted and justified for this particular research. Information on the research area, term definitions and scope are explained. The chapter describes the
methods, sampling and recruiting processes used in the fieldwork. The research contains two stages: a questionnaire survey and semi-structured interviews. Statistical methods and constant comparative methods are applied to the quantitative and qualitative data respectively. The sample information of both the questionnaire survey and interviews are listed, which includes socioeconomic, geographic and health related information. The discussion is of the quality, representativeness and limitations of the sample.

In chapter four, policies and issues related to old age and elder care in Beijing and China are reviewed. It is divided into three parts. First, the chapter reviews literature discussing emerging environmental, social and health issues related to urbanization and economic reform in China. Second, it reviews the development of community in urban China in the post-reform era. Third, it summarizes important polices and government documents on elder care.

In chapter five, the issues of old age and place are analyzed using both quantitative and qualitative data. First, the perception of the physical and social environment by older people, relationships with general aging at home experience and intention to relocate are analyzed using statistical methods. Then, qualitative data are used to explain specific environmental challenges related to urban landscape changes, the changing meanings of place and place identity, coping strategies and thus contribute to the discussion of aging in place in a Chinese context in chapter six.

Chapter seven looks at home and community-based care for older people. The concept of care here has a broad meaning including home care services, community services, and physical, mental, financial and other forms of support for older people in their everyday lives. Quantitative data are first used to draw a general picture of service
utilization patterns, service needs and caregiving. Qualitative data are used to understand the experiences of care from both care recipients’ and caregivers’ angles.

The last chapter concludes the thesis and discusses whether the research goal is reached and limitations. The theoretical and empirical contributions are detailed. The policy and method implications are also included. Finally, it ends with future research directions.
Chapter 2

Literature Review

2.1 Introduction

This chapter aims at reviewing the current literature on the geography of aging, services for older people at home and community levels, care and caregiving. Studies in both Western and non-Western contexts are included in the discussion. First, old age is discussed on both individual and population levels. More specifically, how old age is understood in a non-biomedical sense and the demographic characteristics of population aging are reviewed. Then, literature on the relationship between older people and their subjective or objective environments are reviewed. This group of study focuses on how environment is related to older people’s health, functions, and well-being. The following section is also on older people and their surroundings but emphasizes the affect and experience side of aging. Studies on old age identity, emotion and attachment related to place and space are reviewed. The next section is on home and community-based care for older people. In the first part of the section, studies from a service use perspective are reviewed. Then the discussion shifts to the experience of care, care relations and the spatial implications. The structure of the literature review chapter is in accordance with the overall conceptualization of the thesis.
2.2 Geography of Aging and Aging in Place

2.2.1 Old Age and Population Aging

There are generally two aspects to aging. One is individual aging, which refers to biological, psychological and social aspects of growing old. The other is population aging, which means the processes that affect the proportion of the total population who are aged and reflects the increases in their proportion of the total population. (McPherson, 2008)

On an individual level, a group of studies discusses the meaning of old age and aging. There is a growing acceptance that old age is a social and cultural construction. Harper and Laws (1995) argue that retirement age (60 or 65) is taken for convenience sake to define old age. They question the origins of retirement as male-dominated wage-labor relations that cannot be applied to women, and rural and non-industrial societies. Wyn and White (1997, p. 10) argue that the meaning of age is more than a biological reality, but also subject to historical and cultural processes. Hopkins and Pain (2007) think there is a blurred life-course identity that it is more difficult to use than chronological age indicators. Rather, old age is viewed as a cultural variable and related to social economic processes, lived experience and spatial practices. They believe age should be discussed relationally by taking into consideration the interaction with other age and generational groups, social identities, life experiences and transitions. Jones and Higgs (2010) believe that normal aging is now taking on multiple forms and is related to factors like the generation one grows up with, culture, social norms, and political-economy (Gilleard and Higgs, 2000; Gilleard and Higgs, 2005; Higgs, Hyde et al., 2009;
Jones et al., 2008). They believe that normative aging in contemporary society is articulated around a consumer society (Bauman, 2001, 2005).

On a population level, a group of studies and reports have contributed to the distribution of the older population, demographic characteristics and related policy implications. Most studies use quantitative methods and policy analysis. The United Nations Economic and Social Commission for Asia and the Pacific and the World Health Organization (WHO) have published reports on global aging, demographic trends, explanatory factors and policy implications. Lloyd-Sherlock (2000) links the aging population to global economic, social and political changes, and talks about the policy implication for developed and developing countries. On a national level, Moore, Rosenberg and McGuiness (1997), and Moore and Rosenberg (2001) provide demographic and geographic angles to the aging population in Canada and how the changing socio-economic and ethnic characteristics of Canada’s older population raise issues of service accessibility. Moore and Pacey (2004) use census data of Canada to measure aging in place and net migration of the aging population. They find aging-in-place continues to be the strongest force in population aging. Local economies play an important role in the rate of population aging. For those places with fewer economic advantages, the population aging rate is higher, due to net migration effects. Phillips’ (2000) edited book, studies on the Asia-Pacific region, including East and South-East Asia, Japan, Hong Kong, Singapore, mainland China, Taiwan, Korea, etc., shows the readers population aging patterns and trends in the countries and areas of the Asia-Pacific region. Specific for Mainland China, the discussion focuses on declining fertility rates, rural-urban disparities in aging, inter-provincial differences, ethnic variation, changing
family structure and related policies. On a rural-urban level, studies have been done on population aging, including the ethnic elderly within urban systems, rural aging and aging in place in suburbia. (Frey, 2001; Moore and Pacey, 2004; Kinsella, 2001; Leah and Knapp, 2009).

2.2.2 Older People and the Living Environment

A group of studies in geography and gerontology have discussed both objective and perceived living environments and their relationships with older people’s well-being. In this chapter, the literature emphasizes the impacts of the social and physical environment on older people’s daily lives, functions and health. The scale ranges from home, neighborhood, and community to institution. Some literature discusses older people’s preferences in terms of the living environment.

There is a number of empirical and theoretical studies concerning the broad areas of old age, home/community/neighborhood environment and well-being in a Western context (Lawton, 1973; Rowles, 1983; Cutchin, 2001; Pinquart and Burmedi, 2004; Bowling et al., 2006; Iwarsson et al., 2007; Oswald, 2010; Wahl et al., 2012).

Environment is distinguished as the physical and social environment, and understood in subjective and objective terms by researchers. On a theoretical level, Rowles (1978) discusses place attachment and aged identity from a phenomenological perspective. “Insideness” is used by Rowles to represent the memories and sense of place identity. Lawton (1973) proposes an Ecological Theory of Aging to discuss the relationship between older people and environment in functional ways. The model discusses personal
competence, environmental characteristics and older people’s functional level. Wahl et al. (2012) create an integrated framework of person-environment interchanges as people age. The framework incorporates Lawton’s ecology and aging theories, life span development models, addresses historical and cohort-related changes, and assumes the processes of experience-driven belonging and behavior-driven agency to help better understand person-environment interchanges.

On an empirical level, Bowling et al. (2006) use regression models to investigate perception of the environment and health in old age in Britain. They find perceived neighborhood environment (social/leisure facilities for people aged 65+, rubbish collection, health services, transport, closeness to shops, somewhere nice to walk, noise, crime, air quality, rubbish/litter, traffic, graffiti) are strongly related to health in old age. Measures like social contact and support do not show an association with health or functioning. Iwarsson et al. (2007) introduce the framework of a study on the home environment of healthy aging in urban regions of five European countries. The research aim is to deliver evidence-based guidelines for home assessment and modifications for older people. They distinguish between the objective and perceived environments in their framework and also consider both micro (person-environment) and macro (legislation, socioeconomic standards) level contexts. A mixed-methods approach is used for the study. Oswald et al. (2010) study both objective and subjective physical and social environments of home and neighborhood and their relationships with aging in place with respect to well-being. They divide a cohort into young-old and old-old groups. They use regression models and find apartment size, perceived neighborhood quality and outdoor place attachment are related to life satisfaction. Perceived neighborhood quality and place
attachment are more important to the old-old age group while indoor physical
environmental indicators act as a resource for the life satisfaction of the young–old and a
risk for the old-old. Walker and Hiller (2007) research how older women living alone
perceive their neighborhoods in Adelaide, Australia. They use qualitative methods to
examine older women’s perceptions of social and physical dimensions of neighborhood
and their relevancies to successful aging and social inclusion. They find out trusting
relationship with neighbors, living in close proximity to services and existing social
networks are important for neighborhood satisfaction and sustaining their independence.

There are also some studies on residential environment and well-being of older people,
community-residing versus institutionalized older people, and the factors influencing
moving decision from home to a RCF done in a Chinese context (Phillips et al., 2005;
Zhan et al., 2006; Chan and Pang, 2007; Gu et al., 2007; Cheng et al., 2012). Phillips et
al. (2005) examine residential satisfaction, dwelling conditions and psychological well-
being of older people in Hong Kong by using regression modeling. They show that the
interior environment has greater impact on residential satisfaction than the exterior
environment. Older people’s psychological well-being is related to their expectation of
residential satisfaction rather than dwelling condition. The other studies are on various
aspects of home and community versus institutional living. Gu et al. (2007) compare the
population characteristics of the oldest-old that reside in the community and institutions.
They find institutionalized oldest-old are younger, male, reside in urban areas, have lower
family-care resources and have poorer health compared to those living in the community.
Institutionalized older people also show greater two-year mortality risk than those
residing in the community. Context specific studies on Chinese older people’s relocation
from home to institution have all stressed the importance of children in the decision making process along with other factors, which carry cultural significance. Chan and Pang (2007) study the pushing factors for moving to a long-term care facility in Hong Kong. They find children’s workload, children’s lack of caring skills, lifestyle differences, lack of home care services, housing environment and lack of information on community services contribute to moving to an institution. Zhan et al. (2006) study the attitude towards institutional elder care among older people and their children. Results show that financial affordability and marital status influence the willingness to stay in an institution. For their adult children, those with more siblings tend to give higher ratings to institutions than those with fewer siblings. Cheng et al. (2012) discuss the decision making of relocating to a RCF in Beijing, China. They argue that the traditional value of filial piety continues to influence the decision of relocation and the stigma of residential care still exists. Financial and geographic barriers are also shown to influence access to RCFs for older people in Beijing.

On a more general level, a few studies have been done to understand the elder care system in urban and rural China. Bartlett and Phillips (1997) discuss issues on aging and elder care in China and used Guangzhou as a case study to understand elderly care in the context of socio-economic change in an urban setting. Joseph and Phillips (1999) studied aging and elderly care in the context of rural China taking into consideration rural economic and social capacity, migration population and gender. Wu et al. (2005) give a very comprehensive analysis of the current community-based elderly care system including service delivery, workforce, financing, and quality of care management by using the case of Shanghai.
Literature from both Western and Chinese contexts show the importance of the environment on older people’s well-being in the context of aging in place. More of the studies in the Chinese context discuss home and neighborhood environments in comparison to institutional care. Culture, family and the subjective environment play important roles in aging in place in Chinese society.

2.2.3 Aging, Space and Place

A growing number of researchers have stressed the human-environment relationship in terms of affect, experience and identity. Spatiality of aging includes a broader range of materiality and social construction in relation to old age. In this section, the discussion on aging is situated in physiological and social relations and emphasizes older people’s changing emotional and social interaction with place and space.

**Place attachment, identity and old age**

One possibility is a phenomenological perspective in understanding place attachment, familiar places and accumulative memories in place (Rowles, 1978;). Phenomenological understanding emphasizes the interaction between the “physiological body and the people, artefacts and other forms of materiality it encounters” (Schwanen, 2012). Rowles (1983) studies three dimensions of attachment—physical, social and autobiographical in the case of Colton by dividing older people into young-old and old-old groups. The author proposes the concepts of physical insideness (bodily familiarity of the physical configuration of environment), social insideness (social orders and social networks) and autobiographical insideness (remembered places in a historical sense). It is
argued that the most important aspect of autobiographical insideness is an attachment that is self-created and fictional. (Rowels, 1983) This involves the preservation of artifacts, participation in familiar places, communicating with peers who shared the experience of place. Eventually, autobiographical insideness is more important to personal identity and a sense of self that serves as a component of adaptation in old age compared to physical and social insideness. Young-old and old-old groups differentiated in their attachment to the proximate and displaced environment.

The studies of phenomenon of attachment to place mostly took place at smaller scales such as home and neighborhood. Rowles (1981) develops seven support spaces for the elderly: home, a surveillance zone, vicinity, community, sub-region, region and nation. Among them, home is the central support zone that provides not only physical needs such as a shelter and activities, but also an emotional attachment; home is a symbol of personal identity.

Informed by the concepts of place attachment and place identity, Taylor (2001) collects life stories of older African Americans in a small town in Midwestern US. The study shows the cumulative memories of place create a positive view of aging by older people, despite the “widely reported negative status” from lifelong experiences of injustice. Blunt and Dowling (2006) study attachment to home that it is full of memories and is multi-scalar for older people. It can be a specific part or it can be a whole world for elderly with less mobility. Rosel (2003) discusses the physical and emotional meanings of home space, and the role of home in an older person’s care and living spaces. Place familiarity provides a supporting role for older people aging in place. McHugh and Mings (1996) maintain that the sense of belonging through place making, community formation,
and reminiscence is centered on home places. Fried (2000) argues that place attachment is stronger in deprived neighbourhoods because people who have resources can seek other options. While the discontinuities of place in these neighbourhoods can cause spatial identity dysfunctions so that territorial conflicts may occur.

Time is an important dimension in discussing place attachment and spatial identity. Researchers have stressed the accumulated effects of place. The concept of “insideness” (Rowles, 1983) contains the meaning of lifelong accumulation of experiences in place. As Schwanen et al. (2002, p. 1294) state, “Age and space not simply are co-constructed but also co-evolve” that spatial-temporality of aging is an important aspect to consider. Hokey et al. (2001) put home in a historical lens that past life experiences and events are attached to home space for older people that influence their current aging experience. Andrews and Kearns (2005) study the everyday health histories and the making of present place, how personal identities and attachments are shaped by historical health events in a small town in England.

“Life-course” is another concept discussed by many geographers and gerontologists to unfold place identity (Katz, 2003; Katz and Monk, 1993; Bailey, 2009). Katz and Monk (1993) discuss the idea of a changing life course rather than a fixed life cycle. Life-course incorporates multiplicity of paths in life not just fixed biological stages. Further, Bailey (2009) argues life-course can be used to understand important events and transitions, synchronization of life and space, early life experience accumulations and health inequalities. In McHugh’s (2007) study on seniors living in Arizona retirement communities who identify themselves as Second World War generation, it is argued that collective historical experience in the communities shapes
generational consciousness and identity. Congregating and interacting with others in sanctioned spaces and places create collective norms and values. The norms and values that were generated when seniors were younger were preserved; while with all kinds of social changes taking place along the time line, their identities are constantly affirmed and reaffirmed.

Another stream of studies have stressed the changing nature of place, space and older people. Various spatio-temporal processes that take place between agency and environment may challenge place attachment, spatial identity and result in discontinuities in place. Phillips et al. (2011) aim to understand unfamiliar environments of older people by reviewing the conceptual framework of place attachment and undertaking an empirical study in two town centers in the UK. They argue that unfamiliarity in places can come from globalization, multiple living spaces, the surrounding demographics changes, the new built environment, changing urban landscapes, travelling, relocation and caring at distance, etc. At the same time, older people are experiencing differences in cognitive functions, personal competence, spatial skills, reconstituted families and social networks. Older people may feel insecure and powerless in such contexts. All these changes challenge the “place attachment” concept as a single location on the basis of familiarity. The study illustrates the relationships between older people and an unfamiliar urban environment. The findings show that activity, aesthetics and usability (accessibility and ease of mobility) of the environments contribute to how older people convey meanings in an unfamiliar environment. In a practical sense, older people can contribute to the planning process through their collective memories and experiences. Findlay and McLauglin (2005) put emphasis on personal characteristics, experience and histories and
argue that they are important when older people encounter discontinuities of place. Rowles and Watkins (2003) study relocations in the life course and how “being in place” is redefined. In the case of disruption of a long-established sense of being in place, it is argued that conscious memory (experience of past places), implicit memory (body’s awareness of space) and transfer of possessions (personal items of significance) are the three aspects of transference mechanism. Ekstrom (1994) discusses forced relocation and older people’s emotional experience. The author states five types of emotional changes in relation to forced relocation: stress, trust and security, belonging and meaning, guilt and dignity, and the feeling of having being violated. McHugh and Mings (1996) discuss place attachment for seasonal migrants. They argue that the understanding of home should move beyond a unitary concept; older migrants transform space into place in their winter communities that carry meanings; sense of place and well-being for seasonal migrants comes from recurring patterns of movement; individual experience in early life matters over the life course for the divergent paths older people take. Hockey et al. (2001) study later life spousal bereavement as a spatialised experience. They find that bereavement can transform the quality of the experience of space and change the relationship older people have with space. The meanings attributed to space, place and objects have shifted across time.

“\textbf{Aging in place}”

The term “aging in place” first became popular in aging policies in Western countries. Aging in place encourages the ability of older people to remain living in the residences and communities of their choice as long as they want (Schofield, 2006). Remaining at
home and in a community, avoids costly institutional care from policy makers’
perspectives (Wiles et al., 2011). Schofield et al. (2006) argue that a complex interaction
of situational factors (such as location and social context) and personal characteristics
(such as gender and state of health) affect people’s ability to age in place. Pynoos (1990)
uses the term also to imply the changing needs, environment and emerging social policy
of aging. It is argued that aging in place offers the benefits of sense of belonging,
familiarity, independence and autonomy for those who age at home and in the
community.

An increasing number of researchers have shown interest in the phenomenon of
aging in place in an academic sense. (Cucthin, 2003; Wiles et al., 2011). The term, aging
in place, is vaguely defined and geographical gerontologists have engaged in a more
critical and theoretically informed conceptualization of the term (Andrews et al., 2007).
Wiles et al. (2011) study the meaning of aging in place to older people. They argue that
current policy makers and planners do not seek views of older people and they are treated
as a homogenous category. They address the diverse needs of the older population by
opening up the conversation with older people in two communities in New Zealand.
They find older people’s conception of aging in place is very pragmatic. It is seen as “an
advantage in terms of a sense of attachment or connection, practical benefits of security
and familiarity, and as being related to people’s sense of identity through independence
and autonomy” (Wiles et al., 2011, p.1093). They state that place is a process and
operates at different scales and sites that it is not merely a home. They conclude that there
is no “one-model-fits-all” answer to the question of the ideal place to grow old. Cutchin
(2003) takes a “geographical pragmatism” approach in understanding aging in place.
Unlike ecological and phenomenological perspectives, geographical pragmatism provides a more holistic view of the problematic aspects of experience and action; the interwoven nature of action and meaning in place is addressed. Cutchin (2003, p. 1079) argues that “aging-in-place” represents a “complex set of processes that is part of the universal and ongoing emergence of the person–place whole”. He conveys the ideas of integration and reintegration of place and older people with social efforts and in different situations. Based on qualitative data collected in adult day centers and assisted living residences, a model on the process of mediated aging in place in a service setting context is proposed. The three core processes found are: re-shaping the experiential context, creating meaning through place-centered activity, and contesting space and place. In a practical sense, the importance of flexibility, contexts, processes and meanings within places should be addressed for healthy aging in place.

Understanding older people’s relationship with place has both theoretical and empirical significance. As Schwanen et al. (2012) state that it is now commonplace in the Human Geography literature to refer to aging as embodied, emplaced and relational. The research also carries strong values for policy makers and planners. In fast changing urban environments and with greater emphasis being placed on aging in place as a policy, there is great need to study older people, place and their changing relationships.
2.3 Geography of Care and Caregiving

2.3.1 Home and Community-based Service Utilization and Access

In Western countries, access to services has been studied in relation to health and well-being, vulnerable populations and place. Most of the studies focus on healthcare services, long-term care, specific treatments and procedures, and home and community-based services. Methods adopted are mostly quantitative analysis. Descriptive statistics, logistic regression analysis and GIS are common methods for this group of studies.(Rosenberg, 2013)

Researchers also discuss the conceptualization of accessibility. Donabedian (1972) discusses geographic access in terms of physical and temporal distance to healthcare services. Rosenberg (1988) distinguishes between geographic and economic accessibility. Economic accessibility stands for those who cannot use services because of their economic status. For geographic accessibility, it refers to people living within under-serviced areas have less access to health care (Rosenberg and Hanlon 1996). Service utilization patterns are used to measure accessibility in theoretical models and some studies (Aday and Anderson, 1974; Joseph and Phillips, 1984; Kuo and Torres-Gil, 2001; McDonald and Conde, 2010). More recently, scholars have started to focus on unmet healthcare needs, which is the gap between service needs and uses, to measure accessibility (Chen et al., 2002; Hendryx et al., 2002; Wilson and Rosenberg, 2004; Gu et al., 2009; Nelson and Park, 2006). Some studies use direct questions such as “Whether you perceive or experience unmet care needs” or “Could you get adequate services when it is necessary” to measure accessibility (Wilson and Rosenberg, 2004; Gu et al., 2009). Aday and Anderson (1974) argue that consumer satisfaction should be

The barriers to access are conceptualized in different ways. Archibald and Rankin (2013) distinguish between individual-level and community-level factors that determine access. Individual factors include personal socioeconomic status, health characteristics, care needs and expectation etc. Community-level factors concern place characteristics. Available services and community sources of care vary in different geographic areas. Anderson’s model (1995) has been used to conceptualize barriers to access in some studies (e.g., Kuo and Torres-Gil, 2001; McDonald and Conde, 2010). Factors related to barriers to access are categorized into three groups, which are predisposing, needs, enabling factors.

Vulnerable population groups studied include the older population, racial and ethnic minority groups and people with disabilities. The older population is widely studied for their access to services. Studies in developed countries and China have shown that having access to healthcare services, early in life or as an older person, has positive impacts on longevity, health status and slowing down functional declines (Porell and Miltiades, 2001; Gu et al., 2009). Two Canadian studies have discussed health service use and unmet health care needs of the older population and whether geography plays a role in the patterns. On a national scale, McDonald and Conde (2010) use the Anderson model
(Anderson, 1995) to conceptualize the factors related to health service use and needs, and they found older residents in rural areas made fewer visits to general practitioners, specialists, and dentists relative to urban residents. On a provincial scale, Allan and Cloutier-Fisher (2006) study the use of general practitioner (GP), specialists, hospital, home nursing care, and alternative health practitioners in urban and rural British Columbia. They found that the use of GPs and specialists are higher in urban areas while the use of hospitals is higher in rural areas. Home support and home nursing care visits are higher in rural and remote areas. They also discuss how individual socioeconomic factors are related to service use patterns. When the older populations are studied in the context of ethnic minorities, Kuo and Torres-Gil (2001) find that health service utilization is related to cultural, structural (e.g., living long years since immigration) and functional factors (e.g., chronic conditions and health status) among older Taiwanese in the U.S.

Racial and ethnic disparities in service accessibility were found in a number of studies in North America (Moon et al., 1998; Kuo and Torres-Gil, 2001; Smedley et al., 2003; Kirby and Kaneda, 2005; Archibald and Rankin, 2013). For example, Archibald and Rankin (2013) focus on community context and how certain community resources are related to unequal access to substance abuse treatments. Racial isolation and limited healthcare resources were tested as links to unequal access in the U.S. Similarly, Kirby and Kaneda (2005) study disadvantaged neighborhoods and how community-level factors have impacts on service use and unmet medical needs by controlling individual factors.

A group of studies focuses specifically on home care use and access. Place matters in accessing home care services. Coyte (2003) argues that access to home care depends on where you live. A rural/urban discrepancy is observed in home care use,
eligibility requirements, service hours and payment. Joseph and Martin-Matthews (1993) noticed that in some small rural towns in Canada in which the proportion of the elderly was large and growing, community care translated into elderly neighbours or family members. Forbes et al. (2004) and Mitchell et al. (2006) compare home care use in urban and rural areas in Canada and the indicators of home care use. They find that geographic location played an important role in home care use, as for both the overall frequency of home care use and the preferences for certain types of home care services.

Mitchell et al. (2007) carried out a study in Manitoba on the indicators of home care use in urban and rural settings. They find geographic location plays an important role in utilization. Urban residents are significantly more likely to use home care or certain home care services than small town or rural residents. Physical functioning is the strongest predictor of home care use regardless of place. However, urban residents with fewer years of education are less likely to use home care than those with more education, while the result is reversed in rural areas. Forbes and Edge (2009, p. 121) also maintain that the absence of intermediary services (e.g., Meals on Wheels, caregiver respite programs, supportive housing), specialty services, and long-term care beds in rural and remote communities often result in premature admission to acute care and long-term care facilities. Overall, access to home care is geographically uneven based on rural/urban communities and different provinces in Canada. Geographers in Canada have contributed greatly to the understanding of the geographic patterns of care.

There are also studies on home care use and access in the United States. Kemper (1992) shows that the probability of receiving informal care at home increases with all
measures of need for care, the number of ADL disabilities, availability of immediate family, age, and being African American or Hispanic; and that it decreases with the presence of a state home care program, income, being female and recent changes for the worse. Informal caregivers are not only the most common providers of care in the community, but they also provide the greatest amounts of care. Liu et al. (2000) track the use of home care by disabled elderly in United State from 1982 to 1994. They find that the disabled elderly with lower levels of Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) tend to pay for their own home care. When the dependency increases, Medicare and insurance played a more important role. Also, the proportion of those using both formal and informal care increases. Katz et al. (2000) study the receipt of home care among the disabled elderly population in the United States. Their study shows a large gender difference in receipt of informal and formal home care. Disabled women receive about one third fewer hours of care than their male counterparts. Married women with disabilities receive many fewer hours of care than their male counterparts. They also show that children, largely daughters, daughters-in-law, and granddaughters, are the dominant caregivers of disabled women whereas wives are the dominant caregivers of disabled men. Compared to the studies in Canada, US studies focus more on specific older populations such as older people with disabilities and minority groups. It shows the differences based on mobility level, race, gender, etc. Canadian studies speak more to the urban and rural divide in home care. The health care and welfare systems in the two countries determine the different focuses of studies.
The gaps in the literature exist in at least two ways. First, there is a lack of study in the Chinese context with a few exceptions such as the study by Bartlett and Phillips (1997), Joseph and Phillips (1999), Wu et al., (2005), Gu et al. (2009). Second, most of the studies focus on access to health care services in formal settings while limited studies have looked at community-based services. Since health has gradually been understood in a more holistic way and more health care responsibilities have been downloaded to the community level with the economic reforms and rise of neo-liberalism, community services are important topics to study in the context of an aging society.

2.3.2 Caring Relationship, Experience of Care and the Spatial Implication

Caring Space

Health geographers are showing growing interests in service-users’ and consumers’ experiences of care services, the concepts of “caring” and “care”, management of bodies and spaces, and the investigation of the qualities of landscapes of care or therapeutic landscapes (Gleeson and Kearns, 2001; Gesler and Kearns, 2002; Parr, 2003; Dyck et al., 2005; Milligan and Wiles 2010) More specifically for care at home, Buttimer (1980) and Somerville (1997) conceptualize the caring space as the interaction site of home, work and body spaces, and are interested in the social implication of home care. They also highlight the significance of place in home care provision and receiving. Home is not merely a site for material practice of care provision for a body with medical needs, but also a site for securing the “social body” (Dyck et al., 2005). Williams (2005) analyzes home from a “therapeutic landscape” perspective. Matthews (2007) concludes that there
are three themes within the issue of home as a site of care: territory and boundary; control and cooperation; and the symbolic significance of home.

Home as a caring space is the intersection of work and life, public and private. This sets up conceptual boundaries where wage and burden come into a place with love, duty and need (Prugel et al., 1996). Various researchers have discussed the boundaries between home and work, work and elderly care, family networks, informal, formal home care and other public-sector services (Milligan, 2006; Keeling et al., 2007; Mahmood, 2007; Phillips, 2007).

As for home and work, Mahmood (2007) argue that the boundary blurs when one’s home becomes the site of another person’s work when formal home care delivery happens. As Dyck et al. (2005) imply, the important issues are the room for negotiation, an individual’s ability to maintain some control over the home environment, integrity of self and assurance of security of person, and the maintenance of material and social identity.

While much of the research paints a homogeneous portrait of caregiving provided by female individuals who are motivated by attachment and norms of filial obligations (Pyke and Bengston, 1996), feminist researchers argue that the home can actually be a place of marginalisation and oppression (Dowling and Pratt 1993, Ahrentzen 1997, McDowell 1999). This body of scholarship has led to a more critical understanding of the home as a place of contested, complex and multiple meanings and experiences.

Other than home as a caring space, Conradson (2003) studies community drop-in centers as space of care in a city in England. Such agencies function as spaces of care for individuals who have positive experience
receiving support and practical assistance; while others may find it as an exclusionary environment. The diverse experiences of space are understood by using humanistic psychotherapy.

**Functional Side of Care**

Some studies look at the functional side of elder care. They discuss different types of care and their functions, the division of formal and informal care.

Havens (1995) develops the “continuum of care” model, suggesting different levels of wellness of seniors and what services should be provided to seniors within different levels. The five levels are: the well population who needs community support; the independent but frail population who needs community and informal care; the functionally disabled living in the community who needs home care services; the functionally disabled living in facilities who need special medical care; and the ill elderly who needs intensive medical care (Hodge, 2008). By looking at different levels of wellness of seniors, targeted policies and services can be provided to the groups.

Hellström et al. (2001) relate the dependency on home care of people 75 years and older to the quality of life. They find that care mainly came from informal caregivers, who provide all IADLs and Personal Activities of Daily Living (PADL) tasks with the exception of house cleaning and bath/showering. Children are the main caregivers. Formal care normally deals with medical matters. A small number of care receivers are also care providers, but wives provide significantly more care than husbands. One third of people reported very low quality of life, which related to both physical and mental illnesses. Ryan et al. (2008) study the importance of high-quality community care to
enable older people with complex needs to remain in their own homes from the voices of both older people and caregivers.

**Caring relationship**

Another group of studies focus on caring relationships in terms of both care recipients and caregivers. Most of the studies in this group are from the caregiver’s perspective. Mears (2009) state that the relationship between care workers and the elderly receiving care is a professional relationship based in a familial context. For home care workers, the boundary issues include invisibility of the work they provide in terms of lack of credibility, the role ambiguity and variability in the work and the extra unpaid work in the realm of home and work. Other researchers agree that home care work is not only dependent on the elderly person being cared for physically, but also the emotional labor (Duncombe et al., 1993; Craib, 1995; Mears, 2009).

Informal caregivers’ experience is studied by a number of researchers. When caregiving and receiving occur within the family network, the relationships with family members are widely discussed (Davey et al., 2004; Creedon, 2008). A number of papers focus on caregivers’ burden (Williams, 2006). Aranda and Knight (1997) discuss the “spillover” effect of caregiving into other domains of the caregiver’s life, like family and work. Other researchers argue that care is not always perceived as burden for informal caregivers and they carry a sense of obligation to care (Barker, 2002; Robinson et al. 2009).
Another circumstance is when family members live a certain distance away from the elderly who need care (Neal et al., 2008). Ley and Waters (2004) imply “spatial stickiness”, meaning the longer the distance the less likely people are to provide care. Studies also show that distance from the care recipient influences the decision about who is the primary caregiver (Phillipson et al., 2001). In other studies, research shows that income, employment and gender affect the provision of long-distance care (Neal et al., 2007). A more extreme situation is when the younger generation immigrates to another country, which leaves the provision of informal care more complicated. Baldock’s (2000) research about transnational migrants in Australia finds that distant carers contribute to the care of parents through letters, telephone calls and return visits. She also maintains that care at such distance can be constrained by financial limitations, social implications and political concerns. Policies and new system are needed to support long-distance carers (Neal et al., 2007).

Power relations among care recipients and caregivers in different spaces are also studied. Kittay (2001) discusses the potential vulnerabilities of care recipient, caregiver and employer in the network of care. Meintel et al. (2006) study the power relations based on gender, race and ethnic status and the implications for workers providing home health care.

On the other hand, some studies focus on care recipients’ experience. Aronson (1990) discusses how older women experience contradictions between the cultural norms of being independent, “unburdensome” and the needs for more family care for security. They carry the feeling of guilt when they do not live up to these expectations. Crist (2005) also discusses how elders in western cultures normally attribute negative
meanings to receiving family care. However, in the study she also found that receiving
family care has positive meanings for some elders and they still view themselves as autonomous. Janlöv (2006) finds that older people have little influence and participation in decisions and needs assessment about their home care and help. Lewinter (2003) examines the reciprocal relationships between older people and caregivers in Denmark. Older people’s personality, expressions of gratitude facilitate caregiving for informal caregivers; home helpers also see them as good role models for their own old age. Fine and Glendinning (2005) challenge the concept of “dependency” and “care giving” by indicating care is coproduced by recipients and providers that different kinds of care are exchanged in the relationship. Overall, Wiles (2011) argues the understanding of care relations from care recipients’ perspective are under studied. Given the reciprocity and interdependent nature of care, Wiles (2011) challenges the traditional understanding of vulnerability of older care recipients and proposes understanding care as interdependent. In some cases, there is no clear division of care giving and care receiving. Older people can be caregivers; care recipients can also be giving care and support to other people.

Research on China

Finally, a group of studies are on care, support, social network and well-being of older population in China (e.g., Stroller, 1985; Liu et al., 1995; Krause et al. 1998; Lee, 1998; Chen and Silverstein, 2000; Lai, 2001; Ng, Phillips and Lee, 2002; Chou and Chi, 2005). Research outcomes are consistent that emotional support is crucial in older people’s well-being. Chen and Silverstein (2000) find that the lack of emotional support is crucial for worsening of the elderly’ health status, while the magnitude of instrumental support
received does not contribute significantly to their health status. They also find that the proximity to children will elevate older parents’ health. Having at least one proximate child—regardless of family size and gender composition—improves the likelihood of getting support and better health status (Chen and Silverstein, 2000). Liu et al. (1995) have similar findings. Other studies in China find that receiving emotional support, even more than financial support, has a positive impact on the well-being of older persons (Krause and Liang 1993; Liu et al. 1995; Krause et al. 1998.). Another body of studies indicates Chinese seniors support to their children or grandchildren is positive in relation to their health and well-being. Lee (1998) and Stroller (1985) discovered that providing support to children strengthens the elderly’s power in the family and is important for their psychological health. Researchers from a cultural perspective find that older Chinese parents holding traditional family norms tend to value productivity in later life. Chen and Silverstein (2000) reveal that providing instrumental support to children directly improves elderly well-being. Chinese society encourages older people to occupy productive roles and avoid dependency. The popular slogan that older people should “contribute their remaining energy” reflects the traditional emphasis on encouraging the utility of the older population. Helping children and grandchildren is a way to fulfill the expectation to live an active life in old age (Chen and Silverstein, 2000).

2.4 Chapter Summary

This chapter provides a theoretical context for the thesis by reviewing current knowledge on old age, care and well-being from various geography, gerontology and other social
science literatures. Two main areas, older people and their geographies, home and community-based care for older people, are reviewed. Studies on older people and the environment take a more empirical perspective in understanding physical, built and social environments for older people and person-environment relationship. On the other hand, old age and geography are also understood from a phenomenological and critical perspective on place meaning and identity to older people. The two sets of focus give a thorough understanding of the issues at macro and personal levels by using quantitative and qualitative methods. Home and community-based care for older people is also understood from macro to micro scales in the literatures. The use of and access to home and community services are studied from a population level. The studies depict patterns of use and provision of services. Care and caregiving, caring relationships and caring space are also discussed by analyzing individual experience. They combine to deconstruct the complexity of the issue.

Studies reviewed cover a wide range of geographical areas show both similarities and differences in terms of demographic structure, spatiality of aging, old age support and care in different regions. There are generally more studies from Western countries both in quantity and depth. The few related studies on China are mostly at the population level and lack theoretical discussion. This is related to the infant stage of community construction and also the history of the discipline in China. Geography in this context contributes to understanding and “exposing who, in terms of their socioeconomic and demographic characteristics and where they live, are most affected by either overt action or the lack of action, which directly or indirectly affects human health and, ultimately, exposes the lack of social justice in our communities” (Rosenberg, 2013, p.6).
As Milligan (2003) states the experience of care is culturally and politically constructed across spaces and Skinner et al. (2014) point out the three turns of biographical, relational and non-representational in the discipline. Bringing the Chinese case into discussion contributes to the geographical understanding of aging as a global issue. The gaps in literature lie in empirical study and theoretical construction. By reviewing the above literatures, it broadens my knowledge empirically, theoretically and methodologically; therefore helping in the conceptualization of my own research. The gaps and limitations which exist in the current literatures inform the adoption of mixed methods as a research design. The conceptualization and methodology which informs this thesis are taken up in the next chapters.
Chapter 3

Reviewing Issues and Policies on Old Age and Care in the Context of Urbanization and Community Transformation in Chinese Cities

3.1 Introduction

This chapter reviews issues related to the environmental changes in the context of rapid urbanization, community construction in post-reform urban China and related emerging policies on elder care. This is important contextual knowledge for this particular research. More specifically, the physical, social, political and health aspects of urban change are mainly related to chapter five and chapter six in understanding older people’s changing relationships with space and place. The reform of community construction and the development of elder care serve as context for chapter seven and chapter eight on home and community-based care for older people.

This chapter is divided into three parts. First, the chapter reviews typical social, physical environmental and health issues related to economic reform and urbanization. Second, community construction reform and the development of community service after the dismantling of Danwei are reviewed. Lastly, emerging national and municipal policies specifically targeting home and community level elder care provision are reviewed.
3.2 Urbanization and Community Transformation in Chinese Cities

Before discussing the relationship between older people and the environment, it is important to first set the context. There are multiple facets of urban changes in Chinese cities in the past decades. Literature in geography and public health has identified some key transformations that are related to population health, social integration and segregation. These findings provide important evidence and contextual information in studying changing places for older people.

Gong et al. (2012) review some key characteristics in Chinese cities that are related to population health risks. They discuss the fast growing urban population, rural-urban migration, air pollution, traffic hazards and accidents, changing diets, urban activity and social structure changes that affect the health of the Chinese population. They find age-related increases in non-communicable diseases such as blood pressure and hypertension are related to the transition to western-style diets, sedentary lifestyles, air pollution and social structure changes. Pucher et al. (2007) study the increasingly crowded roadways shared by pedestrians, motorised and non-motorised vehicles. The roadways have high risks for accidents and injuries. Potentially the risks can be much higher for older people due to decreases in functional ability. Chen and Liu (2009) and Joseph and Phillips (1999) discuss geographical separation between adult children and their parents due to urbanization. They argue that it results in restricted familial social support but can provide increased economic support for parents.

The diversity of residential design and standards has seen increases. (Wang and Murie, 2000) Residential and social segregations as a result of rural-urban migration and housing tenure types have been studied in several cities in China (Fan, 2002; Zhang et al.,
2003; Wu, 2004; Li and Wu, 2008; Li et al., 2010). The general findings are of migrants’
enclaves in the urban fringes and that the urban poor living in dilapidated areas in inner
city areas have formed in post-reform China. Li and Wu (2008) discuss five types of
housing tenure in their model, which are affordable housing, public rental, purchased
public housing, commodity housing and private rental. For city *Hukou* holders, four types
of residential stratification are identified: relocated residents, un-relocated original
residents, post-redevelopment returnees and new settlers with *Hukou*.

New structures of social space and neighbourhoods have formed based on the tenure
types, as the results of market-oriented housing consumption, the *Hukou* system and
Work-units. The new middle class is seeking exclusive living in gated communities
suggests declining informal neighborhood interaction. (Pow, 2009; Wu, 2010) In terms of
neighborhood changes, Wu (2012) argues that modernization and marketization have
driven the changes from courtyard/alleyway housing and shared facilities to self-
contained apartment estates and exclusive services and the sense of community changes
due to work-unit destruction under the slogan of “becoming the social man” (Wu, 2002;
Friedman, 2007). In a study of understanding neighborhood attachment, social
participation and willingness to stay in low-income communities, Wu (2012) finds rural
migrants do not identify with the place of living and do not actively participate in
community activities but express a relatively strong willingness to stay in these places.
On the other hand, unemployed and retired urban residents actively participate in
community activities but prefer to leave if possible. He suggests that neighborhood
attachment and stability are not strictly related. It can be concluded that there are some
distinct characteristics of socio-spatial change in post-reform urban China. New forms of
social and residential segregation are found, social structure and relations are under
contant change, air pollution, over-crowded traffic, changing diets and lifestyles have
potential health risk for vulnerable populations.
These findings indicate the changing nature of physical, social and built environments in
Chinese cities. As a generation who have witnessed the transformation take place in the
city, older Chinese urban residents are under studied in terms of their relations with place
and space, especially in the context of aging society.

3.3 Community Construction and Community Service Development
From 1949 to the end of the 1980s, Chinese cities were organized through the state
Work-units system, along with party-state and household registration systems with public
ownership and an economic command system (Wu, 2002). Party branches existed at all
levels including government, enterprises, institutions etc. Work-units, also called Danwei,
organized the urban population by their work place, and also had the functions of
providing housing, health care, and other social services for employees and their
dependents (Wong & Poon, 2005). People working in the same enterprises shared the
same housing, health care, social security and their children went to the same schools.
Coworkers were also neighbors. So Work-units were more than economic enterprises;
they provided a wide range of social–political and welfare functions (Bian and Logan,
1996). Under this system, urban society was stable and governable through the leadership
of state government.

In the 1990s, economic reforms brought drastic changes to the previous system.
Specific reforms such as dismantling the economic command system, making fiscal
contracts with provincial governments, restructuring the foreign trade system,
commercialization of urban residential space, reforming state-owned enterprises and the fiscal system, changes in the relations between the labour market and government, etc. also meant changes in social relations (Kwok et al., 1990; Davis et al., 1995; Lardy, 1998; Wu, 2002) The Danwei system was gradually dismantled and a large number of workers were laid off from previously state-owned enterprises. This group of people no longer received welfare and social services from the central government or the public system. Social problems emerged so that “Societalization of social welfare and social service” was proposed by Ministry of Civil Affairs (MoCA). This policy was to reduce the government’s responsibility in welfare provision and encourage more actors to participate in social welfare (Guan, 2000). The public and private sectors were to share the job of welfare provision and fees were applied to certain services. As some welfare responsibilities were downloaded to the local level governments, community became the key geographic unit for social service provision under “community construction” reform. Besides providing basic social services for people in need, community construction created jobs for local residents laid off from the public system in the form of building infrastructure and new service sector jobs.

Community in China is a geographic concept defined as a “living entity that is formed by people residing in a certain geographic realm.” (MoCA, 2000, translated by author) In urban settings, community generally refers to a “modified Residents’ Committee following community construction reforms”. (MoCA, 2000, translated by author) The “new” Residents’ committee is defined as a residents’ self-governing grassroots institutional entity under the guidance and assistance of the Civil Affair Unit of a Street Office. Some scholars call communities “semi-governmental” organizations
because they are under close supervision of the government and they carry certain social responsibilities from the government (Xu et al., 2005). The Street Office is the lowest level of government in urban administration system and also plays the main role in policy implementation and community construction reform (Yan et al., 2005). Its Civil Affair Unit works closest with the community. In Beijing, the Street Office is not allowed to be involved in any entrepreneurial activities. The Street Office is responsible for offering guidance and support for social organizations or agencies that provide social welfare and civil services. Fees can be charged for certain social services supported by the Street Office, and the fees collected are returned to the Street Office for community construction and other services. Besides social welfare, the Street Office is also responsible for securing public safety and political stability; community sanitation and environmental protection; regulating local health clinics, businesses, community centers and other agencies; and providing a healthy market environment for economic growth (The People's Government of Beijing Municipality, 1999. Translated by author). The Street Office is under the supervision of the district government, and the municipal government is the highest level of governance in the city.

One of the major responsibilities of communities is to provide services to the residents. As stated in No.23 Document Opinions on Promoting Urban Community Construction Nationwide (MoCA, 2000), expanding community service is the “dragon head” in community construction. In this document, community service includes a wide range of services to different groups:
Social assistance and welfare service to elder population, children, people with disability, poor households and key entitled groups; service for the convenience of community residents, socialized service for community institutions, re-employment services and socialized social security services for laid-off workers. Community service is the key project of community construction…. It should follow the directions of socialization and industrialization. (MoCA, 2000)

Document No. 17 (The People's Government of Beijing Municipality, 1999) stated that market mechanisms should be introduced to community services and community services should be supported by profits gained from the services. Street Offices were also required to construct infrastructure for community services. The largest are Community Service Centers, and more than 90 percent of Street Offices had established Community Service Centers by 2000. By building infrastructure for community services, the goals of providing social services and re-employment of laid-off workers were combined. Therefore, the provision of community services is the combination of free welfare services and services for profits.

3.4 Home and Community-based Service for the Older Population

Several important documents were also published at both state and municipal levels specifically addressing community services for the elderly. At the national level in 2011, the State Council of the People’s Republic of China printed “Notice of the 12th 5-year plan on Chinese Aging Development Planning”. The main strategy towards an aging society was to establish a system “based on family care, supported by community services and supplemented by institutional services for seniors.” The goal was to build “a sound network of home and community-based aging services” and create “a new old-
There are several important messages in the document that are relevant to home and community-based care. First, the document states the roles of different stakeholders. The roles should be the combined efforts of government guidance and society participation. It is worth noting that the term “society” in a Chinese context refers to a unit that is not part of the government or individual families. Society may include grassroots organizations, enterprises, public institutions, non-profit etc. The document emphasizes consolidating the role of family in the care of older people and developing societal services for older people. According to socialist market economy requirements, the government’s roles are “policy guidance, funding support, market cultivation and supervision.” Local governments are supposed to purchase services for older people that have “special difficulties.” Market mechanisms play a fundamental function in resource allocation and all social resources are supposed to be actively mobilized.

Second, the document emphasizes regional differences and local innovation in undertakings for older people. Priority is supposed to be given to: resource allocation in remote areas, local level governance, local strengths and regional advantages. Economically, more developed areas are supposed to provide allowances to the oldest-old and those with financial difficulties. System innovation and creativity from individuals are highly encouraged. Third, moral and legal regulations are required. Moral education on “filial piety” is supposed to be widely conducted and legal support for older people is supposed to be strengthened.

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4 Elderly people who have lost the ability to work, who have no source of income, and who have no legal guardians whatsoever to support them, or their guardians do not have the ability to support them. (Information Office of the State Council of the People's Republic of China, 2006)
Local community medical agencies are supposed to provide medical, health care, health surveillance and home nursing care services to older people. For home care, the document emphasizes the importance of developing home care service agencies and how to guide and support non-governmental sectors to provide home care services, especially private enterprises. Also, the range of home care services is supposed to be expanded. For community services, day care, Star-light senior centers, community centers, nursing homes are supposed to be included in community planning. Family and home are fundamental to elder care. The document encourages family members to live with or be in close proximity to older people. The document also states the importance of enriching seniors’ spiritual and cultural lives by increasing educational, physical facilities and encouraging social engagement.

In 2013, State Council of People’s Republic of China published Document No.35, “Notice of Accelerating the Development of Services for Older People by the State Council” (State Council of People’s Republic of China, 2013). The general ideology was similar to the 12th 5-year plan, but it gave more detailed guidance as to policy implementation. At the community level, home care, meals, counselling, and legal services, day care, community, and senior activity centers, and community health clinics and emergency services were supposed to be provided. Local governments were supposed to encourage private enterprises to develop innovative home care models by using technology and the Internet. The market for social services was to be diversified and an industrial clusters formed. At the same time, 10 million jobs were supposed to be created including a professional labor force in the elder service sector.
The document also specifies favorable policies for private and non-profit sectors to take part in service provision, such as land use, tax, subsidies, loans, etc. Social services for the older people can take the forms of “state built and privately run, privately operated with government support, government subsidy, and services purchased by government”.

Following this document, the Municipality of Beijing published Document No.32 called “Notice of Accelerating the Development of Services for Older People by People's Government of Beijing Municipality” to interpret the policy at the local level (The People's Government of Beijing Municipality, 2013). Besides the measures reviewed above, the following initiatives are specified in the local level document in Beijing. First, Community Service Centers are to be constructed under the direction of the Street Offices and the Street Offices are responsible for the management function in home and community-based care service provision. Community, therefore, ties different parties together. Second, a hotline “96156” home care service platform was implemented that helps service providers to connect with community residents. Third, various associations in the “old-age industry” were established to work on service regulations, evaluation, supervision etc. Fourth, support and respite care to family members who provide care to older people was to be provided. Fifth, construction of grassroots associations to support self-management and self-service by older people was to occur. Lastly, multiple methods to attract funding for elder care services such as investment, subsidy, microfinance, risk compensation, shareholding, etc. was to be employed. Financial institutions, innovative financial products and services, widening credit, increasing credit investment in old-age service enterprises and other related projects were encouraged.
Another important document at the municipal level was introduced in 2009 by the Beijing Bureau of Civil Affairs and Beijing Disabled Person's Federation. (Bureau of Civil Affairs of Beijing & Beijing Disabled Persons’ Federation, 2009) The document “Home Old-age Services for Beijing Residents” is also called the “Nine-security policy”. This document announced the “9064” elderly service model, which refers to 90 percent of the older population are to age at home, 6 percent are to be financially supported by the government to help them age in place by using home and community-based care services, and 4 percent are to age in institutions. Other policies written in the document include awarding 10 thousand “Model of filial piety” for those who take good care of their older family members; distributing “Elderly Home Care Coupons” for those who are 80 years old and over or those between 60 to 79 years old with severe disabilities to purchase home care and community services; providing meal services by government subsidized private catering businesses; providing day care services with a mix of government subsidies and out-of-pocket payments; hiring staff to provide and supervise home care services at the Street Level; providing emotional care and counselling services to older people; and providing assistive technology devices to older people with partial government subsidies.

In general, community construction is an important social reform in urban China which has developed since the economic reforms of the 1980s. It not only aims to tackle the problems of social welfare in the post-Danwei era, but also to assist economic development and create jobs for laid-off workers. Community is defined as a geographic concept while it also carries administrative and political meanings. According to the documents and policies at different scales, Residents’ Committees and Street Offices are
important administrative units for policy implementation in community construction. They have multiple functions in communities, and one of them is providing community services for older people, especially in the context of aging-in-place. The services specified in the documents include community health care, home care, meal services, daycare, activity centers, counselling, legal services etc. These services provided at the community level are a mix of fee and free services. The government encourages various parties in society to be the providers, including the public and private sectors, non-profits, volunteers, and individuals. The family has a fundamental role in elder care as moral regulation of filial piety is very much valued. The government secures the care needs of older people with “special difficulties” by purchasing services to help them age-in-place. The government also encourages enterprises that provide elder care services with subsidies and other favorable policies (tax, land use etc.). Market mechanisms have been introduced, and gradually, non-governmental actors are becoming major providers of services under government supervision. The state policy leaves room for local innovation and regulation flexibility.
Chapter 4

Research Design and Method

4.1 Mixed Method Approach

There are four main reasons for taking a mixed method approach in this study. First of all, older people residing at home in urban China have barely been studied in either the geography or gerontology literature. There is limited information available to help locate the research questions. For example, who are the older people aging at home and what their living environments look like; what are the available home and community-based services for them and what are the general patterns? In order to gain an understanding of these contextual questions, a wider net needs to be cast. In the beginning of the fieldwork, I was trying to seek databases that had been built by universities or research agencies. Unfortunately, either the sampling strategy did not match this study or the databases were unavailable. Under the circumstances, a questionnaire survey was designed for the purpose of providing contextual information.

Second, quantitative data collected in the questionnaire survey helped shape and modify the interview guide and provided a sub-sample in the second stage. Informed by the questionnaire survey, interview questions were modified to better target the key issues. Participants in the questionnaire survey became potential interview participants. They were contacted for their willingness to be interviewed. It helped the research to target those who had care experiences, were in greater care need and encountered more challenges in old age.
Third, by using both methods to look at the same research topic and a similar set of research questions, a fuller and more solid understanding of the research issues were gained. Quantitative data showed patterns at the population level. Qualitative data from the interviews provided further explanation to the problems identified in the first stage. Qualitative data are more effective in capturing the lived experience of individuals and interpreting the changing meanings.

Finally, using a mixed methods approach contributes to the methodological discussion in the field of health geography. Rosenberg (2014) has argued that growing theoretical and methodological pluralism has paradoxically led to “new divisions” in health geography. There are still very few examples of health geography research where the same or similar topics are examined using both quantitative and qualitative methods. In this study, the author used both methods to understand the same topics. By comparing the findings from both analysis, similarities and differences were found. The comparison potentially shed light on the discussion of the relationships in quantitative and qualitative studies, the different angles, the effectiveness of combining the two methods and their strengths and weaknesses in the sub-discipline of health geography.

4.2 Research Scope and Area

Only people with Beijing Hukou (Household Registration) are included in the study. This is due to multiple reasons taking into consideration the current pension system, Hukou system, elder care policies and demography in China.
The Hukou system determines the type of social security, pension, and health care one can get. Hukou is used to identify whether someone is a resident of a certain administrative area. The Hukou system is organized by the unit of household, and information registered including spouse, parents, children and whoever lives in the same household. Therefore, a family is registered as a rural or urban household of a certain place. A resident’s health care insurance, education, pension and other social security payments are all determined by where the person’s Hukou is located. Hukou in different places have different policies tied to it, while the difference between urban and rural areas is the most obvious. For example, the pension system is relatively comprehensive in urban China, while in rural China, it is rather incomplete. The basic pension system in urban China gets its funding from government, employers, and employees. Employers pay an amount equal to around 20 percent of employees’ salaries, which goes to social pooling; employers pay around eight percent of their salaries, which goes to individual accounts. Once someone meets the retirement age and has paid into an individual account for more than 15 years, the person gets paid from the two accounts, which contain about 20 percent of the average monthly salary of local employees in the previous year and the other part is about 1/120 of the total funds in individual accounts (State Council Information Office of China, 2004; Ministry of Labour and Social Security of China, 2005, 2007; Cheng, 2011).

In rural China, the pension system is still under construction and only covers a small proportion of the population. Older people without children and relatives get an allowance called the “Five Guarantees” (Kallgren, 1992; Bartlett, 1994). In 2009, Guidance on Creating New Rural Social Pension System for Rural Areas by the State
Council aimed to implement a new rural pension system in 10 percent of the counties all over the country and set up goals to cover the total rural population by 2020 (State Council of China, 2009; Cheng, 2011). Health care coverage is similar to the pension system in term of disparities among places especially rural and urban. In Beijing, as the capital city of China and a global city, the central government has engaged in certain discursive practices and mobilised a disproportionate amount of resources (Yeung, 2000). As a result, its residents may have different sets of social security, health care and other social policies and are given priority to new policies compared to residents from less developed regions. By excluding people without Beijing Hukou, this study provides a methodologically more consistent investigation and analysis.

Another reason for only including older people with Beijing Hukou is the majority of the older people living in Beijing are those with Beijing Hukou. Due to the economic reforms, there is a fast growing migrant worker population from rural China to the big cities and economically more advanced areas. This group constitutes the majority of those who live in Beijing but without Beijing Hukou. Therefore, for the caregivers I interviewed, there were a number of migrant workers (N=11). This subgroup of caregivers was mainly concentrated in the working age cohort. Their older parents would not normally move to the city where their children are located due to economic difficulties. For those older people who move to Beijing where their children are working, they only constitute a small proportion of all of the older people and they are normally economically well-off. Taking into consideration the above factors, elder care recipients were recruited for this study only if they held Beijing Hukou.
The metropolitan Beijing area has been expanding rapidly over the past 20 years. Geographically, metropolitan Beijing is divided into four zones: the urban core, the urban expansion zone, the new developmental zone and the eco-conserving zone from the inner circle to the outskirts. (Fig.1) The urban core includes Dongcheng and Xicheng Districts; the urban expansion zone contains Haidian, Chaoyang, Fengtai and Shijingshan Districts; the new developmental zone includes Tongzhou, Shunyi, Fangshan, Daxing and Changping district; and the eco-conservative zone contains Huairou, Pinggu, Mentougou, Miyun and Yanqing Districts. Each zone has its own distinct geographical features and is experiencing different aging patterns, care needs and provision. The city is becoming a very complex system as it expands enormously. Taking into consideration practical concerns as well as methodological soundness, this research only looked at the urban core and urban expansion zones, which are the six urban districts of Beijing.

At the same time, under the economic reforms, changes toward a local state, entrepreneurial governance and decentralization of social services have been observed in urban China. The destruction of the “work-unit” system and opening up to the private market challenge the state’s ability to maintain social stability. Local governments have to mobilize revenue as part of the economic strategy while their social functions cannot be weakened by their entrepreneurial behaviors. “Community building” is the strategy that the state uses to consolidate its social functions and re-control urban society. Therefore elder care exhibits a more polycentric structure as well with different territorial functions based on revenue earned and capacity. In order to answer properly the research questions, data were collected by communities and analyzed on different geographic scales such as the district, community and neighborhood.
Legend
- Urban Core
- Urban Expansion Zone
- New Developmental Zone
- Eco-conserving Zone

Figure 1 Beijing Four Functional Zones (Source: State Council of China, 2006)
4.3 Methods

The first stage of data collection was a questionnaire survey (See Appendix A). The aim of the questionnaire was to understand the population socioeconomic and health characteristics, perceived physical and social environments, general aging in place experience, relocation intention, care needs, care utilization patterns and accessibility.

To be more specific, section one asks about sex, age, education, socio-economic status and living arrangements of older people. Section two asks about physical health conditions, medical condition and mobility level of the older person. Section three includes questions about mental health status and well-being. These parts answer the questions of who are the older people aging at home and what are their potential health care needs. Section four asks about older people’s perceived social environment. Section five includes questions about the physical and built environments of older people, general satisfaction of aging in place experience and intention of relocating to a residential care facility (RCF). Section six and seven identify specific care needs and available home and community-based services, the caregivers, their satisfaction levels and the reasons behind unmet care needs. The questionnaire also includes an open ended question for older people to comment on some important information they want to emphasize and add.

The second stage is qualitative research on the changing person-environment relations, their experience of aging in place, place meanings, care experience of both the care recipients and caregivers in different places (See Appendices B and C for interview guides). The research design focuses on the specific issues of environmental changes, place meanings, aging in place experience, self-perceived barriers to care, care relationships and caring space. The interviews are used to figure out older people’s
changing relations with their environment, old age and place, what determines the experience of care and what are the power dynamics care recipients and caregivers.

Only frontline caregivers were included in the interviews. Frontline caregivers were interviewed on site.

4.4 Sampling Strategy

For the sampling strategy, a stratified sampling technique was used for the questionnaire survey. The overall sample size was calculated based on the older population of Beijing in 2010. There were approximately 1,560,000 older people in the six urban districts of Beijing in 2010. With a margin of error of four percent and a confidence level of 95 percent, the sample size generated was 473. The second step was to allocate the number among the six urban districts according to their respective older population sizes. The estimated sample size of each district is shown in Table 1.

<table>
<thead>
<tr>
<th>District</th>
<th>2010 Older Population (ten-thousands)</th>
<th>Percentage</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dongcheng</td>
<td>20</td>
<td>13%</td>
<td>61</td>
</tr>
<tr>
<td>Xicheng</td>
<td>28.7</td>
<td>18%</td>
<td>85</td>
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<tr>
<td>Haidian</td>
<td>36.4</td>
<td>23%</td>
<td>109</td>
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<tr>
<td>Chaoyang</td>
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<td>26%</td>
<td>123</td>
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<tr>
<td>Shijingshan</td>
<td>7.5</td>
<td>5%</td>
<td>24</td>
</tr>
<tr>
<td>Fengtai</td>
<td>23</td>
<td>15%</td>
<td>71</td>
</tr>
</tbody>
</table>

Table 1 Estimated Sample Size Calculation

For the qualitative study sampling, a purposive sampling strategy was used. One of the important aims of the study was to look at the social construction of aging and care, to discover the care experiences both individually and contextually. With this in mind, people who did the questionnaire were asked whether they wanted to be
interviewed and a purposive sample was generated from those who indicated that they were willing to be interviewed. I selected those older people who were comparably representative of different groups of people in different places. The selection was based on the results from the questionnaires. Participants also introduced other older people and caregivers to the main investigator. Caregivers of different kinds were interviewed. They included family members as caregivers and live-in caregivers from both private and non-profit agencies. The sample size for interviews was determined by multiple factors such as the demographic, representativeness of different groups, time and cost. The overall principle was when the same information was repeated several times and no more different or new information was offered, interviewing ended (i.e., saturation).

4.5 Recruiting Strategy

To recruit respondents, questionnaires were taken to each community and distributed by random selection. Strategies like being in public spaces, going to special events, snowball, and contacting community officers were used. The specific strategy chosen depended on the characteristics of each neighborhood, such as the type of residents, spatial features, the demographics, etc. Most participants were recruited in public spaces in their communities. For example, parks were especially useful places for recruiting since they are gathering places for both older people and caregivers to socialize with each other. Older people with or without self-care ability were recruited. By contacting local community employees, the researcher was also able to recruit at special events and older people’s homes. Therefore, those who stayed at home most of time are included in the study. Older people already surveyed
introduced others to the researcher, especially those they believed were in vulnerable situations for care. As a result, 90 percent of the respondents were recruited in public spaces and 10 percent were surveyed in home settings. A total of 451 older people were surveyed. The overall margin of error which resulted is 4.87 percent at a confidence level of 95 percent.

The survey was carried out by the researcher and trained research assistants (RAs). The interviewers were undergraduate geography students from the School of Geography at Beijing Normal University and were trained and supervised by the researcher and Dr. Yang Cheng. All RAs signed a confidentiality agreement. Trained undergraduate students also did the data entry after signing confidentiality agreements under the supervision of the researcher and Dr. Yang Cheng.

For caregivers, a similar approach was taken. Parks are an important place to find live-in caregivers for interviews. Some older people also introduced their caregivers, most commonly a family member. Eventually, 47 older people and 21 caregivers were interviewed. All interviews and transcribing was done by the researcher.

Letters of information (Appendix D – Sample Letter of Information) and consent forms (Appendix E – Sample Consent Form) were designed for both the questionnaire survey and interviews. The letters of information provided detailed information about the researcher, purpose of the study, potential risks, the procedures and other related ethical issues. Participants were informed about confidentiality and that they could withdraw anytime they liked during the survey or interview. The consent form asked the participants if they understood what was described in the letter of information and
provided contact information for the principal investigator and General Research Ethics Board (GREB).

At the beginning of each survey and interview, both the letter and form were provided. During the survey, we found out most of the older people were reluctant to sign the consent form. They gave oral consent instead. Eventually, the study was carried out by providing the letter of information and accepting oral consent.

Ethics approval was provided by the General Research Ethics Board (GREB) at Queen’s University (Appendix G).

4.6 The Questionnaire and Measures

The questions asked in the questionnaire include basic information such as older people’s socio-economic status, living arrangements, health status, mobility level, etc. Older people were surveyed for their perception of the physical environment which includes their housing situation and the community built environment. Satisfaction of children’s visit, helpfulness of community and sense of community were chosen to evaluate the perceived social environment. In a general sense, the social environment is understood as social connection and social support from older people’s networks. The reasons for including the question “are you satisfied with children’s visit” are the importance of children in older people’s later lives in Chinese family and it is imposed by law that children should pay regular visit to their elder parents. “Do you think community is helpful when you have needs?” is asked in the context of community construction after the destruction of the traditional work-unit system and the increasing role of the community in providing elder care directed by multi-level policies. Sense of belonging in
the neighborhood is asked to understand how much older people identified and connected with their communities. They were also asked about their general experience of aging in place and if they have intention of moving to a RCF. Questions on home and community-based services were asked in the last two sections. Participants identified the use, needs and satisfaction level of each community service and home care service. They were also asked about unmet needs, the financing of services and the reasons for unmet needs. A personal approach was employed such that each questionnaire was done face to face with one of the researchers or trained research assistants. Each question was asked with clarity and accuracy.

Age was grouped into three categories when describing the personal characteristics of participants (60-69 = 1, 70-79 = 2, 80 and over = 3), gender (males =1, females = 2), marital status (married/partnered = 1, not married/partnered = 2), living arrangement (living alone=1, living with one person=2, living with two or more people=3) education level (high (≥ high school graduate) = 1, low (elementary school or middle school) = 2, never went to school = 3). Income was measured by “monthly average income per capita” (0-2773RMB = 1, 2773-3770RMB = 2, 3770 RMB and above = 3). The classification of income levels are based on the pension levels used by the Beijing Municipal Bureau of Labor and Social Security in 2013. Self-rated health and mental health (separate questions) were measured by responses to the question “Overall would you rate your health/mental health as excellent, very good, good, fair, or poor?” Responses were ranked on a five-point scale (excellent=1 to poor=5). “Need for community care services” and “need for home care services” were dichotomized as Yes (1) and No (2). Satisfaction with children’s care and visits was also ranked on a five-point scale with “very satisfied”
as 1 and very dissatisfied as 5. In the data analysis, satisfaction with children’s visit is
dichotomized in two categories (satisfied and very satisfied=1; dissatisfied, very
dissatisfied and so so=2).

A set of independent variables intended to capture the living environment of
neighbourhoods was based on self-reported perceptions regarding several aspects of the
neighbourhoods where participants lived. Satisfaction with aging in place and age
friendly community were classified on a five-point scale with very satisfied (1) and very
age friendly (1) and very dissatisfied (5) and very age unfriendly (5) respectively.
Community support was measured by asking “how do you feel about the likelihood that
you will receive community support when needed” with the responses ranked on a five-
point scale from very likely (1) to very unlikely(5). In the data analysis, the above
variables were dichotomized as yes or no.

The factors of health care and elder care services included “availability of
community care services”, “availability of home care services” and “accessibility to
health care”. The responses were dichotomized as Yes (1) and No (2), convenient (1) and
not convenient (2).

4.7 Data Analysis

The data analysis is divided into two parts and four stages. Generally speaking, statistical
methods are adopted using SPSS for quantitative analysis. Data analysis of the qualitative
study is guided by the comparative methods described in Strauss, (1998). Indicators of
categories in the qualitative data are coded. Codes are constantly compared to find
consistencies and differences and therefore categories are revealed. Categories eventually reach saturation when no new codes are formed and relationships of categories are validated. In the end, the core categories are determined to explain the research questions. The qualitative data analysis was done in Chinese and translated into English in the chapters that follow.

To understand old age, environment and place, data from the questionnaires are first analyzed using descriptive statistics to identify the basic socio-demographic and health characteristics of the older people. Then, cross-tabulations are used to examine older people’s satisfaction of aging at home, intention of relocation by socio-economic status, health characteristics, perceived physical and social environments. Lastly, regression models are used to test what factors determine older people’s aging at home satisfaction and intention of moving. Qualitative analysis on the same topic is done using Nvivo. A conceptual framework is developed based on coding and the categories generated.

To understand access to care and experience of care, descriptive analysis and cross-tabulations are done in SPSS. Utilization patterns, care needs and access to care are identified on a more general level. Qualitative analysis again is done by using Nvivo. Data are categorized and analyzed by different caring relationships.

4.8 Demographics of the Sample of Older People

4.8.1 Demographics from the Questionnaire Survey
Table 2 shows how the sample sizes from each district match with the older population distribution in Beijing (13%, 18%, 23%, 26%, 5% and 15% in Dongcheng, Xicheng, Haidian, Chaoyang, Shijingshan and Fengtai District). The only significant difference is Fengtai District, where 12 percent of the questionnaires originated compared to 15 percent of the actual population. Although Fengtai district is part of the “Six Urban Districts”, some parts of the area are still rural by nature. The rural parts have different elder care policies and the communities are organized differently. Therefore, I did not include questionnaires completed in rural parts of Fengtai district in the analyses that follow.

<table>
<thead>
<tr>
<th>District</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dongcheng</td>
<td>13</td>
<td>54</td>
</tr>
<tr>
<td>Xicheng</td>
<td>19</td>
<td>77</td>
</tr>
<tr>
<td>Haidian</td>
<td>23</td>
<td>91</td>
</tr>
<tr>
<td>Chaoyang</td>
<td>27</td>
<td>111</td>
</tr>
<tr>
<td>Shijingshan</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Fengtai</td>
<td>12</td>
<td>49</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>399</td>
</tr>
</tbody>
</table>

Table 2 Geographic Distribution of the Sample

Table 3 shows that 48 percent of the sample are males and 52 percent are females. Forty-five percent of the respondents fall into the age group of 70-79 years old and 29 percent belong to the oldest old age group. Sixty-seven percent of the sample is married and 32 percent are widowed. Income is divided into 3 levels based on the pension levels used by the Beijing Municipal Bureau of Labor and Social Security in 2013. Thirty-nine percent of the older people surveyed have incomes below average, 33 percent have medium income levels and 23 percent have higher incomes.
compared to the rest of the sample. Some people refused to tell their incomes due to personal reasons. Most of the people get their incomes from pensions, a small percentage of people receive income from wages, family and their properties. In terms of education level, 46 percent of the people completed primary and elementary school levels and 40 percent of people have high school diplomas or a post-secondary education. There are, however, 13 percent of the older people surveyed who indicated that they never went to school. While there is now a 9-year compulsory education law, it was not implemented until the 1980s in China. The number of children is another factor to take into consideration since the “One-child policy” changed the family structure in urban China in particular. Nineteen percent of the respondents have one child, and most of them are from the younger age group. Thirty-three percent have two children and 32 percent have 3 or more children. In terms of living arrangements, 45 percent of the people live with one other person, usually a spouse, 12 percent of the sample lives alone, and the rest live with two or more people.
<table>
<thead>
<tr>
<th>Gender</th>
<th>% (No.)</th>
<th>Income (Chinese Yuan)</th>
<th>% (No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>48 (194)</td>
<td>0-2773</td>
<td>39 (158)</td>
</tr>
<tr>
<td>Female</td>
<td>52 (211)</td>
<td>2773-3770</td>
<td>32 (131)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0)</td>
<td>3770 and above</td>
<td>23 (93)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Income Source (multiple choice)</th>
<th>% (No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-69</td>
<td>Pension</td>
<td>92 (374)</td>
</tr>
<tr>
<td>70-79</td>
<td>Wage</td>
<td>6 (23)</td>
</tr>
<tr>
<td>80 and above</td>
<td>Family support</td>
<td>6 (24)</td>
</tr>
<tr>
<td></td>
<td>Unemployment insurance</td>
<td>0 (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Minimum living allowance</th>
<th>% (No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td></td>
<td>1 (3)</td>
</tr>
<tr>
<td>Living together</td>
<td></td>
<td>0 (1)</td>
</tr>
<tr>
<td>Widow(er)</td>
<td></td>
<td>32 (129)</td>
</tr>
<tr>
<td>Separated/divorced</td>
<td></td>
<td>1 (4)</td>
</tr>
<tr>
<td>Never married</td>
<td></td>
<td>0 (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>% (No.)</th>
<th>No. of People per Household</th>
<th>% (No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary School</td>
<td>23 (92)</td>
<td>1</td>
<td>12 (48)</td>
</tr>
<tr>
<td>Elementary School</td>
<td>24 (97)</td>
<td>2</td>
<td>45 (182)</td>
</tr>
<tr>
<td>High School</td>
<td>17 (69)</td>
<td>3</td>
<td>15 (62)</td>
</tr>
<tr>
<td>College</td>
<td>10 (40)</td>
<td>4</td>
<td>15 (60)</td>
</tr>
<tr>
<td>Bachelor or above</td>
<td>13 (53)</td>
<td>5 or more</td>
<td>12 (50)</td>
</tr>
<tr>
<td>Never went to school</td>
<td>13 (52)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of Children</th>
<th>% (No.)</th>
<th>No. of People per Household</th>
<th>% (No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2 (5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>19 (78)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>33 (133)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>18 (74)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>14 (57)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 or more</td>
<td>15 (60)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 or more</td>
<td>12 (50)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3 Demographic and Socio-economic Characteristics of Questionnaire Participants

4.8.2 Demographics from the Semi-structured Interviews

The overall sample includes 47 older people and 21 caregivers. Among the 21 caregivers, five of them are 60 years old and over. Table 4 shows the demographic and socioeconomic characteristics of older people who participated in the interviews. Forty-
nine percent of the older participants are male and 51 percent are female. Nineteen percent belong to the younger old group and 38 percent are in the older old group. Fifty-seven percent of the participants are married and 43 percent are widowed. The majority of the participants have elementary or high school degrees. Sixty percent of the participants are in the average income group. Most of the participants have two or three children. Fifteen percent have one child and they are mostly the generation under the One-Child Policy.

Most of participants live with one other person at home, usually a spouse. In some cases, they live with a child or live-in caregiver. Nineteen percent of the participants live alone. For residential type, 57 percent of the participants live in new public housing, which is the most common residential type in Beijing. Only nine percent of the participants live in commodity housing which belongs to their children.

Among the 21 caregivers, 11 are live-in caregivers. They are all female migrant workers. One participant is 30 years old while all the others are between 40 to 51 years old. Two of them have high school education and others have elementary or primary school education. Ten are informal caregivers, who are children and spouses in this case. Among them are five female and five male caregivers.
<table>
<thead>
<tr>
<th>Gender</th>
<th>% (No.)</th>
<th>Income (Chinese Yuan)</th>
<th>% (No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>49 (23)</td>
<td>0-2773</td>
<td>23 (11)</td>
</tr>
<tr>
<td>Female</td>
<td>51 (24)</td>
<td>2773-3770</td>
<td>60 (28)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0)</td>
<td>3770 and above</td>
<td>17 (8)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>No. of Children</th>
<th>Marital Status</th>
<th>No. of People per Household</th>
<th>Education</th>
<th>No. of People per Household</th>
<th>Residential Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-69</td>
<td>19 (9)</td>
<td>Married</td>
<td>18 (9)</td>
<td>Primary School</td>
<td>1 (1)</td>
<td>Public Rental Housing</td>
</tr>
<tr>
<td>70-79</td>
<td>43 (20)</td>
<td>Living together</td>
<td>0 (0)</td>
<td>Elementary School</td>
<td>1 (1)</td>
<td>Purchased Public Housing</td>
</tr>
<tr>
<td>80 and above</td>
<td>38 (18)</td>
<td>Widow(er)</td>
<td>1 (1)</td>
<td>High School</td>
<td>1 (1)</td>
<td>New Public Housing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Separated/divorced</td>
<td>2 (2)</td>
<td>College</td>
<td>1 (1)</td>
<td>Commodity Housing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Never married</td>
<td>3 (3)</td>
<td>Bachelor or above</td>
<td>1 (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 (4)</td>
<td>Never went to school</td>
<td>1 (1)</td>
<td></td>
</tr>
</tbody>
</table>

Table 4 Demographic and Socio-economic Characteristics of Older Interview Participants

In the following chapters, the data and methods described above are used to examine older community living people in urban Beijing and the challenges they face as they grow old in their communities. The statistical analysis identifies health status, socio-economic characteristics of the survey participants, perceived person-environment relationships, service use and attitudes towards care received in a more general sense.
Qualitative data analysis looks at similar research questions and provides more detailed data about aging in place experience and the care experience of both care recipients and caregivers. They are compared in the end for a comprehensive understanding of the research questions.
Chapter 5

Perceived Environment, Aging at Home Experience and the Intention to Relocate

5.1 Introduction

In western countries, concepts such as “aging in place” and “age-friendly city” are promoted by policy makers to encourage older people to stay in their communities. In the academic literature, multiple approaches have been taken to study the complex relations among older people, place and space. When policy is directed towards aging in place in mainland Chinese cities, there is a gap in the current literature in understanding the experience of aging in place in relation to home and neighborhood environments. At the same time, Chinese cities have been experiencing many facets of urban transformation since the economic reform in 1978, and are showing a spatial shift away from socialist patterns in land-use, housing, administrative systems, etc. Older people have to negotiate with home and neighborhood that are undergoing social, cultural and political changes. There are both theoretical and practical needs to understand whether older people are satisfied with aging at home and the environmental factors that might push them toward institutional care in a Chinese context, therefore to create an environment for healthy aging in place.

The purpose of this section is to understand place and old age in the Chinese context. More specifically, how older people perceive their physical and social environment and experience aging in place. Quantitative data from a questionnaire survey will be used to measure older people’s perception of physical and social
environments and whether the environment is related to survey respondents’ satisfaction of aging in place, thus influencing their decision to move to a RCF.

The quantitative analysis incorporates perceived physical and social environmental factors to understand older people’s experience of aging at home and community, and these factors influence the intention to relocate. In an empirical sense, aging in place in this study is understood as those who currently reside in home and community settings. The term residential care facility (RCF) is used to represent long-term care institutions excluding hospitals. The following research questions are answered: 1) Who are the people reporting negative experience of aging in place when tested by individual characteristics and their perceived environment? 2) What kinds of patterns are shown for people who have intentions to move to a RCF? 3) What are the determinants of positive experiences of aging at home and the relocation intention?

A questionnaire survey was carried out in 2013 and older people who resided at home were recruited in six urban districts of Beijing. Four hundred and five valid questionnaires were received and descriptive and multivariate statistical methods were applied. The results shed light on aging policy and further research on home and neighborhood environments for the older population.

5.2 Findings
From the dataset, 78 percent of the older people surveyed had positive general experiences of aging in place. Thirty percent of people had thought about moving to a RCF. Sixty percent of people surveyed found the community not helpful, 32 percent were not satisfied with children’s visits, 36 percent were not satisfied with housing conditions,
49 percent did not think the neighborhood built environment is age friendly, and 49 percent did not have a sense of belonging in the neighborhood.

5.2.1 Patterns of Negative Aging in Place Experience and Intention of Relocation

Cross tabulation is used to find out who tended to report negative experience of aging in place and the intention of moving to a RCF. Only those factors that are significant are shown in the tables. The percentage of people indicating negative experiences in each sub-group is shown in tables 5 and 6. Of the 22 percent who indicated negative experiences of aging in place, results in table 5 show those who also think the built environment is not age-friendly, who are not satisfied with children’s visits and who are dissatisfied with their housing situation. No individual characteristic stands out in the tables.

When the intention of moving to a RCF is tested, individual characteristics stand out rather than the perceived physical environment compared to negative experience of aging at home. The results show that those who are in the younger age group, have poorer health status, married, living with less than two people, and are dissatisfied with children’s visits are more likely to indicate an intention to relocate to a RCF. No physical environmental factors stand out.

In short, children’s visits play an important role in both the experience of aging at home and the intention to move. The physical environment tends to influence the experience of aging at home and individual characteristics tend to affect the intention to move.
### Table 5 Cross-tabulation Results for Negative Experience of Aging in Place

<table>
<thead>
<tr>
<th></th>
<th>Negative Experiences of Aging in place (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-friendly Built Environment***</td>
<td>Yes 11</td>
</tr>
<tr>
<td></td>
<td>No 34</td>
</tr>
<tr>
<td>Satisfied with Children's Visit**</td>
<td>Yes 17</td>
</tr>
<tr>
<td></td>
<td>No 32</td>
</tr>
<tr>
<td>Satisfied with Housing***</td>
<td>Yes 10</td>
</tr>
<tr>
<td></td>
<td>No 43</td>
</tr>
</tbody>
</table>

### Table 6 Cross-tabulation Results for Intention of Moving to RCF

<table>
<thead>
<tr>
<th></th>
<th>Intention of Moving to a RCF (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age*</td>
<td></td>
</tr>
<tr>
<td>60-69</td>
<td>38</td>
</tr>
<tr>
<td>70-79</td>
<td>31</td>
</tr>
<tr>
<td>80 and over</td>
<td>22</td>
</tr>
<tr>
<td>Health Status*</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>26</td>
</tr>
<tr>
<td>Poor</td>
<td>35</td>
</tr>
<tr>
<td>Marital Status*</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>34</td>
</tr>
<tr>
<td>Single/Widowed/Divorce</td>
<td>23</td>
</tr>
<tr>
<td>Living Arrangement*</td>
<td></td>
</tr>
<tr>
<td>Living Alone</td>
<td>38</td>
</tr>
<tr>
<td>Living with one person</td>
<td>35</td>
</tr>
<tr>
<td>Living with two or more people</td>
<td>23</td>
</tr>
<tr>
<td>Satisfied with Children's Visit**</td>
<td>Yes 25</td>
</tr>
<tr>
<td></td>
<td>No 41</td>
</tr>
<tr>
<td>Experience of Aging at Home***</td>
<td>Positive 25</td>
</tr>
<tr>
<td></td>
<td>Negative 50</td>
</tr>
</tbody>
</table>

### 5.2.2 The Determinants of Positive Experiences of Aging in Place and the Intention of Relocation

Having identified the people who have negative experiences of aging at home and have intentions to move to a RCF, the next step is
to examine the complexity of the determinants and their relationship to aging in place experiences and the intention to move using binary logistic regression analysis. Two logistic regression analyses are performed. Each analysis includes four models. The first model includes health status, age, sex, marital status and income as independent variables. Perceived social environment variables are added in the second model including satisfaction with children’s visits, sense of neighborhood and helpfulness of the community. The third model includes physical environment variables (housing satisfaction and age-friendly built environment of the neighborhood). The fourth model only tests the variables that are significant in the previous models.

Table 7 shows four models for experience of aging at home. The first model explores the relationships between demographic characteristics and experiences of aging at home. It shows no demographic factor stands out in determining aging at home experience. With respect to the social environment variables, the odds ratios indicate that the likelihood of having positive experience of aging at home increases when older people are satisfied with children’s visits and they agree the community is helpful. For example, compared to those who are not satisfied with their children’s visit, those who are satisfied are 85.9 percent more likely to report positive experience of aging at home. Those who perceive their community as helpful are 124 percent more likely to have positive experiences. The third model includes physical environmental factors. Both variables are significant in determining aging at home experience. Relative to those who are not satisfied with their housing conditions, those who are satisfied are 448.9 percent more likely to have positive experiences. Those who believe they live in an age-friendly built environment in the neighborhood are 164.1 percent more likely to have positive
experiences. The last model tests the variables that are significant in the previous tests. Three variables including satisfaction of children’s visits, housing conditions and the age-friendly built environment are significant. Satisfaction with housing conditions increases the likelihood of having positive aging at home experiences by more than four times; those who agree that their communities have an age-friendly built environment are 150.2 percent more likely to have positive aging at home experiences; those who are satisfied with children’s visits are 78.7 percent more likely to have positive experiences. The second logistic regression analysis is performed to find out the determinants of older people’s intentions to move to a RCF. In all three models, the only significant variable is satisfaction of children’s visits. In the second model, people who are satisfied with children’s visits are 74.7 percent less likely to indicate an intention to move. In the third model, the likelihood indicating an intention to move increases by 73 percent if older people are dissatisfied with their children’s visits. No other variables were statistically significant.
<table>
<thead>
<tr>
<th>Variables</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
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<tr>
<td></td>
<td>ß</td>
<td>Standard Error</td>
<td>Odds ratio, significance</td>
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<tr>
<td>Demographic</td>
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<tr>
<td>Children’s Visit</td>
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<tr>
<td>Sense of Belonging</td>
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<tr>
<td>Physical Environment</td>
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<tr>
<td>Housing Satisfaction</td>
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<td></td>
<td></td>
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<tr>
<td>Age-friendly Built Environment</td>
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<td>5.488***</td>
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<td>0.971</td>
<td>0.341</td>
<td>2.641**</td>
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</table>

Sample size, 405; Significance *p<0.05; **p<0.01; ***p<0.001. Model 1-4: Nagelkerke R=0.109; 0.270; 0.281; 0.296.

Table 7 Regression Models on Aging in Place Experience
### Table 8 Regression Models on Intention of Moving to RCF

<table>
<thead>
<tr>
<th>Variables</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Estimated Coefficient (β)</td>
<td>Standard Error</td>
<td>Odds ratio, significance</td>
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<td><strong>Social Environment</strong></td>
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<td></td>
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<tr>
<td>Children’s Visit</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sense of Neighborhood</td>
<td></td>
<td></td>
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<td>Helpful Community</td>
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<td><strong>Physical Environment</strong></td>
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<td>Housing Satisfaction</td>
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</tr>
<tr>
<td>Age-friendly Built Environment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sample size, 405; Significance *p<0.05; **p<0.01; ***p<0.001. Model 1-3: Nagelkerke R=0.043; 0.044; 0.073.
5.3 Discussion

When looking at the results individually, the younger age group is more open to the idea of moving to a RCF. Especially for the 60-69 years old group, which is the first generation of the One-Child Policy, they tend to receive less care and support from their only child. Traditional values and attitudes toward residential care are also influenced by social and economic transformation (Cheng et al., 2011); the younger generation tends to find residential care more acceptable than the older generation. Older people in poorer health tend to indicate an intention to move. It is possible that they believe elder care services will be more accessible in a RCF than in the community. The results also show that among older people living alone or with one person, more people tend to have the intention to move than people living with two or more people. People who live with more people tend to have more family support and caregivers than people living alone or with one person. For the sample in this study, 88.5 percent of the people living with one person are living with their spouses, who likely need care as well. People who are satisfied with children’s visits have greater chances of not moving since they may feel enough support from home. Those who are married tend to indicate an intention to move more than those who are widow(ed), divorced or single. This is contrary to previous studies (e.g., Zhan et al., 2006) on marital status and institutional care. It can be further explained when looking at the age composition and health status of the married couples.

The physical environment, including housing conditions and the neighborhood built environment, explain the tendency to relocate to a RCF and also determine the general experience of aging in place. Beijing has various residential types from the traditional Hutong, work-unit apartment
buildings to commercial high rises etc. Some interior dwellings characteristics embedded in different housing built in different times are strongly related to aging in place experience. This issue is taken up in detail in the next chapter using qualitative methods. An age-friendly built environment also contributes to positive experiences of aging in place. With rapid urbanization in Beijing, population and residential densities have risen drastically in the recent decade. Some neighborhoods are mixed with different functions and facilities. Communities have much more diverse group of residents, from local to the younger floating population; neighbourhoods have to cater for various needs from different people. As community construction was launched more recently in China, the population is aging fast and older people are encouraged to age in place, it is crucial to transform built environments into age-friendly ones. It would be helpful to reference the measures that have been used in western countries in transforming the physical environment into age-friendly ones. When comparing housing conditions and built environments, housing conditions show a stronger tie to aging in place experiences. This is in accordance with previous findings from Hong Kong that where it was found that interior environments have greater impacts on residential satisfaction than exterior environments. (Phillips et al., 2005)

The social environment also explains aging in place experience and the intention to move to a RCF. Older people’s children’s visits, as stated in previous studies, are an important factor when discussing aging in a Chinese context. Children play multiple roles in older people’s lives including home care providers, emotional caregivers, financial support, decision making, etc. (Zhan et al., 2006; Chan and Pang, 2007; Cheng et al., 2012). For this study, older people were asked to evaluate the attention and care they get
from their children as a large part of their social environment. Whether older people are satisfied with their children’s visits not only determines their experience of aging in place, but also helps to explain their intention to move to a RCF. As a Chinese saying goes “Raising children for old age” (“养儿防老”), the Confucian culture of filial piety remains strong in older people’s well-being in China.

Another point worth noting is that satisfaction with children’s visits is the only significant variable in the logistic regression analysis of the intention to move. It is not surprising given the complex nature of thinking about the future. It does not mean other factors are not important considering the limitations of the research. Rather, it strengthens the fact that children play a unique role in the cultural context of research on aging in China. The result is also consistent with the idea of stigma that sending older people to RCFs symbolizes abandonment by the family. As stated in a previous study, institutional care is the last resort for those who have no family around, who need special care or so much help that their family cannot cope (Wu et al., 2005).

Another variable that is significant with aging in place experience is helpfulness of the community. Helpfulness means whether the community can solve problems, provide services and be accessible to older people who reside in the neighborhood. As a relatively new concept in China, community was first introduced in the mid 1980s after the destruction of the work-unit system. Community became the key geographic unit for social service provision under community construction reform. As a generation who spent most of their lives under the work-unit system, community is the new organization they can go to when they encounter problems. The effectiveness of community determines aging in place experience to an extent that also cannot be neglected.
Overall, the chapter answers the research question of how older people perceive their physical, built environment and their relationships with the experience of aging at home and intention of relocation to a RCF on a population level by analyzing quantitative data.
Chapter 6
Place Making in Old Age In the Changing Environments

6.1 Introduction
The qualitative study seeks to understand how older people in Beijing deal with the changing landscapes in their neighborhoods and aging in place in a Chinese context. Forty-seven older people who currently live at home were interviewed about their perceptions of home space and the neighborhood environment, experiences of aging at home, the decision to relocate and their ideal place to age in the context of rapid neighborhood and urban transformation in the city of Beijing. Based on the interviews, the following research questions are answered: 1) How are meanings and identities constructed in different types of housing and neighborhood for older people in Beijing? 2) How do older people cope and negotiate with changing person-place relationships? 3) What does aging in place mean to older people in Beijing?

6.2 Conceptual Framework
During the first two stages of coding (constant comparison and open coding), a conceptual framework was derived (Fig2). This framework shows how relocation and housing types matter in person-environment relationships, place identity and place making. Thus how aging in place is understood in a Chinese urban context. The framework was used to further develop themes and construct theories in the next stage of data analysis.

Broadly speaking, older people interviewed can be categorized into two groups: those who remained in the same dwelling from the pre-reform era and those who
relocated in the post-reform era. A series of reforms starting from 1978 was used to
determine if the person interviewed belong to the “post-reform relocated” category. For
those who stayed in the same home since before the reform, there are two housing tenure
types: public rental and purchased public housing. All the housing in this category are
owned or were built by either Workunits or the Bureau of Housing. Older people pay low
rents or they have the ownership of the housing. Two types of neighborhood appear in
coding the data. One is traditional tenement housing located in the inner two rings of
Beijing. The other is mid-rise built by Danwei (Work-unit). These residences are located
near work places.

In post-reform Chinese cities, housing has been opened to real-estate developers
and commodity housing is becoming more common. Gated communities are being built
and they are more exclusive to people with high incomes. Another category is termed
“new public housing”. In this study, it is referred to as resettlement or affordable
housing. Resettlement housing is compensation for those whose residences were
demolished in the process of urbanization and urban renewal. Affordable housing is built
for those with low or no income. A commuter town is located at the margin of the urban
district that mainly consists of commercial buildings owned by working age people.
Some older people were relocated to this area. Working age residents commute to the
inner city for work during the day and the neighborhood is empty. Four neighborhood
types are identified in the qualitative data: gated high-rises, resettled and affordable mid-
rises, and commuter town housing.

Based on relocation experience and residential type, older people develop various
relationships with the physical, built and social environment. Place embodies different
meanings to older people and place identity is shifting due to the changing urban landscape. Older people negotiate and cope with their current spaces, in the process emotions are carried along. Ultimately, older people establish their understanding of aging in place and institutional long-term care.

Based on the framework, codes are categorized into four groups (public rental housing, purchased public housing, new public housing and commodity housing) and are compared among the groups. Relationships are proposed during the data analysis. New public housing is a more common residential form that is reflected in the data. Twenty-seven out of 46 people interviewed lived in new public housing. Those who have never moved are older on average in the dataset. The initial findings show those who resided in commodity housing showed a strong tie to their children both financially and emotionally. Based on residential and neighborhood types, older people reported different experiences of the changing physical, built and social environments. Their interactions with the environment and their life experiences further illustrate their changing place identities. Residential type, socio-economic status and life experiences all play a role in how older people cope and negotiate with their changing spaces. There are also some overlapping themes across the groups. Finally, despite pleasant or unpleasant experiences of their current housing, few older people indicated any intention to move to a RCF compared to the larger sample used in the quantitative analysis of chapter five. In the interviews, the older people expressed their understanding and expectation of aging in place.
In the following sections, environmental changes will first be discussed as situational factors in understanding place meanings and coping strategies. The discussion will be built around residential and neighborhood types. Then, data analysis will reveal how environmental changes, socio-economic issues and health status shape “new” place identities and meanings. The conflicts and tensions emerged in the process of space shaping and negotiation will be illustrated. Finally, how older people’s emotional status and the effectiveness of their coping strategies speak to their anticipation of aging in place will be discussed.
6.3 Older People and the Changing Environments

Environment in this study is understood in terms of physical, built and social environments. Person-environment changes are shown in different dimensions: the changing urban landscapes and social networks with urbanization; the functional and cognitive changes due to increase in age; generational life experiences. The physical and built environment, in contrast to the social environment will be discussed separately with regard to residential and neighborhood types.

6.3.1 Physical and Built Environment

Each residential type contains one or more forms of neighborhood. According to the data, all the people interviewed who live in public rental housing are living in tenements in *Hutong*. This represents the traditional neighborhood in Beijing. With the increasingly crowded inner city and recent gentrification, the current *Hutong* neighborhoods are mixed with poorly maintained tenement housing (*Dazayuan*), upgraded high-end courtyard housing (*Siheyuan*) and guest housing (hostels and hotels) in certain touristic areas. For those who have never moved and have purchased public housing, they are living in either the *Hutong* neighborhood or mid-rises that were built or collectively purchased by their Work-units (*Danwei*). For those who have relocated to new public housing, neighborhood types identified by older people are affordable housing, collectively purchased or constructed *Danwei* mid-rises, commuter town and collective resettled mid-rises. For those who moved to commodity housing, they live in gated mid and high rises. Results show that people in the same neighborhood share common themes in terms of the physical and built environment.
**Hutong Neighborhood**

In the traditional *Hutong* neighborhood, the landscape has gone from *Siheyuan* to *Dazayuan* and to a more mixed form nowadays. Traditional *Siheyuan* housing has been largely destroyed since 1958. The Housing Bureau took over private housing turned them into centralized administered rental housing for the increasing urban population. In the 1970s, even with severe housing shortages, *Siheyuan* housing was modified to create more living space. *Siheyuan* housing was gradually turned into tenements (*Dazayuan*) thereafter. Housing got worse in the 1980s when small factories were built in inner city areas under the policy of turning Beijing into an industrial city. More people moved into the *Hutong* area with self-constructed poor quality housing. After the economic reform, urban renewal projects took place. A number of residents were resettled to new public housing. However, still a large number of local people remain in the tenements. They tend to be older people, retired workers with low incomes, people on welfare and laid-off state-owned enterprise workers. They tend to have low levels of education. Due to the low rent and city-center location, tenement rental housing became popular for migrant workers.

Three themes are generated for the Hutong neighborhood (Liu, 2005). First, certain design features embedded in the *Hutong* neighborhood hinder mobility for older people with their functional declines. The stairs at the entrance of courtyards are high and some need to be fixed. The stone stairs are also icy and slippery during winter. The *Hutong* area is narrow but with an increasing number of vehicles. Older people have to share the narrow lanes with cars and it is a safety concern. A number of people mentioned the public bathrooms.
There is no grab rail in the tenement, now I have artificial limb and we don’t have washroom at home. I have to go all the way to the shared washroom, and this is very inconvenient.”

In general, with their functional decreases, older people living in the Hutong neighborhood found it was hard to get around.

The second theme is housing quality. Dilapidated buildings are quite common in the neighborhood.

“You see, there are so many cracks in the building. Look at that tree attached to my room, it grows bigger and bigger. I am worried one day my house will collapse. It is so cold in the winter and bad circulation in the summer. It is hard on my knees.”

The third theme concerns inner city land use. As the land prices skyrocketed in the old city of Beijing in the 1990s, older people felt that their spaces had been compressed and the built environment does not take into consideration the well-being of older people. They believed that land has been used solely for profit-generating purposes and that there is no activity space for them. They found the only space for them to socialize with other neighbors is the stairs by the courtyard. In areas with many tourists and nightlife, older people found it is hard to live peaceful lives.

One older person who lived next to “Guijie”, the famous 24-hour dining street and tourist destination in Beijing:

“We live on Guijie, with many street food stalls and bars. The whole street is unsanitary and noisy. We have lived here for a very long time and it is getting worse everyday. I couldn’t sleep properly for a long time…Normally it only gets quieter after three or four in the morning.”

However, they agreed that living in the inner city provides them with better access to major hospitals. In general, the historical and social context of the tenements has determined the current living environment for the older residents.
Danwei and Resettled Mid-rises

Danwei is the most common residential type in Beijing. Based on the data, people living in this type of residence fall into the following groups: those who resided in the same Danwei before and after the reform; those who resettled in Danwei in new collective purchased housing; those who resettled due to urban renewal projects; and those who qualified for affordable housing. For neighbourhood types, three types are identified for this study: typical Danwei; resettled or affordable mid-rise communities; and commuter towns.

For the typical Danwei or resettled mid-rises, older people interviewed were generally satisfied with their housing situation. Especially for those who were resettled from depilated housing, they felt grateful that the living situation had largely improved. They also thought it was much quieter compared to the city center. For some older people who have experienced severe poverty in the life course, they found having a place to stay was already a luxury.

No. 40: “I moved with my wife, she is a teacher. There was the policy of improving teachers’ housing condition. So we got relocated to the current apartment. Housing condition has improved a lot compared to when I was in Bajiao, thanks to our government!”

The most reported environmental challenge older people have with this type of residence is the lack of an elevator. Construction regulations say that buildings that have seven floors or more are required to install elevators. Lots of the Danwei mid-rises are less than six floors. Many older people were worried they wouldn’t be able to get out of their homes. Other physical and built environmental challenges identified were sanitary
issues, messiness in the stairways and lack of activity space. Interestingly, in some cases, older people thought their apartments were crowded. Some older people mentioned housing prices were too high for young people and that their children had to move in with them.

No.10: “My biggest concern is elevator. My wife got injured in a car accident and she couldn’t move back home because of it. I can still use the stairs now but I worry one day I couldn’t either.”

Commuter town is another neighborhood type identified in the data. Some older people interviewed were resettled to more marginal areas of the city where commuter towns are found. Older people interviewed thought the pollution was even worse compared to in the city center. They believed the apartments are more spacious than in their older dwellings in the inner city. The most common theme they discussed was the large street dimensions and the demographic structure of the areas.

No.1: “My older home was demolished and I was relocated here. It is further here but the apartment is more spacious. I am on first floor so I even get a garden. I am planting flowers and people love my garden in the neighborhood… The streets are so wide here and the cars are driving fast. It is very scary to cross those intersections. The traffic light changes when I am still not half way through… The whole area is empty in the day and most of the people living here are young people. They only come back here to sleep. We don’t have activity center. There are no supporting facilities for older people. I guess because there are not enough older people living here?”

**Commodity housing**

The four older people in this category are all widowed and they moved to their children’s property. Depending on where the housing is located, two older people found the location was not convenient for them to go to the hospitals. Two of them showed certain levels of maladaptation to the new high-rise where they lived.
No. 46: “I don’t think the new apartment is more comfortable than my old home. I was living in the courtyard in old city. It was much older housing but I get lots of sunshine. I moved here for my daughter.”

6.3.2 Social Environment

In terms of the social environment, four groups of people were mostly discussed by participants: old neighbours, family, community staff and “new comers” in the neighborhood. Relationships with caregivers are not discussed in this chapter. That discussion can be found in chapter eight. Here, the social environment emphasizes the social network changes along with urban transformation. Results show that the relocation experience and their relocated neighborhood type mattered in how they responded to their changing social environments.

Rental and Purchased Public Housing (NM)

Table 9 displays the common responses from older people who have no relocation experiences. In general, people who do not have relocation experiences had strong ties with their neighbors. For some people, their neighbors were also their colleagues from the Danwei housing. Old neighbors are the largest component of the social networks for most of the people. At the same time, interview participants also identified the fact that more people were moving out if they can afford a new place. As for family members, various responses were received. Some believed their children needed education on filial piety and some had satisfying relationships with their children. Most of the participants did not have a positive relationship with community staff. However, they expressed understanding for the difficult job community staff have. Older people and the “new comers” in the communities barely interact with each other. Some participants also
mentioned how they had very distinct life styles and renters were often depicted as “out-of-towners”.

<table>
<thead>
<tr>
<th>Common Responses</th>
<th>Old Neighbours</th>
<th>Family</th>
<th>Community Staff</th>
<th>“New Comers”</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.45: “My social life is chatting with my old neighbours. No other people really provide emotional support to me other than them…. We trust and help each other. I have a pretty strong sense of belonging here. But more of them who have some money are moving out of here…”</td>
<td>No.18: “I am not happy with my children. I think they are too selfish and need more education on filial piety. I think they get better after my education but still not good. The sense of morality of this generation is getting weaker, also civic mindedness.”</td>
<td>No.16: “I am on welfare and the staff is very attentive. I live alone and I am moved by how much they care about me…”</td>
<td>No.21: “We are close to Gujie, there are too many migrant workers renting here who work there. They have night shifts and come home late…Our schedules never match…”</td>
<td></td>
</tr>
<tr>
<td>No.16: “I have strong sense of community…. Those who are well off are gradually moving out and renting out their places here. There are still some old neighbours I can chat with, but I don’t social with most of the new people here. I don’t trust people that easily now.”</td>
<td>No.45: “…My children are good. I talk to them when I have issues or need to solve problems…”</td>
<td>No.10: “We simply don’t have old-age service. But I understand that current community isn’t working great, cause they couldn’t make decision without more support from upper level administrations.”</td>
<td>No.16: “Now lots of the people living here are out-of-towners. Fewer neighbours are native Beijingers. I don’t know those people.”</td>
<td></td>
</tr>
<tr>
<td>No.14: “Most of people living here are still our old colleagues from Danwei, say three quarters? We lived in the same neighbourhood for decades and we know each other very well. We get along well, and care about each other.”</td>
<td></td>
<td></td>
<td>No.14: “Maybe our Danwei residence is not located in the city center so there is less renters from elsewhere.”</td>
<td></td>
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</tbody>
</table>

Table 9 Subjective Views of the Social Environment by Older People Who Have Never Moved
Relocated New Public Housing and Social Environmental Changes

For those older people who live in relocated new public housing, their perceptions of their neighbors varied based on if they were relocated with their old neighbors or Danwei. In general, older people live in new public housing showed strong attachment to their old neighborhood relationships. They expressed the loss of trust and sense of security in the new environment.

No.1: “I miss my old neighbours in my old neighbourhood…. They are all my old colleagues and we trusted each other. We greeted and helped each other often. I’ve lived here long enough but we simply don’t talk much. I don’t feel at ease here cause there are theft and even murder once in the neighborhood. I am wary of my surroundings.”

For those who were relocated with their old neighbors or Danwei, they showed stronger ties with neighbors compared to others. One participant was taking an older woman in a wheelchair for a walk:

No.32: “We used to be neighbors in our old houses and now we relocated together to the commuter town. My wife is taking care of our grandson now that I don’t have much to do at home. So I take her out for a walk everyday. There are mostly young people living here and we don’t communicate with them. We happened to live next door again after relocation and we take care of each other.”

Another participant was relocated to the Danwei:

No.5: “I moved here in 1988 and I feel attached to my neighborhood. Most of my neighbors are old comrades from Danwei, we always help each other out. When I have any difficulty, I will talk to my colleagues for solutions. We have cultural activities so we often get together.”

In discussing their relationships with family members, they generally showed understandings of the social pressures on the younger generation; and in a number of
cases, their adult children are living with them because of the high rent and housing prices in Beijing.

No. 2 “My children are very busy, I understand. I don’t count on them as much. They even need my care. They work very hard out there….”

Interview participants showed high level of dissatisfaction with the community staff and the “disconnected” relationships with them. They believed unlike the old days when the interaction with the local government or Danwei was for the good of people; now it is about profit-driven activities.

No. 3: “Community staffs treat their work as purely a job instead of the undertakings of serving people. There is no emotion and passion. It is unlike the old relationships of the party and the masses. They just want to get the task done. I have no idea who they are. Instead, we connect more with property management when things are broken at home.”

Some participants believed place matters in terms of relationships with the community. They thought since they had been relocated out of the old city, community construction was less grounded compared to in the city center.

No. 1 “Here is not like the old city, community construction is falling behind. They don’t have the basic publicity, not to mention others. We don’t interact with them…. Maybe here there is a great number of floating population and they don’t know who the old folks are. I don’t see any action from them.”

For those who were relocated with their Danwei, they felt indifferent about the community and community staff.

No. 38: “Our Danwei takes good care of us retirees. I don’t care if community staff takes care of me or not…. Our Danwei has Retirees’ Division that is responsible for our retirement needs and I am very happy with what they offer to us.”

Older people who resided in new public housing also discussed their relationships with new comers. They were generally
suspicious of the constantly changing renters and other people in the neighborhood such as sales people. They believed the high mobility of people made them less likely to trust the new comers.

No.2: “People move in and out, I don’t know who lives here. Things get stolen if you are careless, not like when we were in a courtyard, nobody steals no matter where we left our belongings. I lost a case of stuffs once, I am too afraid to tell my partner…. I am always alerted.”

Commodity Housing (PRR)
For the four participants who live in commodity housing, their social networks have shifted greatly. Their families have taken over most of their social lives instead of neighbors from their old communities. They generally felt satisfied with filial piety of their children. The relationship with community staff is very weak.

No.23 “I live with my daughter and son-in-law and they are both very filial to me…. I listen to them about everything and I have no worries. Look my shoes and cloths, my children bought them for me. I don’t even have to cook and do grocery. I also have very good relationship with my daughter-in-laws. My children support me financially and I give my pension to them as well. My grandchildren are now in college or have started working. They are all doing very well. I eat and sleep well cause I have a happy family.”

6.3.1 Environmental Changes and Challenges for Older People
The above findings show residential and neighborhood type matter greatly in how older people perceive their surrounding environments. They experience different environmental challenges.

For people who have no relocation experience and live in the Hutong neighborhood, they face more built environment challenges while they show stronger ties with neighbors and community staff. At the same time, more old neighbors are moving out and a growing number of migrant workers or “out-of-towners” are renting in the
tenements due to the location and cheap rent. The majority of them reside in declining and even dangerous housing, experience shrinking public space due to the soaring land values and various land investments. The design features of tenement courtyard living, such as public washrooms, can hardly meet the needs of older people in a modern society. Whether they are renting or have purchased their current housing differences in their perceived environment does not show.

People who have relocated to new public housing, enjoy improved housing conditions while they feel strong nostalgia for their old neighborhood relations. Unless they were relocated with their older neighbors or colleagues, they are generally skeptical about their social environment due to the transient nature of the new residents. They are also disconnected from the community staff with the exception of those who still have Danwei taking care of them. Some of them have their children moving in with them due to the high rents and property values young people cannot afford. This makes their apartments crowded. The biggest built environment barrier for this type of residence is no elevator. Other physical environmental problems older people identified, especially those who live in affordable housing, were sanitary conditions and the messiness of the hallways. For those who were relocated to commuter town housing, they expressed concerns about pollution, traffic and crossing the wide streets.

Older people living in commodity housing have more modern dwellings but still show maladaptation to a certain extent, because of the high-rises and their distant locations. They felt especially disconnected with people other than their children with whom they are co-residing. However, they all were extremely content with their children’s filial piety.
6.4 Place Meanings and Identity

Many facets of environmental changes have been driven by urbanization and rapid development. In this section, findings reveal how older people interpreted the meanings of place and their identities in the changing environments. I seek to understand which aspects of the past are present in current place identity construction and why among the older people interviewed. It is argued that for the older generation, their place identities are deeply rooted in pre-reform Collectivism and shaped by different socialist ideologies (equality, standardization, uniformity etc.). However, the current physical, built and social environments inform the meanings of place and challenge their identities that have been established throughout the life course. The representation of the socialist past among older people is circumscribed by their economic conditions and environmental situation. The identity for those who reside in public rental housing (NM) is associated with socialist equality. This group of people still lives in dilapidated tenement housing, encounters many built environmental barriers, does not have housing ownership and tend to have low incomes. They did not gain much from the economic reform, and face even more challenges from social support network changes and declining living conditions. They talked about how unlike in the Maoist era when all necessities were provided, now the responsibility is downloaded to individuals. However, they firmly believed all occupations are equal in terms of their contributions to socialism and they felt unfairly treated after their lifetime of work. With the destruction of Danwei and the weakening of old social support systems, the feelings of being forgotten and denied got stronger. Their old identity is being threatened while any new identity has nowhere to be established in a place which carries mixed or even chaotic meanings for them.
No. 20 “…People from the Housing Bureau say our houses are under Danwei not them, but our Danwei does not have a department for housing. I don’t know where we belong…. We were workers and believed all professions were equally important…. We used to have low incomes before the reforms but everything was covered. After the reforms, our incomes increased but it is not socialism anymore. The wealth gap is way too big…. We’ve all contributed to socialism all our lives, but we live in such terrible housing, nobody cares. It feels like all the contributions being denied…”

For those who reside in purchased public housing (NM), place to them is more of a habitual status and convenient location. The most common theme was how much they were used to living in the neighborhood. Since people who have never moved tend to be those who are in the oldest-old group, their reduced mobility and declining health strengthened their sense of continuity in place.

No.15 “I have lived here long enough and I am so used to live here. It’s like inertia…. It’s a good location, very convenient for going to hospitals. I had stroke and my brain doesn’t function as well as before. So there’s no way I am going to move. ”

People who are on welfare and/or live in affordable housing (PRR) shared similar thoughts as those who reside in rented tenement housing. They had a strong collective consciousness and devotion to socialism but were disappointed about social inequities in their current place.

No.6 “I think we as old folks, should give more living spaces to young people. We should leave more opportunities to them. Community can construct collective retirement area that we old people can take care of each other, to save some space. But I think now, people are too selfish. They only care people who are well off. It’s like they are given priorities to basically everything. Don’t you think so?”

One older woman moved in with her son in his affordable housing:

No.31 “My husband passed away more than a decade ago. He was a soldier for Lin Biao’s army. He experienced countless dangerous battlefields and risked his life fighting the war. He has very poor health because of his injuries. We are too honest and naïve; we don't receive much education and we never know how to ask for things. Then we ended up having nothing. I just moved to live with my son in his affordable housing. My husband and I used to live in a tiny dilapidated room near the Fengtai train station. There
was not even tap water. He still insisted in paying the party membership dues even he was immobile and in poverty. I was waiting for demolition and relocation notice for years and now I can’t wait anymore. It simply doesn’t worth it…. “

As indicated in the previous section, interview participants who live in resettlement housing (PRR) enjoyed improved housing conditions while they felt strong nostalgia for their old neighborhood relations. Their identity is more bound up with the socialist collective lifestyle. They are used to the Danwei system where they have strong social ties with old colleagues and/or neighbours. The loss of trust and sense of security in their current social environments brings back their identity that is inherent in socialist collective living.

No. 39 “If you ask me if I have a sense of belonging here. Well, I feel attached to the people not the community. Our Danwei has been removed; I still keep in touch with my old colleagues who still live here…. The new Residents’ Committee isn’t working…. Our generation is used to collective living. The feeling gets stronger when I get older. Danwei used to gather us together but here I feel left out. Empty nesters like me need collective activities. It would be nice if we can gain a sense of collectivity in the community. ”

Depending on their age or life experience, those who experienced different historical events and political turbulence believed their generation was easy to satisfy.

No.11 “…Our 80-years-old generation is very easy to satisfy. We have been through wars, starvation and revolutions. As long as we have a place to stay and enough food to eat, it’s alright….”

In general, there is a generational shift over identity and value systems. Those who built socialism and/or grew up with it encounter an identity conflict with the generation whose lives have been shaped by the processes of marketization and privatization5,

5 Marketization means the reform of state-owned enterprises to operate as market-oriented firms. Market economy was established to replace planned economy in the pre-reform China. Many sectors were privatized, including enterprises, housing, finance, education, health care etc.
No. 39 “Young people nowadays don't understand what older people have been through. Social polarization is too severe now. I sometimes try to find help from community but they don’t get my difficulties. Young people simply don’t get it!”

Older people who reside in commodity housing with their children have constructed yet another identity based on family and filial piety. They all receive sufficient financial support from their children. Family relationships are most valued and are the source of life satisfaction.

No. 46 “Home is a warm place. Life has no meaning if without home and family. I enjoy my family life very much. I don’t know my neighbours here but I am happy.”

In sum, the socialist past is selectively manifested in older people. Different places hold various meanings for them through their changing environments. By analyzing the data based on their residential types, it shows older people’s environmental changes, economic and health status are related to how they interpret place meaning and identity. For people who grew up in pre-reform socialism and absent from the current economic gains, their identity is highly contested and a new identity has not yet formed. They are confused about why housing, community and family work differently for different people in different places despite the shared history and contribution to socialist society. The notions of equality and uniformity come back into play and are in conflict with their changing environment. Their declining health and constrained mobility reinforce the sense of continuity in place. For older people who have relocated to resettlement housing, their identity is more informed by social environmental change. The pre-reform identity of collectivism is threatened by the destruction of Danwei and the construction of community. A small group of people, who receive strong financial and
emotional support from their families, have formed an alternative identity in their old age. Material well-being and filial piety of family members tend to contribute to the construction of this new identity. However, the majority of the older generation did not benefit much from the economic reform; rather, they experienced different facets of environmental changes with which they find difficult to cope.

6.5 Negotiation, Coping and Emotions: Place Making in Post-Reform Beijing

In this section, findings illustrate how older people cope with environmental changes and negotiate with challenged place identities. One common theme emerged, the role of children, regardless of older people’s residential types, socioeconomic and health status. Some of them talked about how they would follow whatever plans their children might have for them; others indicated that they would depend on their children when they can no longer cope. Some participants were not satisfied with their children’s filial piety even though they educated them constantly in the hope that they will be taking on more responsibilities in their later years:

No. 18 “My children are not very filial to me. I think they need more education on it. I always talk to them about the virtue. They are getting better now, but still not good enough.”

However, not everyone thought of relying on their children as a coping strategy. People who belong to the young-old group (most of them are part of the one-child generation) did not believe that children are dependable due to the sorts of social pressures they face every day.
Another common theme that comes up is communicating with the community (Residential Committee or Street Office) about the challenges they are facing. Except those who reside in relocated commodity housing, it is a common strategy that the rest of the older people use. Most of them did not find it was an effective way of problem solving, but they were still trying with the expectation that the new community will treat them the same way as their Danwei.

No.5 “I tried many times negotiating with staff at the Street Office, they just don’t want to take the responsibility…. I went there in the name of an old comrade. They gave me attitude and thought I was superfluous…. My intentions were good but it felt like they threw cold water on me…”

There are also some other place-specific negotiation strategies older people took. Some older people living in purchased public housing (NM) remade neighbourhood space into a more welcoming place that gave them a sense of continuity of collective living in the old days. They expressed the importance of creating a pleasant physical and built environment for the residents. They also tried to check in with each other every day in case of any emergency. The space reshaping efforts were effective because the neighborhood had a number of old neighbors/colleagues who remained together. For neighborhoods that are less socially cohesive, space reshaping can hardly be initiated.

No.14 “Since Danwei is now part of society, we belong to the community. No one is responsible for us anymore…. Some of us old neighbors still care about each other and the community. Look at these chairs, tables and games! We bought them. We made those cushions as well. We also clean the public space ourselves. We pick up the garbage whenever we see some…. We volunteer in the neighborhood and keep each other informed about our recent developments. If we don’t see the old folks showing up within a day or two we will knock on the door making sure everything is OK. They are some very frail ones who live alone. We pay special attention to them.”
On the other hand, some participants stayed in the tenement housing neighborhoods (NM) where not many old neighbors remained and with a mixed demographic structure. Their coping strategy was avoidance of an undesirable environment. They were either avoiding dealing with life struggles or interacting with their social surroundings. One participant illustrated how he protected his own space by never stepping out of his home.

No.15 “I barely get out of my room now. For one thing my health condition makes it a bit difficult for me to move around. But I just avoid interacting with anyone beside my partner, unless I have to. I simply don’t want to talk to anyone in the neighborhood. I stay at home every day, do some reading and writing. I even lose my temper sometimes with my partner. I know it’s no good. ”

Adaptation is a strategy frequently mentioned by older people who relocated. Lawton’s concept of individual competence and “environmental proactivity” can be applied here in understanding how older people develop coping strategies under environmental press. The adaptation skills identified by participants include: developing an optimistic mentality, actively maintaining physical independence and boosting endurance. They believed their generation had been through many difficulties experienced as part of various historical events so the abilities to adapt and endure hardships were strong.

No.2 “I try to be positive, tolerant and philosophical about things. I know the importance of keeping a good mentality…. I have limited economic resources, the government doesn’t provide much convenience and I don’t think I can rely on my children. I don’t know. I’d better exercise more to keep healthy. In that way I don’t have to count on anyone. But you can never predict, can you? I just take one step, and look around before taking another. I dare not think too much about the future. ”
An alternative adaptation strategy is taken by a small group of participants who live in relocated new public housing (PRR). They started renting out their extra bedrooms and became landlords. They conformed to the changing social and economic environments under the processes of urbanization. Participants in this group are all in good health and belong to the young-old age group. They live in areas (e.g., Wudaokou) where there are a number of universities and these areas tend to be mixed with international students and expatriates. They found it was an effective way of saving for their old age security and also maintaining an active social life.

No.4: “My life is dealing with my renters. I got compensated for this apartment when my old one was demolished. I have three bedrooms so I rented out two to university students. I earn thousands of Yuan each month. It is very good income and I am saving for my later life if I need more care. I like chatting with them as well. I like making young friends. This area is also very popular with international students who come to learn Chinese. I had foreigners living here too. We got along pretty well. They brought me souvenirs from their countries.”

Some older people to cope with their relocation experiences and overcome place isolation in their new neighbourhood used public transit to go to the old city or their old neighborhood every day for the familiar social environment. Participant No.1 also mentioned how taking the bus is getting more difficult for them due to their decreased functions and the over crowded buses in a rapidly urbanizing city.

No.24: “I live on the East 5th ring that I take bus for one and half hours one way every day to come to the park here in my old neighborhood. No one talks to each other in my new neighborhood. Things and people have changed in the old city too but I feel much more connected here…”

Participant No.23 cope dealt with social isolation by developing hobbies and learning new things such as calligraphy, painting and sports. This strategy was mostly
used by those who have their basic living needs satisfied, are in better health and have higher education.

In face of identity loss, some older people created spiritual spaces of their own. No.40 mentioned how he still believes in the Communist Party and that maybe policy will favor older people one day. Several other participants started practicing Buddhism for their peace of mind.

Some more extreme measures were taken in certain cases. For those who live in public rented tenement housing (NM), sense of insecurity came from no property ownership. In some cases, they brought lawsuits against the housing bureau in fighting for housing ownership (No.18). One participant (No.21) who lives next to the nightlife area called police multiple times about the severe noise. She indicated that moving is not a feasible option for them due to their limited knowledge of property trading and poor health status.

In conclusion, older people have adopted various strategies to cope and negotiate with environmental challenges and changing place meanings. Children and community staff were most contacted when they encountered problems. Their expectation of community came from the identity embedded in the pre-reform Danwei system. Space shaping takes place when people live in the same neighborhood and share a collective identity. Older residents actively negotiated the process so that they could preserve a sense of security and belonging. However, with the rapid changing demographics in most of the communities, space shaping is not an easy action to initiate. Most of the participants took a more individualistic approach, such as environmental adaptation, avoidance coping, time-space compression, practicing religion, developing new hobbies
and legal solutions. How older people choose to negotiate with their changing spaces depends on their situated environment, age, life experience, social capital and health status. Their emotional state reflects identity negotiation and the effectiveness of coping.

6.6 Anticipation of a Place to Age

After articulating older people’s changing relationships with the environment, their conflicted place identity and their negotiation and coping strategy, this section is intended to shed light on their anticipation of aging and place. In understanding aging in place for older Chinese who currently reside at home, questions of where they plan to age and their ideal way of aging were discussed with participants. Findings show that despite the positive or negative experiences of aging at home, few older people have the intention of moving to a planned residential care facility (RCF). They expect the community has more to offer for older people who wish to age in place. The few participants who have considered relocation to a RCF were in poor health status and have higher income or get financial support from their children.

According to the data, no participants who stayed in the same place before and after the reform showed any intention to relocate. Most of them were not satisfied with their current living environments, especially the physical and built environment, but they were still not considering moving to a RCF. On one hand, although place identity is vague, they felt living in their current place as a habit accumulated over decades (or “inertia” according to participants) and home provided a sense of freedom. They also enjoyed the convenient location of their current homes. On the other hand, they felt incapable of moving due to limited incomes, long waiting lists and the distant location of many RCFs.
No.15 “It is my property but in poor condition. Neighborhood environments are not good for our old people. I have no income. I depend on the 2000RMB pension my wife receives every month. So I don’t even think about moving to residential care facilities. Even if I have the money, I don’t want to move there…. I am used to live here…. The location is convenient…. At least I have autonomy at home. I don’t want too much restriction.”

For those who relocated to new public housing (PRR), they shared some of the same reasons for not wanting to move to a RCF with those who have never moved: too expensive, waiting lists too long and too many restrictions. They also had concerns over the quality of RCFs. They believed the nice ones were expensive and the affordable ones were difficult to get into. One participant recently returned to her home from a RCF because of the negative experience. Another participant had no trust in private enterprise and believed the operators of RCFs were mercenary in nature. They did not mention attachment to the current dwelling as a reason for their reluctance to move, but they did anticipate aging in their homes and communities as a better way if a community could offer more, especially in terms of increasing social cohesion in the community and creating a collective way of aging.

No.5 “My children are very busy so I couldn’t ask them to take care of me. They need to survive too. If community can help me it would be the ideal way of aging. I don’t have to leave my home and I won’t feel disconnected from society. I guess it will be more affordable as well.”

No.13 “Aging is expensive nowadays. My children still need my support so I cannot depend on them. If community could help us to solve some problems, it would be great! I really hope that community can organize collective aging…. We need companions in old age and I hope the community could bring our old comrades together.”

Those who currently reside in commodity housing with their children did not show any uncertainty about aging in place. They believed they could receive the best care at home and they had the resources to choose where to age.
No.46: “I definitely don’t think about moving to a residential care facility. My home is comfortable. I have live-in caregiver and my daughter is supporting me. I have no financial pressure so I can choose whatever way to age myself.”

Lastly, some older people refused to anticipate where to age. They felt there is no place to age for them in the future so they simply avoided thinking about it unless they have to.

No.28 “My only daughter is a new immigrant in the US and I don’t think she will move back. My partner and I have very average income and I don’t think there’s an affordable place for us. I dare not think too much, I dare not…”

Overall, older people’s unwillingness to move to a RCF is not because they felt attached to a current place. Rather, the incapability of moving due to practical reasons, the concerns over service quality, living conditions and loss of autonomy in RCFs were major reasons they did not anticipate aging in an institutional setting. The majority of older people showed a strong willingness to help each other and believed in collective aging in the community but they did not know how to initiate collective aging. For some people, they did not see a place of aging for them. Those who received sufficient financial and emotional supports from their children showed no hesitation about aging in place.

6.7 Discussion: Aging in Place or No Place?

After discussing each part of the conceptual framework, it is necessary to look at how they are interconnected and thus contribute to an understanding of aging in place in a Chinese context.

Many facets of urban transformation have taken place in China since the reform in 1978. In this context, the findings show that there is an imbalance between older people
and the changing environment. People living in different types of housing and neighborhoods face various physical, built and social environmental challenges (poor housing quality, inaccessible designs, social isolation etc.). Along with their life experience, current socioeconomic and health status, are relevant factors for understanding place identity and meaning for older people. The discussion is both generational and situational. Generational factors, such as life experience, historical events and the times they grew up in, have shaped individual identity before the economic reform. It is rooted in the socialist past that carries the ideas of equality, uniformity, collectivism and dedication to the construction of socialism. Equality represents universal coverage of education, health care and housing etc., and also every occupation is equally important in terms of its contribution to socialist society. Since the economic reform, urbanization and urban renewal have brought drastic changes to the urban landscape; marketization and privatization have influenced people’s everyday behaviour and value systems. Generational shifts in ideology have created conflicts and tension between older people and the younger generation. However, the socialist past and the identity it carries are selectively manifested in each individual depending on specific situational factors. Older people or their children who have benefited from the reform have formed new identities, while most of the older people from the generation are absent from the economic gain and forgotten. Old identities have been challenged and new identities have not yet formed. Place conveys different meanings to people facing different environmental challenges and with distinct individual characteristics. Meanings embedded in place speak to how older people cope and negotiate in the changing space (Table10). Some strategies were effective while others resulted in conflict and tension. In
the current social environment, most of the people took individual approaches while some still held a strong hope of reconstructing collective aging. This hope is reflected in their anticipation of place of aging. In Western studies, aging in place conveys the importance of place attachment and familiarity to older people. This study shows place carries different and complex meanings compared to Western studies. Conceptually, the understanding of aging in place in the Chinese context should be put into the dimensions of time, space and culture. There is genuine discontinuity in place and a sense of placelessness was developed among the older generation. They had their anticipation of place, but in a space full of unfamiliarity and individuality, they felt powerless. Being powerless has had a great impact on older people’s well-being.

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<thead>
<tr>
<th>Place Meanings</th>
<th>Negotiation and Coping Strategy</th>
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<tbody>
<tr>
<td>Inequality and inequity</td>
<td>Negotiation with community staff (individual and collective); Legal means (individual); Becoming a landlord (individual).</td>
</tr>
<tr>
<td>Habit and inertia</td>
<td>Avoidance coping (individual)</td>
</tr>
<tr>
<td>Social ties with old neighbors/colleagues</td>
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<td>Shelter and basic needs</td>
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<td>Family and filial piety</td>
<td>Negotiation with children (individual)</td>
</tr>
<tr>
<td>Social isolation and unfamiliarity</td>
<td>Return to old neighborhoods (individual)</td>
</tr>
<tr>
<td>No meaning or unknown</td>
<td>Practice religion; developing new hobbies (Individual)</td>
</tr>
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Table 10 Corresponding Strategies Towards Place Meanings

When current policy is pointing in the direction of aging at home and community, it is important to first provide a more thorough understanding of place. Place should be more than a shelter in the community or an alternative to an institution. Aging in place
does not equal staying at home because of the incapability of moving to a RCF. Although aging in place in China carries the sense of downloading responsibility of care to all actors in society, the significance of the discussion lies in how to recreate a sense of security and belonging for older people in a changing environment, and thus encouraging them to age in place. For a generation that carries strong imprints from their past, collectivism matters in providing a sense of place continuity, rebuilding lost identity and supporting the frail elderly; it will further contribute to community construction in the new era. Community should provide an opportunity for older people to continue their familiar ways of social interaction, but also encourage a meaningful social mix among different groups and establish communication between generations, before it becomes “aging in no place”.

This study focuses on the understanding of “place” within the notion of “aging in place”. The above findings open up the study of home and community-based care in the next chapter as another important component of aging in place. The discussion will link frailty, old age support and place.
Chapter 7

Home and Community-Based Services for Older People in Beijing

7.1 Introduction

Providing care to older residents at the home and community levels is the basic strategy of the Municipality of Beijing. The local level government (Street Office) is mainly responsible for delivering services to the older people aging in place. According to the policy makers, home and community-based services provision should be the joint efforts of both the public and private sectors. This chapter illustrates home and community-based services provision and utilization on a population level by answering the following research questions: What are the available home and community services for older people? What are the unmet needs for home and community services? Who are the people in need and use these services? Who are the caregivers? Is there equal access to the services and what are the potential barriers for accessing the services?

The chapter is divided into two main parts. The first part looks at community services provided by formal caregivers including home care. In the second part, home care services are analyzed in more detail. Both formal and informal home care services are included in the discussion. Questionnaire survey data and statistical analysis are adopted in this chapter.
7.2 Community Service for Older People in Beijing

Seven types of community services were chosen for the questionnaire survey based on government documents. Home care includes formal home care services that are provided by either the public or private sector. It does not include informal home care provided by family and friends. Community clinics provide basic doctor services and prescribed medication services. They are not-for-profit health services and under the guidance of the Beijing Management Center for Community Health Service (BMCCHS). BMCCHS is fully funded by government and is a public institution. Local health care institutions were reconstructed in 2006 to form the current community health clinic system. (Community Health Service Center (clinics) Site and Construction Planning of Beijing, 2006) Day care provides space and care services to older people who need to be taken care of during the day. Food services aim at providing nutritional, affordable and accessible meals for older people who have problems preparing their own food. Meal services are provided in the form of dining tables (i.e., communal tables where meals are provided to older people either at a community service center or a restaurant) or meal delivery. Counselling focuses on the mental health of older people. Community centers are organized under “Community Service Centers” of each Street Office. Most of them provide spaces for social events, sports or cultural activities or other forms of entertainment. The aim of the community service centers is to enrich older people’s cultural and intellectual lives. Legal aid provides basic legal advice to older people.
7.2.1 Service Availability and Unmet Community Service Needs

Figure 3 shows the respondents’ perceptions of whether certain types of services are available in their communities. Most of the respondents are aware of community clinics in their communities. Half of the older people know community centers and home care services exist in their neighborhoods. Food services for the older people have been discussed frequently in recent years by policy makers and media. Data show that 23 percent of the elderly know that there are food services in their communities. The least known community services are legal aid, counselling and day care; less than 20 percent of the respondents knew that these services existed in their communities.

![Figure 3 Perception of Community Service Availability](image)

Figure 4 shows the needs for services and the actual utilization of the services among the older people surveyed. By comparing the rates of need and use, unmet service needs can be estimated. It shows there are big gaps between service needs and use in home care, day care, food services and community centers. Food services shows the most
significant gap, with 36 percent in total need of food services but no frequent users and only eight percent who indicated that they sometimes use the service. The gap between home care needed and use is also large, with 34 percent who indicated need and 13 percent who indicated they use home care. Among the eight services, 30 percent of older people indicated that they frequently needed community centers, while only 11 percent actually used them frequently. The total demand for day care is 19 percent, while it has one of the lowest usage rates. Community clinics show a relatively even distribution between need and use. For counselling and legal aid, the use and need rates are both low. On the one hand, the services do not apply to everyone on an everyday basis. On the other hand, counselling and legal aid are relatively new and unfamiliar to the older Chinese generation. It is possible that they feel uncomfortable using these services.

![Figure 4 Use and Need for Community Services by the Older Population](image)

Figure 5 shows the satisfaction level among service users for the seven community services. There are three services that have
satisfaction levels above 50 percent. Community clinics and senior centers have the highest satisfaction levels. The rest of the services have substantially lower levels of satisfaction. The most noticeable is food services, which has the lowest satisfaction level at 13 percent.

![Figure 5 Community Service Satisfaction Level](image)

**7.3 User Characteristics of Community Services**

Community home care (formal home care) services, community clinics and community centers are tested individually with age, sex, income, education, marital status, living arrangement, self-rated health status and self-care ability. The other four services are not tested because the utilization rates are too low for analysis. Socio-economic factors are aggregated for statistical purposes. Education is recoded into four categories: Never went to school, primary/elementary school, high school/college, bachelor degree and above. Marital status is recoded into two categories: married/living together and divorced/widowed/separated/never married. Living arrangements is recoded into three groups: living alone, living with one person and living with two people or more. Number of children is recoded into three categories: zero or one child, two children, or three or
more children, Formal home care users tend to be 80 years old and over, have limited self-care abilities and have higher incomes. Chi-square results show that formal home care use is statistically significant with age, income and self-care ability factors (Figure 4). Figure 6 shows that 33 percent of people who do not have self-care ability use formal care services compared to 10 percent of those who have self-care ability. Twenty-three percent of people in the higher income group use formal care services compared to seven percent of the people in the low income group. Twenty-two percent of people who are in the oldest old group use formal care services compared to six percent of the younger groups. For sex, education, marital status, living arrangement, and self-rated health status, there are no significant patterns shown.
(Self-care ability, significant at p<0.001; Income, significant at p<0.05; Age, significant at p<0.001)

Figure 6 User Characteristics of Formal Home Care Service

No particular groups stand out statistically in the use of community health clinics. They tend to be used ubiquitously by older people regardless of any socio-economic characteristics that otherwise differentiate them.
Community center users tend to be those who have higher incomes, higher education levels and fewer children (Figure 7). Forty-two percent of respondents in the higher income group use community centers, while only 29 and 14 percent of those who are in the medium and low income groups use them. Thirty-five percent of people with high school education or above use community centers and the percentages go down with lower education levels. Older people with three or more children are less likely to use community centers. Although self-care ability is not statistically significant with the use of community centers, overall 93 percent of the users have self-care ability. (See Figure 7)

Figure 7 User Characteristics of Community Centers
Based on the results from the above analysis, it is obvious that income is an important factor in the use of formal home care services and community centers. Age and self-care ability are related to the use of home care. Obviously, as one gets older and/or health status declines, one is more likely to need and use formal home care services. Although self-care ability is not statistically significant with the use of community centers, most of the users of community are capable of taking care of themselves. People with higher education levels are more likely to use community centers. Family structure is also related to the use of community centers. People with more children are less likely to use community centers. Community clinics use is evenly distributed among the different groups, and the utilization level is higher. It means the service is better implemented in most of the communities and people have equal access to the services.

7.3.1 The Characteristics of Older People in Need

It is also important to look at who are the people in need of community services and their socio-economic and health characteristics.

Home care need is statistically significant with health status and self-care ability. People who have poor health status and do not have self-care ability tend to need home care services. Figure 8 shows that 45 percent of those who identified themselves as in poor health status needed home care service compared to 23 percent who report good health status. Figure 8 shows that 52 percent of those who do not have self-care ability need home care services compared to 31 percent who have self-care ability. The other factors are not statistically significant with home care need.
(Health Status, significant at: p<0.001; Self-care ability, significant at: p<0.01)

**Figure 8 Characteristics of Older People in Need of Home Care**

Similar to home care need, those who are in poor health status and do not have self-care ability tend to need day care services. Twenty-seven percent who reported poor health status need the service compared to 10 percent in good health status. Thirty-eight percent of those who do not have self-care ability need the service while 15 percent who have self-care ability need the service. (See Figure 9) The other factors are not statistically significant with the need for day care service.
Food services need is related to health status and living arrangements. Forty-five percent of those older people who are in poor health need food services and 28 percent in good health status need the service. Forty percent of those who live alone and 45 percent who live with one person need services. Twenty-seven percent who live with two or more people need services. Most of the people (87 percent) who live with one person are living with their partners. People living with two or more people tend to live with younger people (e.g., sons, daughters or in-laws). Households containing only older people tend to have more need for food services. (See Figure 10)
Figure 10 Characteristics of Older People in Need of Community Food Services

The need for community centers is statistically significant with education and age. People who have a high school education or above need the services compared to those who never went to school. People who are in the younger age group need the service more than those people in the oldest old age group. (See Figure 11) The other factors are not statistically significant with the need for community centers.
(Education level, significant at p<0.05; Age, significant at p<0.05)

Figure 11 Characteristics of Older People in Need of Community Centers

7.3.2 Section Discussion
Perception of availability is low for several services. Day care, food, counselling and legal aid services are still being developed and they are not available for the older population in most of the communities. At the same time, there are some other possible explanations for the low availability rates. First, the respondents do not have needs for certain types of services, so their knowledge of the services is limited. Second, it is possible that people understand “availability” and “service” differently. For example, some community staff see setting up dining tables for seniors in a regular restaurant as “providing food services” while the older people do not think it is what food services are supposed to look like. Third, during the survey it was observed that there is space available in the community for day care or counselling services with signs saying “Day Care Center” or “Counselling Service”. However at this stage, there are no full-time staff working in those spaces and providing services. Residents are not informed about the facilities and services.

Economic barriers stand out in the use of formal home care services and community centers. Most of the formal home care services in the community are
privately run by “Home Service Agencies”. They are agencies that recruit workers, normally young to middle-aged female migrant workers, and charge part of their salaries as service fees once they are hired. The Street Offices also employ “elder care staff” to provide home care to the older people with special difficulties. However, the current number of staff is very small compared to the older population in the communities. So there is barely any care work that can be done. In this case, income level determines the ability to purchase formal home care services.

Community centers are run under the guidance of Community Service Centers. As stated in the government documents, they provide a mix of free services and services with fees. Fees can be a barrier to access the services. Education also stands out as a potential barrier in the use of community centers. One of the main purposes of the centers is to “enrich people’s intellectual and cultural lives” (MoCA, 2011). People with less education might find the activities do not fit their needs or they are uncomfortable using the services.

The general experience of using each service varies. When looking at the rates of availability, satisfaction and unmet needs together, the services with higher availability and satisfaction levels also have smaller gaps between need and use. For example, food services have the lowest satisfaction level and one of the lowest availability rates; the survey results also show one of the biggest gaps between need and use. Day care shows similar pattern. In contrast, community clinics had the highest satisfaction and availability rates; as a service, community clinics also have the smallest service gap. Community centers are relatively available and satisfaction levels are high while the service gap is still big. This might be related to the sufficiency, accessibility or variety of services.
provided at community centers. Home care sits in the middle among the seven services while less than half of the users are satisfied with the service.

It is more urgent to develop food services followed by day care services since they have the largest unmet needs and lowest availability rates. A further concern is not only with the availability of the facilities but also how services are provided in a way that is accessible for older people.

Community health clinics have the highest availability rate and the smallest unmet needs. Community health clinics are part of the health care system that the older people can use through their medical insurance coverage. Under years of construction, community health clinics have met the medical needs for many residents in their communities.

To achieve equal access to community-based services for older people, people with poorer health status and less self-care abilities should be given priority in receiving home care and day care services regardless of their economic status. Those with poorer health status and living alone should be the target population of food services. Community centers should also provide more diverse activities and take measures to include people with different socio-economic characteristics.

The government encourages the private sector and other social organizations to provide care services for older people, and in turn, purchases services for older people that are in need. One of the programs mentioned earlier is a program the Elderly Home Care Coupon for those who are 80 years old and over to purchase home and community services. In the case of home care, the coupon from the government is not enough to make home care service accessible to people with lower incomes. Since food services
and day care services are largely not available at this stage, the effectiveness of the elderly coupon requires further consideration.

7.4 Home Care Services for Older People in Beijing

In general, 83 percent of the people surveyed (337) used home care. In this section, home care utilization patterns, service provider, caregiver and unmet home care needs are identified.

7.4.1 Who Are Home Caregivers and What Are the Services Provided by Different Caregivers?

Descriptive statistics are used to provide an overview of the general service provision patterns. According to the survey, home care services are disproportionately provided by informal caregivers (family or friends). Eighty-five percent of the total services received are provided by family or friends, three percent is provided by the public sector, 10 percent is provided by the private sector and one percent is from non-profit organizations. Participants were also asked to identify their main caregiver. Fourty-two percent of the older people identify children as their main caregiver, 37 percent have a spouse as the main caregiver, followed by sons or daughters in-law (10%), nursing maids (7%), hourly housekeepers (2%) and community workers (1%).

When looking at specific services provided by different caregivers, the top three services provided by family and friends are housework (26%), emotional care (25%) and meal preparation/delivery (16%). Similarly, the top three services provided by the private sector are housework (36%), meal preparation/delivery (27%) and attendant services (11%). The top three services provided by the public sector are assistive
technology (32%), other health care services (25%) and medical equipment or supplies (14%). In general, family, friends and the private sector provide more non-medical services and the public sector provides more technical and medical related services.

### 7.4.2 Who Are the Users of Home Care Services?

Cross-tabulation is used to find out what kinds of pattern are shown in terms of home care service use. Service utilization is tested with sex, age, health status, marital status, income level, living arrangement, self-care ability, number of children and education level. Table 11 shows the percentage of people in each sub-group using the service. Results that are statistically significant are shown here. Income level is not statistically significant for any service so it is not shown in the table. For nursing and medical care, other health services, those who have no self-care ability are the main users of these services, although the overall utilization rates are low. For personal care, those who are female, older, with poorer health status, not married, with limited self-care ability, with lower education levels and have more children are the main users. Personal care use is highly related to age, health status and self-care ability; those with more children tend to have more care resources. Medical equipment users tend to be those who are older, with poorer health status and without self-care ability. The overall utilization rate for housework is high and those who are male, older, with poorer health status, without self-care ability, not living alone and have more children tend to use more services. Meal preparation and delivery services are widely used and those who are older, with poorer health status, not married and without self-care ability are the main users. People who are older, female, with poorer health status, not married, without self-care ability, with more children and with lower education levels
tend to use more attendant services. Those who have poorer health status, have more children and with lower education levels receive more emotional care compared to the other groups.

Overall, home care utilization patterns are highly related to old age, health status and self-care ability. Sex, marital status, education, number of children and living arrangements also show significance among certain service uses.
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Sample size, 405; Significance *p<0.05; **p<0.01; ***p<0.001

Table 11 Percentages of People in Each Sub-group Using the Service
7.4.3 Who Are the Users of Formal Home Care Services?

A question “Have you used home care service provided by the public and private sectors” was asked in the survey. Survey data show among people who have formal caregivers, 60 percent of them live with their caregivers. Cross-tabulation is used to find out the main users of formal home care service (See Fig 12). Formal home care users tend to be 80 years old and over, have limited self-care abilities and have higher incomes. Thirty-three percent of those who do not have self-care ability use formal home care compared to 10 percent of those who have self-care ability. Twenty-two percent of people who are 80 years old and over use formal home care compared to six percent and seven percent of the younger age groups. Besides age and self-care ability, income also stands out. Twenty-three percent of those in the higher income group use formal home care compared to seven percent and 12 percent in the lower and medium income groups. At this stage, formal home care users are mainly physically dependent and able to afford the service.
Figure 12 Characteristics of Older People Using Formal Home Care Services
7.4.4 Are There Unmet Home Care Needs and Who Are the People Having Unmet Needs?

In the questionnaire survey, older people were asked if they ever needed home care services but they did not receive them in the past 12 months. Twenty-seven percent of the respondents reported unmet home care needs.

Fig 13 shows the percentage of people who use and need each home care service. It indicates that housework, emotional care and meal preparation and delivery are the three most needed services. It also shows that there are gaps between service needs and actual utilization of services. For nursing and medical care, other health care services and assistive technology, although the needs are relatively low, the gaps between need and use are quite large. Meal preparation or delivery shows a 14 percent gap between people who use and need the service. The other services all show different sizes of gap between use and need by the older population.

Figure 13 Needs and Uses of Each Home Care Services by Older People
Cross-tabulation is used to find out who are the people who have unmet home care needs (See Fig 14). The results show that those who have poorer health status, are single or widowed, living alone, have limited self-care ability and female tend to have unmet home care needs. Forty percent of the people with poorer health status have unmet home care needs compared to 19 percent of those who are in good health status. Thirty-seven percent of those who are single or widowed have unmet home care needs while 25 percent of those who are married have unmet needs. The percentage of people who have unmet home care needs drops when the number of people they live with increases. Forty-three percent of those who live alone have unmet home care needs. Older people with limited self-care ability have a much higher chance of reporting unmet home care needs than those who have self-care ability. Fifty-nine percent of people who have limited self-care ability have unmet home care needs. Thirty-seven percent of females have unmet home care needs compared to 20 percent of males.

(Health Status: significant at p<0.001)  
(Marital Status: significant at p<0.001)
(Living Arrangement: significant at p<0.05)  (Self-care Ability: significant at p<0.001)

Figure 14 Characteristics of Older People Who Have Unmet Home Care Needs
Older people were also asked follow-up questions on the reasons for unmet home care needs. The top three reasons given were: service not available (55%), cost too high (27%) and service cannot meet standards (12%). The data show: the supply of home care service is far from enough; economic barriers exist in accessing home care; and the quality of home care is of concern for older people.

7.4.5 What Is the Role of Government in Home Care Provision?

Home care service development has already been stressed by governments at different levels in China as one of the key strategies toward aging. Part of the survey looked into the role of the government in the home care sector.

A question was asked about financing of home care to find out whether home care services are paid or partially paid by the government. Only one respondent said the service is paid by the government. Fifty-seven percent of the older people surveyed pay for their own home care services and nine percent have their children pay for it. Besides direct financing, older people were asked about other forms of home care support they get from the government, including the elderly coupon, allowances, door-to-door services and other services. Seventy percent of respondents said the government provides no support. Less than three percent receive either an allowance or door-to-door services from the local government. Twenty-five percent of the older people surveyed receive elderly coupons from the municipality. Those who have received elderly coupons were asked about how they use them. Eighty-seven percent of the people who received coupons spend it on daily shopping. Eight percent use it for community food services and
four percent use it for hiring nursing maids or hourly workers, which means 12 percent of
the people in total use their coupons toward home care services.

Overall, the majority of older people do not receive financial support from the
government. The elderly coupon is the most common form of benefit older people
received from government in terms of home care.

7.4.6 Discussion
Home care in Beijing is largely an informal system at this stage. Informal caregivers are
the main provider of home care services. Among informal caregivers, children, followed
by spouse and children-in-law are the three most common caregivers of older people.
Most of the formal caregivers are from the private sector.

The most commonly used home care services are housework and meal services.
The public sector provides more medically related home services, assistive technology
and equipment. On the other hand, informal caregivers and caregivers from the private
sector provide mostly non-medical services that require no technology and less
professional skills, such as housework and meal preparation and delivery. The survey
results show that different sectors can contribute to different home care areas. However at
this stage, the utilization rate for medical and health related home care services, assistive
technology and equipment are quite low. It is important to discuss how to develop
services and products that can be adapted to Chinese older people’s home environments
and make the best use of innovative technologies.

Being older, have poorer health status and limited self-care ability increase the
likelihood of using housework services, meal services, medical equipment and personal
care. Physical vulnerability comes with old age and requires services that assist basic
daily living. Gender plays different roles in personal care, meal services and attendant services. Older men use more personal care and meal services while older women use more attendant services. Further research is needed in discussing gender roles in care and caregiving in old age in the Chinese context. People who are married receive more personal care, meal services and attendant services than people who are divorced, widowed or single. Spouses are an important source of care in old age. Emotional care is more likely to be used among people with more children and lower education levels. Children are crucial in providing emotional support for their older parents.

Comparing the above findings with the group of people who are more likely to have unmet home care needs, those who are single/widowed/divorced, have poorer health status, limited self-care ability and fewer children require more attention from policy makers. They have fewer care resources in terms of informal caregivers. Accessible formal home care services are essential for this group of people.

On the other hand, multiple barriers exist in accessing formal home care services. Publicly funded or provided home care is still being developed and available services are very limited. Alternatively, the cost is high for older people to hire live-in caregivers from the private sector and the quality of service is another concern. When the one-child policy generation is entering their old age, it will be important to give priority to the development of the formal home care sector.

Besides policy-making and financial support, governments and other public sector actors should play the leading role in developing professional home medical services and seeking assistive technology for home settings. These services have the lowest utilization rates and show the biggest gaps between need and use. Governments and other public
sector actors have more resources to develop professional home care services and thus satisfy the needs of older people.

Another service that requires the effort of the public sector is meal services. Meal services is one of the most needed home care services and there are large unmet needs. Meal services require the supervision of the government in terms of food safety and special dietary needs of older people. It is important to find ways to provide affordable services for older people and operational models for service providers. Government’s direct support for home care is mainly through the distribution of elderly coupons to those who are 80 years old and over. However, older people do not see it as a form of support that the government pays or partially pays for the home care services they receive. Most of the older people use the coupon for daily shopping instead of consuming home care services. The ideology behind delivering elderly coupons is “government purchasing home care service” thus encouraging more enterprises to enter the home care sector. At present, service availability is limited and the cost is high for home care, the 100RMB coupon can hardly be redeemed towards targeted services.

7.5 Chapter Summary
This chapter identifies the available home and community-based services for older people in Beijing. Based on the quantitative data from the questionnaire survey, it shows the majority of community services are still being developed. Economic barriers exist in accessing formal home care services and community center services. Education level also affects the use of community center services. The need for food and day care services are high while the services are largely unavailable. For home care services, it is largely an informal system. Housekeeping, emotional care and food preparation are the three most
needed services. People in general report the lack of government support in receiving home care services. The elderly home care coupon is available for people who are 80 years old and over; however, most of the elderly use their government coupons for daily shopping. People who are widows(ers), have poorer health status, less self-care ability and fewer children tend to have more unmet home care needs that require more attention.

In the next chapter, qualitative data will be used to find out if similar utilization patterns and access problems exist. The qualitative analysis will also look into the individual experience of care from both caregiver and care recipient perspectives. Eventually, specific issues emerged from different caring relationships will be identified.
Chapter 8

Experience of Care and Caregiving

8.1 Introduction

The aim of this chapter is to understand older people’s and caregivers’ experiences of different types of care, caring relationships and how these experiences produce and reproduce caring spaces. Methods wise, care discussed here includes physical, emotional and financial supports that assist older people’s everyday living. The qualitative data includes 47 interviews with older people and 21 interviews with frontline formal and informal caregivers. The following research questions are answered in the chapter: 1) what are the different caring relationships of older people aging at home in Beijing? 2) What are older people’s and caregivers’ perceptions and experiences of different types of service and care? 3) What are the spatial implications of care experiences and caring relationships?

The findings are illustrated based on the types of caring relationships identified in the data. After the first round of coding, three caring relationships are derived from the data: the relationships between older people and family members, live-in caregivers and the community. The caring experiences from the perspectives of both care recipient and caregiver are discussed.

When translating qualitative data into English, culture specific terms were used. A live-in caregiver is called a “maid” (Baomu) by Chinese people. Older people also use a gender-neutral term “old partner” to refer to their significant others.
8.2 The Caring Relationships Between Older People and Their Family Caregivers

8.2.1 Care Recipient-Spouse Relationship

Spouses are an important source of care. The care provided by a spouse ranges from physical, to emotional care to financial support. In the sample, the one who had better physical and mental health and a higher income provided more care and support to their significant other.

From the care recipients’ perspectives, they relied heavily on their spouses’ care while showing senses of worry, guilt and insecurity. At the same time, the generational ideas of practicing diligence and thrift as virtues showed strong imprints on caregivers, especially among the oldest old group. Some care recipients mentioned how their partners would not hire a live-in caregiver if they could handle the amount of work themselves.

No.38 “I want reduce my old partner’s burden. It is a lot of work for her taking care of me. I was thinking about hiring a maid or going to a RCF. I checked out a few facilities myself and I didn’t find one that fits my condition. Some are poorly maintained and the good ones have very long waiting list. So I abandoned this idea. My old partner doesn’t want to hire a maid. She thinks she can handle the care works and it will save some troubles. There will be a time she can no longer taking care of me.”

The way older people experienced the caring relationship is very personal. Some had satisfying relationships while others showed tensions.

No.15 “I live with my old partner and she started taking care of me since I had stroke. I have bad temper and sometimes feeling restless. I lost my temper to her…. We’ve always had conflicts in communication. The ways she is doing and thinking about things are quite different from mine, although she is more tolerant…. I don’t have income and I don’t have self-care ability. I am all relying on her…”
From the caregivers’ perspectives, they believed they could offer the best care even when they were in poor health. They have strong senses of responsibility and morality in marriage.

No.1 “I take care of myself and my old partner…. I am in very poor health but his is even worse. I have lymphoma and breast cancer. But I am tough! My partner and I were arranged and we were in long distance relationship for 19 years. There is no affection there at all. This is my responsibility to take care of him and I have to…. I have to be strong for my family, no matter how hard the works are.”

Some caregivers expressed how they could cope physically but not mentally. Emotional loneliness was shown in the caregiving experience.

No.6 “I don’t have children and my old partner is disabled. I need to take care of her. I don’t get much support from anywhere, so I hope I can get emotional support from people…. I am used to exhaustion every day, although my own health isn’t that great. But there’s no other way and I can endure…. I don’t hire helpers at home and I can do all the works…. I don’t have much education and grew up in a farmers’ family. So I don’t ask for more, I just need more emotional support, the feeling that people care about you…”

In sum, older spouses were heavily involved in caregiving. They themselves could be frail and required care. The caring relationship could be unstable, insecure, unbalanced and created senses of helplessness and loneliness. It needs to be recognized that when older people are involved in the care of their spouses, they potentially put their health at risk.

8.2.2 Older Person-Children Relationships

Traditional Chinese culture values filial piety greatly and children play very important roles in supporting their older parents. However, the findings show that giving direct physical care to older parents is becoming less common; the relationship between older
parents and their children are shifting due to the One-Child Policy and increasing social pressure on the younger generation. The relationship is getting more disconnected or reciprocal. Those who do not have children carry a stronger sense of insecurity for future. For frail older people who require intense direct physical care and have their children as main caregivers, the child is either retired, laid off or has flexible working hours. The siblings provide respite care. Giving financial support and long distance emotional care are increasing.

Four themes emerged for discussion: children as main caregivers; the declining role of children in the caring relationship; reciprocal caring relationships; older people with no children. The main caregiver here is defined as those who provide the majority of the physical care.

Children as main caregivers
According to the results from the previous section, 42 percent of the older people surveyed in the first stage have their children as their main caregiver. This means children still play an important role in older people’s caring networks. According to the qualitative data, older people as care recipients generally had satisfying experiences with children as caregivers. They felt thankful that their children were loyal to them. There was no tension recorded and they accepted the ways their children cared for them. They felt comforted and appreciated that they received care from their children.

No.16 “My son takes care of me mainly. I am not very mobile and I have artificial limbs. He does grocery for me every day. I eat whatever he gets me and I am not demanding at all. He does housework for me. He takes me out for walk sometimes. You know I cannot step out of my home without him. He makes decision for me as well. Whenever I encounter troubles in life, I will talk to him. I trust his decision.”
On the other hand, caregivers expressed the emotions of exhaustion and anxiety in everyday care. Depending on the care needs of the older person, the care responsibility was often shared among siblings. The main caregiver was the one who has no fixed working hours. For example in this sample, the participants were either unemployed, retired or could work from home. The siblings would take over in the evenings or weekends for respite care. The demographics of children caregivers were not gendered. The male caregivers outnumbered female caregivers in the sample. They could be older people as well. No participant in the group was from a one-child family.

CG.No.10: “I was laid off in the late 90s during the reform of state-owned enterprises (SOEs). I have no job since so I take care of my mom full time now. It’s 12 hours a day, 365 days a year. There’s no holiday for me. What else can I do? I am responsible for breakfast and lunch. My sister takes over at 7pm every day when she is off work. She has her kid to take care of too.”

Caregivers’ emotions were related to the amount of caring work they provided and the frailty of the care recipient. Conflicted emotions were common among caregivers. Those with frail older people and intense care work showed strong emotions of frustration, anger, anxiousness, and at the same time self-blaming for having negative emotions.

CG.No.10: “It's really hard communicating with my mom. She couldn't hear properly. I had to scream to her that is lots of energy. I got impatient and angry sometimes but I have to keep my emotions down. I feel nothing seems to my way in life, but I have to restrain myself. I am actually a very patient and well-tempered person, but it’s hard…”

CG.No.11: “I’ve been through up and downs in life and I am used to being independence. I try to keep my emotions and weakness to myself. I vent to myself and tell myself that can’t expect everything to be satisfactory. I give mental support to myself.”

Age mattered in how they perceived the caring work. Caregivers who are older saw it as filial piety. They thought the moral obligation of giving back to parents should
be inherited. Most other caregivers viewed caring work from very practical perspectives. They found the most feasible and efficient ways of meeting care needs that could not be put off. They were normally out of choices due to financial restrictions and care recipients’ preferences. Also if they were available time wise, they took on the caregiving job.

CG.No.11: “I should be happy living every day. I will continue contributing my productivity if I could…. Taking care of my mom is an inheritance, from generation to generation. The society cannot offer too much help so as children we should take on the responsibility…. At least we are not starved.”
CG.No.14: “It’s kind of worked out. I am doing three things at the same time and it’s efficient…. I work for creative industry that I have rather flexible working hours. I can work from home. I have a newborn baby as well so I normally work while keep eye on my daughter and mom. I take care of meals and take them out to the community park. My sister is here to help whenever she finished her job…. It’s good that my sister is sharing the work.”

Caregivers generally showed low levels of physical and mental well-being, especially when the care work was time consuming and involved intensive physical work. They reported a number of chronic conditions due to age increases in themselves. They faced stress coming from the amount of caring work, limited resources, uncertain future health conditions of older parents and their own life outside the caring relationship. Some found it hard to cope, some developed hobbies and others were trying to control their psychological well-being.

CG.No.9: “I am not really healthy myself. I have diabetes and I need care myself. But I have to take care of my father. Every day I woke up in the morning I can only see tons of work. I am not coping well mentally. I couldn’t even handle people talking about aged care and I am nervous. Can we not talk about it?”
The decreasing role of children in the caring relationship

Contrary to the above discussion, another common theme that emerged is how busy their children were that the caring relationship did not exist. Their children occasionally paid a visit to their older parents or made a phone call. Older people showed great understanding of the lack of physical or financial support from their children. However, emotional support from their children was important for them. Most of the participants in this group belong to the one-child policy generation.

No.2 “I have one child. My son works very hard. He works over time every day. His company doesn’t even give him the option of sick leave, let alone taking care of me…. I am trying to be independent physically and financially. Young people now face too much pressure. Housing and raising kid are too expensive…”

Milligan (2010) discusses “caring about” in understanding care as an embodied phenomenon even when it is distant. In this study, knowing about children’s lives or receiving phone calls from them served as great emotional comfort for older people. The emotional proximity between older people and their children, even when they were physically distant, was essential for their mental well-being. A mental space formed as a place of care.

No.46 “I have a son and a daughter. My daughter lives in Beijing and my son’s family immigrated to Canada. My daughter keeps me company everyday for a few hours. We don’t actually talk much. But I feel secure when she is around. We have very good relationship. My son lives in Windsor, Canada. I was there visiting once but it’s too cold there. I heard they are helping new immigrants settle down there. I feel happy whenever I am thinking about them doing nice things to people.”

This group of older people also showed concerns about their care needs and that their children could not offer much if the situation got worse.
No.39 “I need care and sometimes ask my community for help. But they think you have children, so you are not considered for receiving care. But even us with children, they are so distant away and busy. We have our difficulties too…”

**Giving care to adult children**

The discourses of dependency and vulnerability are often used to label older people. In more recent literature some researchers have argued that there are reciprocal caring relationships between older people and others (Wiles, 2011). Supporting this view, the data show it is quite common for older people to provide care to their children in various ways. They offered what they could to their children who cannot cope in their lives. The supports ranged from financial support, to housing support to grandparenting. As indicated in the last chapter, the current older generation is the not the main beneficiary of the economic reforms taking place in China, and some of their children were laid off during the SOE (state-owned enterprises) reform. Reemployment is not easy to find and precarious work is becoming more common among those who were laid off. The group represents a large number of families in urban China.

No.43 “My old partner passed away a few years ago. My son and his wife both got laid off. They don’t have stable jobs and of course they couldn't afford housing in Beijing, not even renting. They have a child. They moved to my small apartment. It is simply too small a space for this many people. I receive a very average amount of pension and I have to pay for the living expenses…. We barely eat meat, eggs, milk or fruit, to save money…. I am not happy about my life. But I am glad my health is fine and I can still make the family working. It’s not living, it’s trying to survive…. I don’t even go to the hospital to do health check, I am scared that if there’s something wrong then I need care that I cannot afford…”
Grandparenting is getting very common among the young-old group and the one-child generation families. Older people perceived grandparenting as giving support to their children who are busy at work and cannot cope. They believed they could alleviate some burdens from their children who were overworked all the time.

No.47 “My old partner and I moved to my daughter’s home to take care of her kid. I am responsible for taking the kid out to play and she is at home cooking. It is not easy work taking care of the little one, but our daughter’s work is even harder. We should be here and help her out…. I just hope this little one can grow up fast that my daughter will have less pressure on her…”

The exchanging role in caring relationship between older people and their children ties into social changes that have taken place in China in the past decades. Reforms and policies have created a new rich class while others were left behind and sacrificed. When linking these changes to the aging of society, having adult children is not necessarily an advantage for older people as they age, but it can potentially be an extra burden on older people and their families.

Challenges for older people who do not have children
Older people who do not have children showed a sense of insecurity about the future. They tended to worry about financial security, potential care needs and the lack of a decision maker they could trust in critical moments.

No.42 “My biggest difficulty right now is I have no guardian. I have no children and my partner passed away. If I get sick, no one makes decision for me, no one does paper works and banking for me…. My sister lives in Beijing too but she is old as me, she can’t even look after herself…. I am in my 90s and I don’t want to be a burden to anyone. Maybe I am too old that my younger families never invite me for things. I have to count on myself. I feel powerless lots of the times…”
In conclusion, according to the four types of relationship discussed above, the traditional children-older parents caring relationship based on filial piety is shifting. Older people viewed the caring relationship from very practical perspectives. They understood the challenges. They would take on caring work for their children if health and finances permitted. Caregivers were also generally pragmatic about the care work. They cared more about feasibility and efficiency. Even when care recipients were very satisfied with the care they received from their children, the children experienced difficulties in coping with the amount of caring work and the emotions involved. Generally, the care work was shared among siblings. In the context of the one-child policy and various emerging reforms, the role of children in old age support is changing drastically. Filial piety was still manifested in emotional or financial support in some cases while direct physical care was less common. What is more, older people had to provide care for their children in many situations.

8.3 The Caring Relationship Between Older People and Live-in Caregivers

The majority of formal caregiving is provided by live-in caregivers in Beijing. According to the qualitative data, they are mostly from private agencies and a small number of them are from non-profit organizations. They are all female migrant workers from rural China. The average education level is primary school to middle school. Most of them are between 40 to 50 years old, with two exceptions that are in their 20s. Care recipients who hire live-in caregivers tend to be in poorer health, have limited self-care ability, and have higher incomes or receive financial support from their children. The monthly fee charged to care recipients is around 3000 RMB for caregivers who live at older people’s homes 24 hours per day and seven days per week. Private agencies charge
service fees to both caregivers and care recipients. Non-profit agencies do not charge service fees.

Four themes are discussed in this section: the functionality and perception of care work; the negotiations between care recipients and caregivers; and the barriers of accessing live-in caregiving services.

8.3.1 The Functionality and Perception of Care Work

To older people, hiring a live-in caregiver meant ensuring basic everyday living and alleviating the care “burden” from their families when economic conditions permit. For caregivers from private agencies, they generally had low self-esteem. They believed themselves to be poorly educated and older, so being a live-in caregiver was their only job option. They all sent their incomes back to their homes in rural areas. They talked about rural areas where the poverty levels were still high and the welfare system had not been established yet. They mentioned how farming was no longer a reliable source of income and they needed to support their children and older people in the family. At the same time, they believed kindness and sense of responsibility were important.

CG.No.5 “Why did I choose to be a live-in caregiver? Cause I am useless, I am not well educated, I am from rural area and I am old. I don’t know how to do other jobs so this is my only option…. I find myself to be warm-hearted and a caring person, so I think it is a good fit for the job…. I believe in karma, we don’t want to be treated badly when we are old.”

CG.No.4 “There is nothing to like or dislike about this job. It is a way of making money for me. I am from mountain area and we are very poor. My two daughters dropped out of school cause we cannot afford it. We sent our son to high school and college….He is now working in Xi’an and he earns less than 1000RMB a month. I just want to make more money to help him find a wife. You know, it is not easy to find a wife nowadays cause we are from rural area and don’t have money. I need to save money for my son to buy
housing to get married. My parents are old and they don’t have enough pension. Maybe they cannot farm one day soon. I need money for them too. ”

Caregivers from non-profit agencies perceived their job as more than money making. They saw it as a learning process and self-realization. However, caregivers from non-profit agencies represented a very small percentage of the overall cases.

CG.No.1 “I learnt a lot from the organization and this job. I need the money to support my family but also hope to get more knowledge in caring for old people. I think I am a very kind person that I enjoy helping older people…. You know in our rural areas, old people are in even worse situation. No one takes care of them and they have to farm and take care of grandchildren in their 80s. My dream is to learn more in this profession, accumulate more experience and asset, and then give back to my hometown. Older people in rural area deserve good later lives too… ”

8.3.2 Negotiation of Care between Older People and Live-in Caregivers

The conflicts between older people and their live-in caregivers were mainly manifested in two aspects: duties/hours/payment of care and skill training. Since there was lack of regulation and formality in the elder care sector, caregivers and recipients negotiated their own ways and established rules in their caring relations. Power imbalances based on age, geography and education level were shown in these themes.

Care duties are not formalized in China. Both caregivers and care recipients agreed that duties and working hours were negotiated privately and it was a constant process. According to caregivers, they did almost everything to assist the older people at home or outside of the home. Duties normally included non-medical care such as cooking, housework, bathing, toileting, feeding, laundry, grocery shopping, and attending to emotional care. In some cases, they were also asked to provide medical care. They also mentioned how care duties are mostly determined by the older people or their families. Their duties sometimes extended to serving
older people’s family members. Depending on the care needs of the individual older person and available respite care, some live-in caregivers were working longer hours than others.

CG.No.4 “My job is taking care of every aspects of her life: dressing, cooking, feeding, using the bathroom, taking shower, housework, taking him out, chatting etc. It’s all my job cause he cannot do anything…. I do whatever they (care recipient and her family) asked…. There was one time I went to hospital to take medication and do some paperwork for her. It was my first time going to a big hospital in the city, I was so nervous cause I didn’t know how it works…. I used to take care of another old lady, she asked me to give her an injection. I was under lots of pressure cause I was worried if something goes wrong. I have never given injection in my life. I felt forced to do the job…”

Older people on the other hand, also talked about how some care expectations could not be achieved.

No.42 “I like to go out for a walk and checkout the city parks or other cities. She doesn’t want to take me to those places and she only let me stay in the neighborhood park. I am frail and I cannot go to those places myself. I depend on her…. It is not easy to change caregiver, especially I am single and without children…. I had to give in.”

The above quotation also shows the power dynamics changed when family members were not involved in the negotiation process. Older people found it was not easy to negotiate by themselves because they were in a more vulnerable position and depended on their live-in caregivers.

No.42 “She likes to talk about how much other live-in caregiver earns. I am actually very generous compared to lots of other people. But she just likes to mention it all the time. So I was telling myself, I don’t use up my pension anyway so I increased her salary within my capacity.”

In the triangular relationship, live-in caregivers talked about how it was much more difficult to “deal with” older people’s younger family members. They were seen as
from the countryside with limited education, so they were not in a position to negotiate or they could be “fooled” easily by urban dwellers. One caregiver had the awareness of her legal rights on working hours but failed to negotiate with the younger family members:

No.12 “The old person is pretty nice. It is the young people that are difficult…. I actually signed a contract with my agency. It says according to the Labor Law, I can take one day off per week and I can get double paid in public holiday. But it does not work that way. I mentioned it to the granddaughter in law. She was like, all right, you take a day off per week to go home. She knows it takes one day one way for me to go home. She deliberately makes things difficult for me. I have never got double paid during public holidays. She even went to my agency to talk bad things about me. The agency couldn’t do anything and asked us to negotiate ourselves. I gave in cause I needed the job. Maybe I am just unlucky to encounter an unreasonable person. ”

In some cases, live-in caregivers found younger family members created tensions at home that made their works more difficult. Their jobs sometimes extended to taking care of the whole family. They tended to have more positive relationships with older people while they had to compromise with younger people in the family.

CG.No.12 “To be honest, it is much easier taking care of older people…. I don’t mind listening and chatting with them. I don’t think changing dirty pants is that much of an issue…. Young people in the family always give me headache. For example, the old person wants to eat more plain tasting food but the young ones want spicy food. I had to cook twice to make everyone happy. I have to do housework for them as well. They do nothing at home and count everything on me…. I am not happy most of the times but I have compassion for the older person…”

At the same time, when younger families were involved in the caring relationship, there were more resources for respite care.

CG.No.7 “I can take two days off per month. This is what I negotiated with my customer, as long as everyone agrees. I go back home for Chinese New Year. Whenever I am not there, his son and daughter in law can take care of him. They all live together so it is not as complicated.”
The second major issue for negotiation is training. Private agencies do not provide any training to live-in caregivers. The learning process thus falls onto older people and caregivers. Older people had to show caregivers how to do care work and caregivers had to find their own ways of doing the job. Conflicts occurred in some cases. Care recipients believed that if live-in caregivers were not well educated and from rural areas they would have a hard time understanding how things work. The training ranged from using home appliances to care work.

No.46 “I don’t know if I am happy with the job she does. I have to teach her how…. After all she has low education level and not very compassionate. I think she is indifferent. She couldn’t fully understand my requests and do them the way I wanted her to. You cannot ask too much…. It is mutual restraint.”

The live-in caregivers mentioned that they normally used experience and common sense for care work they had never done before. It took them some time to get familiar with certain techniques and skills needed for taking care of older people.

CG.No.12 “Now I am working with good skills cause I have a few years of experience. When I just started, I did not know how to do certain things. I was not very happy back then when the family criticized my work. It was not easy to do some works. Skills and physical strengths are important. As I accumulate more experience, I work fine now.”

CG.No.4 “It was very difficult in the beginning. When I first started taking care of an old lady I had zero experience. I used my common sense to think about things and she taught me how to do things as well. It is important in that stage to keep good communication. For example the first time I had to deal with bowels on the pant, I didn’t know how to do it and it felt gross. Then I used my brains and she also taught me. I understand how to deal with it now perfectly…. Now I am confident in what I am doing. We get along very well cause we have good communication.”

Conflicts were drastically reduced for live-in caregivers who were from non-profit organizations. Non-profit organizations provided training and empowered live-in caregivers with education on their legal and labor rights. A more formal contract was
provided by non-profit organizations and they would negotiate with care recipients about care duties, hours and payment.

CG.No.1 “We had trainings before we worked for the household, so it is easy for me to do the job at his home. Now every weekend we have different types of training, from caring skills, cooking, legal course, computer courses etc. We have exams and we will be receiving qualifications. Last week we had a lecture on care for people with dementia. I learnt a lot…. I felt it is not just a job, I feel proud of my career…. We came to the big city from small rural town, we should learn more knowledge, not just working for the sake of making money…”

In cases where conflicts were resolved, older people and live-in caregivers tended to establish more reciprocal relationships and attachments grew as time went by.

CG.No.12“I don’t find caring works are of any difficulty to me now. The longer I take care of him, the more I find he is like a kid. You just had to talk to him about meaningless things, he would be happy…. He has dementia and he is very nice to me. You feel attached when you take care of him for such a long time. I want to stay with him till the end…”

From older people’s perspectives, they would also give care to their caregivers in different ways.

No.45 “When she gets sick, I would give her medication. If it is very serious, I would take her to the hospital. If it is not too much money, I just pay for her. You know she doesn’t have medical insurance in the city…. I would give her bonus for Chinese New Year, or buy some cloths for her…”

8.3.3 Home and Parks as Caring Spaces for Social Bodies

According to the data, home and parks are the two most important caring spaces in the care recipient and live-in caregiver relationship. Parks are an important activity space for older people. It is an even more important caring space for live-in caregivers. The home as caring space is under constant negotiation. Household norms are constructed and...
reconstructed; territory is closely related to senses of security and well-being; thus the home carries different meanings for care recipients and live-in caregivers. The two types of spaces show different power dynamics and family members play important roles in controlling the space.

To discuss home space, three themes are identified: negotiation of household norms and control; personal space and well-being; meanings of home space. Both care recipients and caregivers’ perspectives are included.

Household norms are long established by older people and their families. Norms include not only routines but also cultures and life styles. Since live-in caregivers spend most of their time with the older person, they have to coordinate daily habits such as diet, daily activities and schedules. They also have to learn the differences in life styles and cultures due to place of origins (the North/the South, urban/rural). Caregivers all agreed that compromises and communication were necessary.

Caregivers in general did not have too much control in the home space and they tended to adjust themselves to the routines of the older person as much as they could. They also recognized the differences in ideology and culture, which was crucial in showing understanding and making compromises. Live-in caregivers found urban dwellers tended to be suspicious and it took some time before trust could be established. Older people’s family members also played important roles in insisting on household norms and imposing rules at home.

CG.No.4 “I didn’t feel very comfortable when I first came here. Every household has its own habits. Sometimes I didn’t get why things were working certain ways. The family would tell me what to do. I listened to them and followed their requests. I had barriers communicating with the elderly sometimes but we ended up getting along. We definitely had conflicts in daily habits and schedule. For example, I like to take him out for a walk
everyday but he prefers staying at home most of the time. I don’t like staying inside for the whole day but I have to learn tolerance. It is not easy being old so I will try my best to satisfy his requests…. Every job has restrictions. It is the same here. It is eventually their place…”

Some household norms had to be changed because they were not as easy to follow for caregivers who came from distinct cultural and economic backgrounds. Older people showed some understanding under certain circumstances.

No.27 “I think dietary habit is the biggest issue, like how much water to put in when cooking rice. I prefer soft rice…. She does not like meat so she doesn't want to cook them. So I barely eat meat now…. But someone has to compromise… She is from Northern rural area, and she has different levels of education, life style and culture with urban dwellers. You cannot ask her to behave the way you like in one day. It takes time. It is important to adapt to each other’s habits and to keep good communication. ”

Whether caregivers have their own private space is crucial for their well-being. Care recipients also found if caregivers had their own space, it avoided unnecessary conflicts and was easier for them to keep to their own routines.

No.42 “After she came to my home, I don’t feel uncomfortable or having to change my routine too much. I mean I gave her a private room so we all feel secure. I do and think about my own things. I don’t feel things have changed too much at home after she came… ”

On the other hand, when caregivers and recipients had to share a bedroom due to limited living space or care needs, caregivers reported severe sleeping problems and exhaustion. Poor sleeping quality was a very common problem for live-in caregivers, especially among those who did not have a private room.

CG.No.5 “I feel lots of pressure working as a caregiver, mainly because I don’t sleep well. I work very long hours every day but I have problem sleeping. I share room with the elderly. The grandchildren sleep late and the elderly gets up early. The elderly wakes me
up during the night too if there are some care needs. If they don’t sleep I couldn’t sleep either.”

With the caring relationship established between older people and live-in caregivers, home is where work and attachment, public and private spaces, intersected. Despite the presence of live-in caregivers, older people still related home space with familiarity and security while at the same time felt their spaces had been compressed.

No.26 “Home is good, it’s where you can go back to and get out freely. I have computer and TV. I write my blogs. My family and friends can visit me here anytime. I can choose to eat at home or dine out. It basically considers my own needs and I don’t have to worry about bother other people. I do have some problems after she came here. She likes to tell me what to do and I feel restricted at home sometimes…”

Some older people mentioned how the private sphere of home space could be secured when a third person was also present, such as another family member. The power balance is shifted towards the care recipients when it is a triangle caring relationship at home.

No.45 “You sometimes feel insecure when you are in a private space with a stranger, especially you are frail and need care. I would feel less safe if I am at home alone with a live-in caregiver…. I have a private room for my caregiver, she has her own furniture and air conditioning, so we don’t disturb each other. My daughter in law also lives here and she can keep an eye too…. I am happy with my current condition.”

Based on individual care experience at home, some caregivers saw home space as purely a work place; some felt the boundary was blurred with the gradual established attachment in the caring relationship.

CG.No.2 “Of course my hometown is my real home, this can never be changed. Here I sometimes feel it is like my home when you stay with a family long enough. It mostly feels like a working place. Here have better living condition with nice bathroom. But still, it is their home and you have to follow their habits. You cannot live your own way.
Everyday when I close the door of my own room, I feel more comfortable…. It is eventually a job. Back at home I feel much more free and at ease.”

A few live-in caregivers had established good relationships with care recipients and they found the space was more than a work place. It also carried meanings of home to them.

CG.No.1“I feel at home here. I live here most of time in a year and it even feels more like home than my hometown. Sometimes when I go back to my home I feel unfamiliar. The elderly and his children are like my family, and we have shown respects and understandings to each other. We try to work out things together and it is not like who should listen to whom. I am happy here.”

Another important caring space for both caregivers and recipients is the community park. Especially for live-in caregivers, parks are places for stress release and healing. In contrast to home space, they felt they could “breath” in the park. For older people, they enjoyed socializing with others in the park as well. But for some, they felt insecure outside of their home space and they were unwilling to go to the park. In this case, caregivers had to negotiate with care recipients.

Parks are also an important gathering point for live-in caregivers. They normally take older people to the park in the day for a few hours and it is a common practice among live-in caregivers. They talked about the care recipients and their families as the only people they interacted with every day at home and so parks provide them with opportunities to meet other live-in caregivers with similar social backgrounds. Parks are also places where private time and spaces for live-in caregivers can be created. When older people were immersed in the physical and social environments in the parks, live-in caregivers had the chance of doing things on their own.
CG.No.5 “My only way of stress releasing is taking the elderly to the park for a few hours every day. Whenever I get out of home, I feel relaxed all of the sudden…. I can work on my embroidery and crafts. I don’t have social life myself. I face the elderly and his daughter every day. After I came to the park, I got to know sisters in the same profession. We chat and we get to see what outside environment looks like.”

The importance of parks as places of healing for live-in caregivers reinforces the power imbalances within home space. Homes can be spaces of oppression and compromise for some live-in caregivers and parks dilute the control of power over them.

8.3.4 Barriers to Accessing Live-in Caregiving Services

As indicated in the previous section, parks are an important gathering point for live-in caregivers. However, other park users, such as older people in the neighborhood who do not have live-in caregivers, judged live-in caregivers’ behaviors as irresponsible and indifference to their jobs. These attitudes towards live-in caregivers create one of the barriers to the use of live-in caregiving services.

No.2 “I am not going to consider hiring a live-in caregiver. They have bad reputation and I have no good impression of them. I see a lot of them in the park every day and I don’t like their attitude. They just focus on themselves and do not care for the elderly. No one supervises them and the elderly couldn’t give them orders. This is not working…."

Economic barriers also existed in accessing the service. The average monthly fee for a live-in caregiver is 3000 RMB, which is higher than the average monthly pension in Beijing. It is still an exclusive service for those who can afford it.

No.13 “It is too expensive to hire a live-in caregiver. My pension could not even pay for half of the salary…. Plus, I am worried I would be abused. People are not as nice and kind as before. They are not professional and they are irresponsible…”
Overall, these quotations strengthen the bias against live-in caregivers. This puts them in a vulnerable position even before the caring relationship is established. Both care recipients and live-in caregivers can potentially be the abusers and victims of power abuse.

The following quotation from a care recipient serves well as a concluding comment for this section:

No.42 “I have a few thoughts on the caring relationship between us old people and live-in caregivers. I think first and the most important is respecting her dignity. They come to the city to do housework and care works for old people; in return, they make money. It should be equal to any other profession. There is no high or low in dignity…. I know some live-in caregivers, they dislike when they are introduced by the old person as Baomu. This reflects that some people in our society disrespect them and see this profession as lower class…. Also we should be more trustful to them. It is disrespectful to check them all the time about money and property…. Every household may have different situations or problems when it comes to the caring relationship. Live-in caregivers are vulnerable and require more respects. My rule is, since you decide to hire one, you should be prepared to make compromises and show understandings…”

8.3.5 Power Dynamics Underlying the Caring Relationships

The profession of live-in caregivers is highly gendered in China. All live-in caregivers, whether from the private sector or non-profit organizations, are female migrant workers. Age, care needs, place of origin and education level shape the power dynamics within the home space. In most cases, care recipients and their family members have more power in terms of care duty negotiations and control over the home space. Live-in caregivers normally have a lower education level and are from rural areas. They often encounter discrimination and their profession is lowly valued in the cities. Their stereotypical
identities are located in the home space where they have limited negotiation power, especially when facing family members who have no care needs. The power balance shifts when there are no family members involved with care recipients and live-in caregiver relationships. When the care recipients are older and have more care needs, the power shifts in favor of live-in caregivers.

Outside of the private sphere of the home, parks have become the most important caring space for live-in caregivers. Care recipients and live-in caregivers sometimes have to negotiate the use of public and private spaces. Care recipients have little control when situated in public space and live-in caregivers experience parks as places of healing. This reinforces the sense of self and social status in home spaces with personal meaning (Rubinstein, 1989; Milligan, 2003). Live-in caregivers normally socialize with other caregivers or practice hobbies such as embroidery in the park. At the same time, other park users, normally neighbors in the community, observe their behaviors as forms of irresponsibility. This creates a potential barrier for people to hire live-in caregivers. In the cases where conflicts arise, excluding and being excluded are manifested on different scales for both live-in caregivers and care recipients. At the home level, exclusion comes from individuals who have control. Outside of the private realm of home space, an individual’s control declines. Exclusion can also be felt by live-in caregivers from outside of the caring relationship. Their identities are bound up with the broader population groups of “migrant workers” and “out-of-towners”, where bias pre-exists. From an empirical perspective, some conflicts come from the unregulated nature of the formal care sector. Most of the live-in caregivers are from private agencies where no training is provided, contracts are not strictly enforced and care duties are vaguely
defined. Older people, their family members and live-in caregivers expend a great amount work and long periods of negotiation time, where conflicts may occur. Non-profit organizations, in contrast, empower both live-in caregivers and care recipients by making regulations, following contracts and providing training.

Power imbalances based on age, education and geography were reduced to a limited level by imposing mutually agreed rules by non-profit organizations. Live-in caregivers, care recipients and their family members all showed high levels of satisfaction in care experience, and this contributed to the well-being of older people and care workers. However, non-profit organizations are limited in number and size and hardly apply to the general older population. Policy makers in this sense should step in and play an active role in regulating the system. What is more, the use of formal care is still limited to those who of better economic status. Reducing economic barriers and regulating the system will tremendously improve formal care accessibility, and thus contribute to the political goal of aging in place.

8.4 The Caring Relationship Between Older People and Community

In chapter seven, the results show that community services for older people are still in the process of developing in Beijing. Some services are in place while others are unavailable at this stage. The user characteristics and unmet care needs were identified. In this section, discussion is focused on older people’s experiences and perceptions of interacting with communities and use of community services. Four themes are derived: the provision of community services is unequal based on profession and geography; barriers to access of current services; the changing experience of care in pre and post reform China; high
expectations of community services as a solution for future care needs. This section only focuses on older people’s experience.

8.4.1 Unequal Access to Community Services

The data show that people who are retired cadres, belonged to the “special difficulties” group, and resided in communities in the city center, tended to have better access to community services and staff. Those who retired as government cadres enjoyed special care by the government. Profession matters as what kinds of support will be given after retirement. According to the data, they generally received higher pensions and had people from Danwei and the community to provide special care. Care provided was mostly in the form of emotional care. They were visited during festivals and given presents. They received emotional care through phone calls. Although no physical care was directly provided, it gave them a sense of collectivism.

No.42 “I was a high-level government official so I receive special care from the community. They visit me from time to time to make sure I am doing well…. I also receive phone calls asking if I have any need… ”

On the other hand, people who had ordinary jobs complained about inequities within the elder care system based on job types.

No.12 “I think what I need most is the government could provide fairer treatment and policy to our old people. Now the society treats old people with different work categories and professions too differently, especially after the reform in the 70s…. I live in this really old affordable housing community, there is not even space for elder care here…”

Older people who belong to the “special difficulties” group tended to have better
access to community services. The community prioritized this group to receive community care and support. This is in accordance with the national document on elder care discussed in the earlier chapters.

No.16 “I received lots of support and care from the community. I am disabled, live alone and on welfare. The community staffs care about me more everyday. I am very touched by the kinds of care they gave me. I have people visiting me at home. They give me haircut and physical check. They also chat with me to make sure I am doing fine…. I am in need of assistive medical tools at home, such as walking sticks and sphygmomanometer. The community would help me getting those supplies…. There are also community activities I can attend…. The emotional support from them is very important to me…. For me, I spend all my money on rent and basic food, so it is impossible for me to hire caregiver or go to a facility. I am thankful for the community. Otherwise I cannot cope by myself.”

On the other hand, older people who did not belong to the “special difficulties” group but were also in vulnerable positions were excluded from community supports.

No.39“I have very low income and I have many care needs. I sometimes ask for help from the community. But they think I have children so they would not help. But nowadays, children don’t live with me and they have very limited abilities in supporting me…. We also have our difficulties…”

Access to community services is also unequal geographically. Those who resided in older communities in the old city tended to have closer connections with the community and thus had better access to services. Those who were relocated to newer neighborhoods found it difficult to access community services.

No.32 “We were relocated here and lots of young people live here. We don’t have much connection with the community. Everything seems to be far away. There are no community services here and I don’t think we have activity space for old people…. It is not like the old communities in the city center, here is more lagged behind….”

8.4.2 Experience of Using Community Service and Barriers to Access
Many services are still not available in the communities. Results from the quantitative analysis show that meal services are one of the most needed services by older people. Some communities have developed food programs for older people in different ways. Those who used the services found that the meals did not cater to either their health needs or to their tastes, thus they stopped using the services.

No.38 “We have food service in the community and I tried it. It is not going to work for me. First, it is too salty and greasy. It is no good for old people. Cause the meal service is also opened to the public and we just pay a lower price, they gave the good meat to other customers and left us with bones. So I stopped going…. The price is pretty reasonable but I concern the quality. I think this may work for old folks who live alone. They can just get lunch and eat leftovers for dinner…”

Although the meal prices were relatively low for people with average incomes, older people with lower incomes still found the services costly.

No.16 “My community has meal service and it is fairly priced compared to food in the restaurant. But I still cannot afford it. My income is way to low…”

As described in the chapter seven, the Elderly Home Care Coupon is delivered to those who are 80 years old and over to purchase home and community-based services. The quantitative data show that the coupon is not being used for its intended purposes. The qualitative data show the barriers to receiving the coupon.

No.9“I don’t think the coupon is accessible for all the people qualified. I know an old man who lives by himself and do not have self-care ability, he never receives it cause he cannot go to the community himself…. They (community staffs) don’t deliver it to people who are not mobile…”

A small number of communities started day care services for older people. At this stage, they open solely to those who are healthy and have self-care abilities. Those who
have more severe chronic conditions and do not have sufficient self-care abilities are not eligible for applying for the service.

No. 5 “They only take people who are healthy. Before we were taken in here, we had to go through physical check. They gave priorities to those who are healthier. For people who have similar health status, it is first come first serve.”

Those who used the service found it was a good model but not without a number of problems.

No. 7 “I am lucky that my community have day care service. I come here in the day and they send us home in the evening. I eat my three meals here. They also have activity rooms that I can socialize with other old people…. One problem is you have to follow their schedule. We are picked up very early in the morning everyday. We also have to eat dinner at four o’clock in the afternoon cause they need to get off work on time. It is not very reasonable schedule for me…. Also we eat at the restaurant that belongs to the owner of the day care center. It is also opened to the public so the food is very greasy and salty. I don’t think it is healthy diet for old people. They are not preparing special meals for us.”

8.4.3 The Changing Experience of Care in Pre and Post Reform China

In chapter six, it was noted that older people’s identities are tied to pre-reform collectivism. Their experiences and perceptions of current community services reinforce their identities. Some of them believed that community services were reduced after the reforms. They talked about how some services that were previously provided by Danwei no longer existed. They perceived the lack of services as a decline in morality and the growth of a profit-driven ideology in current society.

No. 40 “Before the reform, we have regular physical check. If something went wrong about our health they would send support and care to us. Now I am older and there is no service…. It felt like son without mom….”

Older people mentioned the shrinking of their spaces in the community. They believed some public spaces that are
supposed to be used for them were used for profit.

No.13 “It is all about money and profit. The Street Office and Residents’ Committee rent out our activity spaces for profit. They didn’t consider using these spaces for our elderly residents…. I knew a 90 years old man who lived alone and in poor economic and health conditions. No one would take him cause he has no money to pay. He passed away and it’s sad…”

8.4.4 High Expectations for Communities from Older People

Despite some negative experiences with community services and barriers to accessing services, older people had high expectations for their communities as the future solution for elder care. They noted children had decreasing roles in elder care, live-in caregiving services were expensive and unregulated, and they would prefer to age in place rather than go to a RCF; therefore, they expected the community to play a more active role in providing care to the older population.

No.5 “If community could help us to solve some problems, it would be great! I really hope that community can organize collective aging. For example, building community homes, day care center. Then older people can age together. Now I think the most needed services are day care and meal service. I have talked to the community couple times but there was no response…. there are a number of widowed elderly in the community. If the community can use space to build a day care center, we can care for each other there…..”

No.29 “I want to age in my home and I think the community can do more in elder care. I have thought about a model a lot. Since now I am in my 60s and I am still healthy and capable, I can take care of those who are older. Then I receive points or hours for taking care of them. When I get older, I can spend my points and get care…. In this way, our old people could stay at home and rely on community while we are aging. Without community’s efforts, it is very difficult to do anything…”

Overall, community services in China are still under development and are only used by a small group of people at this stage. Older people reported unequal access to community care and barriers were identified. For services that were in place, older people found certain problems existed and improvements were needed for future community
service development. They tended to compare current experiences to pre-reform experiences. This further confirmed that pre-reform ideology was imprinted in older people’s identities. Despite the positive or negative experiences with communities and community care, older people believed that community care is a feasible and effective solution to help them age in place. They hoped that communities would offer more elder care in the future.

8.5 Chapter Summary

This chapter uses qualitative data from both frontline caregivers and care recipients to understand the experience of care and caregiving and its spatial implications.

Older care recipients generally have positive experiences when their children are the main caregivers. Children experience stress and inability to cope. Children are playing a decreasing role in caring for older parents and it is now common for older people to provide care to their adult children. Spouses take on large amounts of care work when their health permits. Care recipients showed concerns over their spouses’ health and well-being.

The caring relationship between older people and live-in caregivers is under constant negotiation. Older people and live-in caregivers are constantly negotiating about care duties, hours, skill trainings, household norms etc. Since the sector is not regulated yet, conflicts and tensions are quite common within the home space. Parks have become an important caring space for live-in caregivers. Power imbalances exist in both the spaces of the home and park. Economic and psychological barriers exist in accessing live-in caregiving services.
Community services at this stage are under development and exclude certain groups of people. Access to community services is unequal. People who have used the services that are in place pointed out the problems and improvements that are required. Older people hope that communities can play a more active role in helping them age in place.
Chapter 9

Conclusion and Discussion

9.1 Chapter Introduction

This dissertation aims to contribute to the understanding of place, the experiences of aging and care for those who live at home in the community and the geographical knowledge of old age in urban China. In achieving the research goals, the dissertation first explores the changing person-environment relationships, place identity and negotiation in the context of urbanization in post-reform China. Thus, it indicates the experiences of aging and intention of moving to a RCF for older people living in different residential types. Second, it discusses access to home and community-based care services by individual socioeconomic characteristics. It also shows the experience of caregiving and care receiving in different caring relationships and the spatial implications.

This chapter summarizes the key findings by revisiting the two main research themes in the dissertation. It compares the findings from quantitative and qualitative methods and discusses the similarities and differences. Then it compares the findings from this study to the existing literature. The chapter also identifies the policy implications, limitation and future direction of the study.
9.2 Revisiting Old Age and Place

Chapters five and six use both quantitative and qualitative methods respectively to understand environment, place, and old age. The results from the two sets of data share some consistencies and differences in findings. They together provide a comprehensive understanding of the research questions from different perspectives.

Both results from quantitative and qualitative analysis show the importance of the physical and built environment to well-being, place identity and healthy aging in place. The quantitative analysis shows that housing conditions and age-friendly communities are determinant factors for the general experience of aging in place. The qualitative analysis reveals that older people face different physical and built environment challenges and the challenges affect their place identity and coping strategies. Chapter six provides further explanation for the specific environmental challenges people encountered in different residential and neighborhood types, which quantitative data could not identify.

In terms of the social environment, the quantitative results indicate the importance of children and community in positive aging in place experience. On the other hand, the qualitative analysis shows that the role of children is weakened by the one-child policy and increasing social pressures with which the younger generation has to deal. Chapter six also suggests that despite the important role of community in positive aging experience, older people feel disconnected from the community. Although sense of belonging is not statistically significant
with aging in place experience in chapter five, the qualitative analysis of chapter six points out that older people have a strong sense of nostalgia for their old social networks in the neighborhoods which is hard to maintain in a changing environment. The qualitative results reveal how neighborhood type matters in understanding perception of the social environment and speak to the changing nature of the environment; while the quantitative data show the relationship between the social environment and general aging experience with a more static view of the environment.

In understanding moving intentions to RCFs, the quantitative analysis looks at demographic and community environmental factors; the qualitative analysis goes beyond the environmental and demographic factors in understanding place, considering the complex nature of thinking about future decisions. More specifically, the quantitative analysis shows people in the young-old group tend to have a better acceptance of RCFs, health status and marital status tend to explain moving intentions and children are an important factor in keeping older people at home. Chapter five also indicates the general trend of gradual acceptance of RCFs among the older population. Results from the qualitative analysis suggest that unwillingness to move to a RCF is related to older people’s incapability of moving, negative views of RCFs and a sense of autonomy at home. Eventually, older people held the expectation that their communities would be able to offer more in the future. Both results shed light on the “9064” policy.

Chapter six furthers an understanding of identity, place meanings and coping strategies, which quantitative data cannot
measure. The findings suggest the importance of environmental factors in identity shaping, meaning, transferring and place negotiation. Chapter six also brings into the discussion the dimension of time to the discussion that historical events and life experience co-constitute what place means to older people. The discussion of identity and place negotiation is crucial for understanding mental well-being of the older population. It also has strong policy implications for community construction and aging in place strategies.

Overall, chapter five and chapter six achieve the first research aim by identifying perceived physical, built and social environment by older people, their relationships with experiences of aging in place and moving intentions. The discussion of chapter six is based on residential types, the study thus informs how both generational experience and current situational factors shape place identity and understanding of aging in place. A theoretical framework is developed to illustrate how place and old age are interconnected. Both chapters contribute to the understanding of old age, environment and place in a Chinese context.

9.3 Revisiting Home and Community-Based Care for Older People

Chapters seven and eight both discuss care received by older people from formal and informal caregivers at home and community levels by using different research methods. Chapter seven conceptualizes care as specific home and community-based services by using quantitative data from the questionnaire survey. Chapter eight treats care as a more open concept. Both sets of findings speak
to the research questions of types of care and services, roles of caregivers, accessibility
and barriers. Chapter eight furthers the discussion of the experience of care on an
individual level. By comparing the two sets of findings, it contributes to a more complete
understanding of elder care in urban China.

In terms of community services, findings from the quantitative analysis serve well in
illustrating patterns on a population level and providing a context for further analysis.
Qualitative data identified user experiences. Both sets of data speak to the user
characteristics and test the geographic variations in service use on different scales.

Although the specific community services need to be provided have been enshrined in
official government policies, they are still underdeveloped in most communities. For the
existing services, there are barriers and challenges for older people to access. The
majority of older people, besides retired cadre and people with “special difficulties”, have
difficulty accessing community services provided by the public sector. Street Offices in
the older neighborhood in the city centers tend to deliver more services to their residents.

Community as a concept developed in post-reform urban China, tends to be compared by
older people to their old Danwei. They believe the decline in services types and quality is
due to the change of ideology in people who work in the public sector. However, they
expect community has more to offer to help them aging in place.

At the home level, both sets of data answer the questions of home care types, the
roles of different caregivers, and barriers accessing home care. Quantitative analysis
reveals the main caregivers, main users, service types and unmet care needs. It shows
home care in Beijing is largely an informal system. Family members provide the majority of home care. Most of the formal caregivers are from the private sector. They provide mostly non-medical services. The utilization rate for medical related services and assistive technology and equipment are extremely low and they are mostly provided by the public sector. Both quantitative and qualitative analysis show that income matters in accessing formal home care.

Compared to the quantitative analysis where unmet home care needs are discussed on a more general level, the qualitative data sheds light on the spatial implications of care experience of both caregivers and care recipients. Instability is discussed by care recipients when a spouse is the main caregiver. Older people tend to worry about the care burden and their spouses’ health. Spousal caregivers see it as a duty in marriage. The results from the quantitative analysis show that children are still the most common caregivers for older people. However, qualitative data show the children-older people caring relationship is shifting due to the One-Child Policy and increasing social pressures on the younger generation. Giving financial support and long distance emotional care are increasing. It is getting more common for older people to provide care and support to their children in various ways. Both data sets show formal home care is mostly provided by live-in caregivers from private agencies. Conflicts are common between caregivers and care-recipients as the system is not regulated. Power dynamics are shaped by age, care needs, place and education level within the home space. The quantitative data depicts the current patterns of caregiving while the qualitative data
speaks to the trends in caregiving relationships.

Overall, chapter seven and chapter eight achieve the second research goal by showing different types of home and community-based services and their accessibility issues, the user characteristics, main caregivers, the caring relationships and care experiences of both caregivers and care recipients. By using mixed methods, the dissertation identifies both the current patterns and trends in elder care. It also widens the range of discussion by including population and individual levels results on different geographical scales.

9.4 Comparing the Findings to the Current Literatures
This section compares the findings from this study and the existing literature. Some differences and similarities are discussed.

9.4.1 Old Age, Environment and Place
Theoretically, Lawton’s Ecological Theory of Aging (1973) may fit better in the Chinese context than Rowles’ phenomenological model on place attachment (1978). Chinese cities are under undergoing rapid social and economic changes that reflect in neighborhood changes in terms of landscape, demographics, social networks, functionality etc., and place attachment might be difficult to acquire when the surrounding social and physical environments are under constant change. A group of studies have been done in the West emphasizing the importance of place familiarities and attachment influencing a sense of belonging and aging experiences for older people. (e.g. McHugh and Mings, 1996; Hokey et al.,
2001; Rosel, 2003.) In a Chinese context where past experiences or events are not attached to the current place or taken away, the concept of place attachment can hardly be applied. On the other hand, as people age and self-care ability declines, the functional side of the environment becomes more important. The construction of age-friendly built environments has not kept up with the speed of economic growth. The physical environment is important in determining older people’s aging in place experience. Lawton’s model can be borrowed for further research in understanding personal competence, the environment and older people’s functional level.

Another group of studies emphasize the changing environment and discontinuities of place (e.g. Ekstrom, 1994; Fried, 2000; McHugh. 2007; Phillips et al., 2011). Phillips et al. (2011) use the concept of “unfamiliarity” to challenge Rowles’ (1978) conceptual framework on place attachment. Changes come from all aspects of life that older people may feel powerless in the new situations. The concept of “unfamiliarity” fits better in explaining old age and place in a changing environment like China. However, the divergence lies in specific findings from different case studies. Taken into consideration of recent historical events such as the Cultural Revolution, the economic reforms, and rapid urbanization, how older people convey meanings and construct identity in the new environment vary greatly to the findings in the West.

Empirically, the physical environment is significant in studies in both Western and Chinese contexts. The difference lies in the social environment. Several studies (Bowling et al., 2006; Oswald et al., 2010) show place attachment is important for life
satisfaction in later life; social contact and support were not, however, statistically significant in this study. This study shows sense of place or place attachment does not stand out in determining aging in place satisfaction or the intention to move, while support from children and community influence aging in place experience. The distinction lies in cultural and societal differences with North America, thus context-specific research is needed in understanding aging as a global issue.

In terms of relocation intention to a RCF in a Chinese context, this study shows whether people have the intention of moving does not relate to their current aging in place experience. To put it another way, negative current aging experience at home and community does not contribute to the intention to move. What influences intentions are the concerns over affordability, service quality, living conditions and loss of autonomy in a RCF. Older people in general are becoming more open to RCFs with the decreasing family care resources from their children. These findings are in accordance with previous studies (Zhan et al., 2006; Cheng, 2012) in terms of the financial aspect of moving and the stigma of RCFs. What is different in this study are older people are getting very practical about places to age. They show understanding of the lack of care provided by children and they do not tend to connect reluctance to move to a RCF to filial piety. Finally, the understanding and implication of aging in place in China is contextually different. Studies in the West emphasize the senses of security, belonging, familiarity and independence with aging in place (Pynoos, 1990; Wiles et al., 2011). This study indicates that in a place where identity is highly contested and new identities have not yet formed,
aging in place does not offer the benefits shown in Western studies. At the same time, older people do not trust what RCFs have to offer. The discussion thus raises doubt about how to recreate spaces that are age-friendly physical and built environments and familiar social environments before they become aging in no place in Urban China.

### 9.4.2 Home and Community-based Care

In general, results from this study are consistent with other studies that the public sector provides more medical related care services. For the differences, education level is related to the uses and needs of community center services in the case of Beijing as most of the services provided in community centers are social and cultural activities. People with lower or no education do not see themselves using these services. Occupation before retirement is related to the available care resources. Retired cadres from the government tend to receive more care. Geographic factors do not stand out when tested by district in this study. However, qualitative data show older communities located in the city center tend to deliver more services. In a number of studies that have been done in North America, rural and peripheral area, racialized neighborhoods, ghettos and other disadvantaged urban communities have related service access problems (Moon et al., 1998; Kuo & Torres-Gil, 2001; Smedley et al., 2003; Kirby & Kaneda, 2005; Archibald & Rankin, 2013). Beijing shows a more divergent path of urban change compared to cities in developed countries (Gu & Shen, 2003) and each district in Beijing is mixed with multiple urban functions (Tian et al., 2010). Districts may not be an appropriate scale for testing geographic variation in service access.
Another fundamental difference lies in the social structure and development stage in China and compared to those in developed countries. The Chinese older generation experienced the transition in social and health services from the employee-centered Work-Unit system to the socialist market model. Community and community services have different definitions in the Chinese context. Community services are still under construction and home care is largely an informal sector. Children play the biggest role in providing home care to older people. All these contextual differences need to be taken into consideration. However, we see a general pattern of those who are in poorer health status and with higher incomes use more services than others. Urban China also shares similarities to some cities in developed countries with increasing social polarization and rising income inequality (Gu & Shen, 2003). Income levels largely determine the use of community services for older people in Beijing. This finding raises concern as to whether those who are in need benefit from the construction of the aging industry and community reforms. The government’s role in providing or supporting home care is limited at this stage. The state government recently proposed “government purchasing community service for the older people”. The ideology embedded within these policies can be traced in Western societies, for example, the community care reform in UK and the “managed competition model” of home care in Ontario, Canada (Williams, 2006). How
“neoliberalism with Chinese Characteristics” (Harvey, 2005) is embodied in services for older people requires further studies.

Caregivers’ burden is a common issue discussed in this study and other literature (Aranda and Knight, 1997; Williams, 2006). They all show caregivers experience physical and emotional exhaustion in many cases. Caregiving patterns based on gender are different in China compared to the findings in the West. According to this study, informal caregivers are not gendered. Feminist scholars in the West discuss the filial obligation attached to women (Dowling and Pratt 1993; Pyke and Bengston, 1996; Ahrentzen 1997; McDowell 1999). In the case of Beijing, the caregiving responsibility among informal caregivers is decided upon more practical reasons. However, formal caregivers in China are all female.

Both Western studies and this study show similar themes in discussing home as a caring space. Home is the intersection of work and life, love, duty and needs (Buttimer, 1980; Somerville, 1997). Various boundary issues are discussed by researchers (Milligan, 2006; Keeling et al., 2007; Mahmood, 2007; Phillips, 2007). Similarly in this study, household norms are under constant negotiation and the maintaining of personal space is difficult in some cases. Both caregivers and care recipients experience boundary problems within the realm of the home. What has not been shown in Western studies is the role of the park as a caring space for live-in caregivers. In this case, the park is a place of healing for live-in caregivers from everyday care work.
Power relations between caregivers and older people are discussed in this study and studies in the West. Similar issues include ambiguity in the work and extra unpaid work provided by care workers (Mears et al., 2007); and both care recipients and caregivers have potential vulnerabilities in the caring relationship (Kittay, 2001). The differences lie in the factors shaping the power dynamics. In this study, it is found that age, education level and place of origin are important factors. In Western studies, discussion is centered on the roles of gender, race and ethnic status. Also crucial in a Chinese context is the lack of professional training, regulation and law in clarifying caring duties and enforcing legal contracts for live-in caregivers and older people. As a developing sector, this requires the immediate attention of policy makers.

Filial piety is often seen as a fundamental difference when discussing children’s role in caregiving in a Chinese context. However, this study shows that although children are still the largest caregiving group, the caring relationship between children and older people is shifting. Filial piety is still valued by Chinese people but an increasing number of older Chinese tend to be very pragmatic when they think about their future care needs. Similar to what Wiles (2011) has found that there is no clear division of caregiving and care receiving in some cases, this study also shows that the caring relationships are becoming more reciprocal, especially between older people and their children. However, there are differences in terms of types of reciprocal care and their effects on older people. In this study, it is found that the forms of care older people provided to their children included financial support, housing support, grand parenting etc. Most of the older people
indicated that these activities put extra burden on them and have negative effects on their well-being. This finding is different from what Stroller (1985), Lee (1998), Chen and Silverstein (2000) have found that providing support to their children has positive impacts on older people’s health. Long distant care is getting more common in this case similar to other studies (Baldock, 2000; Neal et al., 2007).

Overall, both convergence and divergence are shown in caregiving and care receiving patterns and experiences. The discussion of elder care cannot be separated from the fast economic, political, social and cultural changes taking place in China.

9.5 Policy Implications

The study also carries policy implications. When compared to the “9064” model proposed by the Beijing municipality, the study findings, raise the following questions: does the 9064 ratio make sense? Should policy makers push increasing the number of RCFs or make the home and community environment more satisfying for older people? Thirty percent of the people surveyed indicated an intention to move to a RCF. Although it does not represent the percentage of people who would actually make the move, it sheds light on a trend of gradual acceptance of RCFs, due to the changes in cultural values or practical considerations. According to the qualitative analysis, rather than feeling attached to their current home environments, the incapability of moving due to practical reasons, the concerns over service quality, living conditions and loss of
autonomy in RCFs were major reasons older people did not anticipate aging in an institutional setting. On the other hand, older people were also conflicted about their current living environment at home and in the community. A healthy social environment is getting more difficult to maintain in terms of family support due to the One-Child Policy and the increasing responsibility young people face in other parts of their lives. Imposing laws on children alone cannot alleviate the growing care gaps between older people and their children. With various relocation experiences and the collapse of the Work-units system, older people lost their social networks and familiar ways of collective living. Communities are still figuring out methods of administration and providing services to a more diverse and aging population. Community has become an unappealing place of aging for some older people but they are incapable of moving somewhere else. In the long run, whether the goal of “9064” is achievable requires critical analysis and needs to be revisited.

The physical and built environment requires more immediate attention from policy makers. Measures such as upgrading interior facilities, installing elevators in residential buildings, reconstructing old hallways, incorporating the concept of “age-friendly” in neighborhood reconstruction and design should be taken into account to improve aging-in-place experiences for the older population. What is more, recreating community social environments that incorporate collective ideas is essential in encouraging older people to age in place.
Although government documents have been published on the types of community services to be provided and the strategies for developing the services in Beijing, there is a lack of planning and guidance for specific services. The documents leave space for innovation and flexibility among local level governmental bodies, at the same time, services are not regulated and lines of accountability are blurred. The documents also leave space for management bodies to interpret and execute services differently with various standards. In the case of formal home care, which is mostly run by private agencies, issues like service range, client-caregiver boundaries, labor conflicts and training arise without formal regulation. The absence of regulations and rules governing formal home care have left older people and live-in caregivers to deal with the problems on their own. It is essential for policy makers to regulate the sector and provide formal training to live-in caregivers to avoid further conflicts. Results show that people who actually access the services are retired cadres and people with “special difficulties”. The policy states that government will assist elderly people with “special difficulties” and disabled elderly to age in place. When taking a look at the criteria, people who have no income, no working ability and no support or have disabilities fall into the category. It leaves those who are in lower income groups, have support but without caregivers, unattended. Moreover, it overlooks health status and self-care ability factors. In the current social environment, the younger generation is facing increasing challenges and pressures, older people have to provide support and care to them in many cases. Having children sometimes means an extra burden to older people while they are excluded from
many services due to the fact they have children. Evaluation of those who are eligible for government assistance in using community services needs further assessment.

How should resources be allocated within different services? Market mechanisms are used to develop community services for older people except medical services at community health clinics. However, there are fundamental differences in providing, for instance, day care services and a dancing class. Without sufficient support, “social resources” have limited ability to provide more professional and sophisticated services, and most of the resources will go to one area more than the other. As shown in the results, food services and day care are largely unavailable. These services require more support and guidance from policy makers.

Although children’s roles in providing care to older people is decreasing, older people generally have the most satisfying experience of care from their children. On the other hand, children caregivers have to compromise with their work and health. Governments need to implement policies to compensate family caregivers for taking care of their older parents.

Lastly, since community services for the elderly are still under construction, it is especially important to empower the elderly with information and knowledge that will help them navigate the “new” system. As a generation whose life experience is intertwined with the socialist Work-units system and were born when the 9-year compulsory education law had not been implemented, information imbalance may exist
between the community and older residents when services have gradually been “societalized.”

9.6 Limitations

There are some general limitations in terms of sampling strategy. First, almost 90 percent of the sample was recruited in public spaces like neighborhoods and parks, and only 10 percent were recruited through references by the Street Offices and other participants at seniors’ homes. This may exclude the most vulnerable seniors that stay at home all of the time and with very limited social capital. Second, the interview excludes frail older people who have barriers communicating. These people are the main users of home and community-based care. This leads to another important issue of how to engage frail older people in the research process. Third, this study includes a limited number of communities in the six urban districts. The findings cannot be generalized to suburban and rural areas of Beijing. The findings have implications for other Chinese cities but cannot be applied to the understanding of old age and elder care in other areas, as China is a geographically diverse country. Fourth, only older people with Beijing Hukou are included in the study. There are a growing number of older people who move to Beijing from elsewhere in the country for various reasons. This study does not speak to the experiences of this group of older people.

Specific to the quantitative and qualitative methods adopted in each chapter, there are limitations as well. In chapter five, the variables chosen to evaluate the environment are all opinion based. The study does not
include objective measurements of the environment. Also, due to the scope of the research, it is hard to be inclusive of all physical and social environment factors. Included are the factors that are essential to older people’s daily lives and are stressed by current policies.

In chapter seven, only individual level factors are considered in discussing home and community-based care. Community level factors were not discussed. Districts were examined for geographic patterns of service use, which might be too large scale for discussing community service accessibility in the case of Beijing.

For the qualitative analysis in chapter six and chapter eight, the main challenge concerns how to convey diverse individual experiences on such a large scale. It requires careful analysis and discussion as not to over interpret the data collected. If time and funding had permitted, a larger sample size for qualitative research would have been preferred. Based on grounded theory, other research themes might have emerged.

Overall, the chapters have their strengths and weaknesses. By adopting mixed methods, they complement each other to provide a more complete story and bring different foci to the fore in understanding the issues.

9.7 Future Direction

China is the most populous and the fastest developing country in the world. The economy is booming but many social issues have emerged while the new social security system is still under construction. Population aging is a challenge faced by the government, policy makers and all citizens. It requires
intensive and up-to-date research for the benefit of all the stakeholders in the system. As part of the generation when One-Child Policy was implemented and the economic reforms were initiated, I understand the growing gap in elder care and the issues our generation is about to face. As a researcher, I hope to bring some perspective to contribute to the construction of the elder care system in China.

As a discipline mainly developed in the West, it is important to bring the Chinese case into the sub-discipline of health geography. Aging and caring for the older people shares some universal characteristics while China also carries its uniqueness in an academic sense. A contextually sensitive discussion is necessary on concepts, models, approaches, and representations of aging and care in China. This dissertation hopes to open up more academic discussion on issues of aging and care in China. A next necessary step is to take a political-economic approach in understanding the mechanism behind the various environmental challenges and the landscape of care (Milligan, 2010). It is equally important to consider the rapidly changing nature of the population, the elder care sector and social policies. This dissertation is one of the first geographic studies to look at old age and care at home and community levels in China. Based on the findings in this study, it is helpful to develop research topics looking at more specific issues. The future research topics can be built on different residential types, age cohorts, caring relationships, neighborhood types etc. Follow-up and updated research is crucial to contribute to the understanding of aging in the Chinese context.
Bibliography


Bureau of Civil Affairs of Beijing & Beijing Disabled Persons’ Federation (2009), Home Old-age services for Beijing residents.


Appendix A

Questionnaire

Information Fulfilled by Interviewer
Interview’s Name: _________________           Today's date:________________
Address: __________________
District, Street office and Residents’ committee: _________________________

Interviewee’s sex:
01 Male
02 Female

Interviewer introduction
INTERVIEWER: Introduce yourself
I am here for a PhD project of Queen’s University, Canada. This survey asks older people who choose to age at home from all districts of metropolitan Beijing about their health, care experience and service use. One of the main goals of the survey is to gather information to help improve health programs and services provided for the increasing elderly community in your region. All information collected in this survey will be kept strictly confidential. Interview can be ended anytime if the interviewee is feeling uncomfortable answering.

1. Basic Personal Information/socio-economic characteristics

1.1 What is your age?
1.2 What is your marital status?
01 married
02 living common-law
03 widowed
04 separated
05 divorced
06 single, never married

1.3 How many people living in the same household including yourself? (Physically living here not registered ones.)

01 one
02 two
03 three
04 four
05 five or more

1.4 Who are you living with within this household? (Multiple choices)

01 Husband/Wife
02 Father/Mother
03 Son: specify birth, step, adopted
04 Daughter: specify birth, step, adopted
05 Brother/Sister
06 Foster son/daughter
07 Grandson/daughter
08 In-law: specify
09 Other related: specify
10 Unrelated: specify

1.5 What is your monthly household sum income level?

01 Less than 450RMB
02 450-850RMB
03 851-1200 RMB
04 1200-2000 RMB
05 2000-3000 RMB
06 3000-5000RMB
07 5000RMB and above

1.6 What are your major financial sources?

01 Pension
02 Relative: specify
03 Government subsidies
04 Personal Financing plans
05 Salary from rehire
06 Income from self-employment
06 Savings (monetary and real estate)
06 Other: specify

1.7 What is your education level?
01 Elementary school degree
02 Less than high school diploma or its equivalent
03 High school diploma or a high school equivalency certificate
04 College or other non-university certificate or diploma (other than trades certificates or diplomas)
05 Bachelor’s degree
06 Above bachelor’s degree

2. Physical Health and Well-being
2.1 In general, would you say your physical health is…?
01 Excellent
02 Very good
03 Good
04 Fair
05 Poor

2.2 How do you evaluate your independency level (the ability to take care of yourself)?
01 fully capable of taking care of myself
02 sometimes caregivers are needed
03 cannot take care of myself

2.3 What kinds of chronic conditions do you have?
01 cancer _______ 02 stroke _______ 03 arthritis _______
04 high blood pressure _______ 05 heart diseases _______
06 cataracts _______ 07 back problems _______
08 urinary incontinence and diabetes _______ 12 diabetes _______
09 migraine headaches _______ 10 bowel disorder _______
11 Alzheimer’s Disease or any other early dementia _______
13 other, specify ____________________________
2.4 Do you have any difficulty hearing, seeing, communicating, walking, climbing stairs, bending, learning or doing any similar activities?
01 Sometimes
02 Often
03 Never

3. Mental Health and Emotional Well-being

3.1 In general, would you say your mental health is…?
1 Excellent (Go to 3.3)
2 Very good (Go to 3.3)
3 Good (Go to 3.3)
4 Fair
5 Poor

3.2 Whom did you see or talk to if you report fair or poor mental health?
01 Family doctor or general practitioner
02 Psychiatrist
03 Psychologist
04 Nurse
05 Social worker or counsellor
06 Other – Specify

3.3 I have close relationships that provide me with a sense of emotional security and well-being.
01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

3.4 There is a trustworthy person I could turn to for advice if I were having problems.
01 Strongly agree
02 Agree
03 Disagree
04 Strongly disagree

3.5 Where do you think you get most of emotional support from?
01 partner
02 son/daughter
03 grandchildren
04 other relatives
05 friends
06 co-workers from before
07 volunteer
08 formal caregivers
09 neighbors

4. Social Capital in the Community
4.1 Do you think neighbors trust each other?
01 trust very much
02 trust
03 so-so
04 not very trust
05 do not trust

4.2 Do you think most of people like to help each other in the community?
01 very much
02 yes
03 so-so
04 no so much
05 no

4.3 Do you feel a sense of belonging living in the community?
01 very strong
02 strong
03 so-so
04 not very strong
05 not strong at all

4.4 Do you think the community is age-friendly?
01 very much
02 yes
03 so-so
04 not very
05 no
4.5 If you have difficulties, does the community try to offer help?
01 lots of help
02 help
03 sometimes help
04 not much help
05 no help at all

5. Activities of Daily Living (ADL)

5.1 Because of any physical condition or mental condition or health problem, do you need the help of another person with preparing meals?
01 Yes
02 No

5.2 Because of any physical condition or mental condition or health problem, Do you need the help of another person with getting to appointments and running errands such as shopping for groceries?
01 Yes
02 No

5.3 Because of any physical condition or mental condition or health problem, do you need the help of another person with doing everyday housework?
01 Yes
02 No

5.4 Because of any physical condition or mental condition or health problem, do you need the help of another person with personal care such as washing, dressing, eating or taking medication?
01 Yes
02 No

5.5 Because of any physical condition or mental condition or health problem, do you need the help of another person: with moving about inside the house?
01 Yes
02 No

5.6 Because of any physical condition or mental condition or health problem, do you need the help of another person with looking after your personal finances such as making bank transactions or paying bills?
01 Yes
02 No
6 Home environment and housing condition
6.1 What is the type of your housing?
01 Ownership
02 Children’s housing
03 Public rental
04 Private renatl
05 Other

6.2 Are you satisfied with your housing condition?
01 Very satisfied （to 6.4）
02 Satisfied （to 6.4）
03 so so
04 Dissatisfied
05 Very dissatisfied

6.3 If dissatisfied, what are the reasons?
01 Poor interior facilities
02 Poor quality
03 Unpleasant room temperature
04 Interior design not age-friendly （kitchen, washroom etc.）
05 Hall way, stairs etc are not designed age-friendly
06 Neighborhood build environment is not age friendly
07 Other : __________

6.4 In general, are you satisfied with your aging experience at home?
01 Very satisfied
02 Satisfied
03 So so
04 Dissatisfied
05 Very dissatisfied

6.5 If you are not satisfied, what are the reasons?
01 Not taken care of
02 Poor housing
03 Built environment not age friendly
04 Not convenient
05 Other:

6.6 Have you ever considered moving to an institution?
01 Yes
02 No
7. Community-based Care for Older People

7.1 Are there services or facilities available in your neighborhood?

<table>
<thead>
<tr>
<th>Community Service</th>
<th>Availability¹</th>
<th>Utilization²</th>
<th>Needs³</th>
<th>Satisfaction⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal Home Care*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Clinics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consulting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: _______</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Yes or No
2 Number 1,2,3 represent often use, sometimes use and never use
3 Number 1,2,3 represent have needs, sometimes have needs and do not have needs
4 Number 1,2,3,4,5 represent very satisfied, satisfied, average, not satisfied, very unsatisfied

7.2 If you have never used community service or did not receive enough service, why?

01 I don’t need the services
02 Services I need do not exist
03 I cannot afford the services I need
04 I do not know how to use or access the services
05 Using service makes me feel uncomfortable
06 Others: please specify

8. Home Care

8.1 Have you ever used these home care services? Can these services meet your needs?

<table>
<thead>
<tr>
<th>Home care services</th>
<th>Utilization¹</th>
<th>Needs²</th>
<th>Satisfaction</th>
</tr>
</thead>
</table>

222
<table>
<thead>
<tr>
<th></th>
<th>on Level 3</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and medical care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other health care services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical equipment or supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meal preparation or delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Company (Shopping, seeing doctor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistive technologies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other – Specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Number 1,2,3 represent often use, sometimes use and never use
2 Number 1,2,3 represent have needs, sometimes have needs and do not have needs
3 Number 1,2,3,4,5 represent very satisfied, satisfied, average, not satisfied, very unsatisfied
4 Service providers include: 01 Nurse/doctor from community clinic, 02 public sector including Residents' committee and government sponsored public service organization, 03 Homemaker, nurses or other support services from a private agency, 04 Government-subsidized private agencies, 05 Homemaker or other support services from grassroots non-profitable organization, 06 Neighbour or friend, 07 Family member or spouse, 08 Volunteer, 09 Other – Specify

**8.2 During the past 12 months, was there ever a time when you felt that you needed home care services but you didn’t receive them?**

1 Yes
2 No (Go to END)

8.3 Thinking of the most recent time, why didn’t you get these services?
01 Not available - in the area
02 Not available - at time required (e.g., inconvenient hours)
03 Waiting time too long
04 Felt would be inadequate
05 Cost
06 Too busy
07 Didn’t get around to it / didn’t bother
08 Didn’t know where to go / call
09 Language problems
10 Personal or family responsibilities
11 Decided not to seek services
12 Doctor - did not think it was necessary
13 Did not qualify / not eligible for home care
14 Still waiting for home care
15 Other – Specify

8.4 Again, thinking of the most recent time, what types of home care was needed but you have not received or not enough?
01 Nursing care (e.g., dressing changes, preparing medications, V.O.N. visits)
02 Other health care services (e.g., physiotherapy, occupational or speech therapy, nutrition counselling)
03 Medical equipment or supplies
04 Personal care (e.g., bathing, foot care)
05 Housework (e.g., cleaning, laundry)
06 Meal preparation or delivery
07 Shopping
08 Respite care (i.e., caregiver relief)
09 Assistive technologies (telephone, assistive buzzer)
10 Other - Specify (Go to HMC_S10)

8.5 Where did you try to get this home care service?
01 government sponsored program
02 private agencies
03 family member, friend or neighbour
04 volunteer organization
05 Other
9. Open Question
What do you want to add concerning your health care needs?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

END
As part of this study, we may need to get in touch with you in the future. If you are willing to participate in the follow-up interview, can you leave your contact information?

______________________________________________________________________

Thank you very much for your support and patience!
Appendix B

Interview Guide with Older People

INTERVIEWER: I am here for a PhD project of Queen’s University, Canada. Here is the follow-up interview after the questionnaire survey. Please remember that you do not have to answer any questions that make you uncomfortable. The interview will begin only after you have had the chance to read and sign the informed consent form and any questions or concerns about the research project have been addressed. All information collected in this survey will be kept strictly confidential. Interview can be ended anytime if the interviewee is feeling uncomfortable answering.

1. Experience of Aging at Home and Community
What kind of neighborhood are you living in and how would you describe it? How do you like your home and community environment? How do you perceive your environment change? Why do you choose to age at home instead of an institute? What kinds of support you get from the community you currently living in?

2. Caregiving network
Who is your main caregiver? Who else take care of you? How do you perceive the care received from above people? (do you think they are helpful and satisfying? Do you find them important and necessary? Or do you think it is too much care?) What kinds of roles they are playing in your network? Are there any barriers or difficulties encounter between you and your caregiver?

3. Experience of Care
What do you think of the services provided to you at community level? (Adult day care, counselling services, meal service etc.) What do you perceive as the most needed but unmet service to you? What is your biggest barrier to access the services now?

How do you compare services provided by government, private companies, non-profitable or volunteer organization and family/friends? Which is more important to you considering your current situation? Which parts of the services you think need to improve more? What do you think is your biggest need now? (Financial needs, emotional needs, daily care needs, or medical needs etc?) What do you want to add about the challenges you are facing? Do you have any suggestion?

Thank you very much!
Appendix C

Interview Guide with Caregivers

INTERVIEWER: I am here for a PhD project of Queen’s University, Canada. Please remember that you do not have to answer any questions that make you uncomfortable. The interview will begin only after you have had the chance to read and sign the informed consent form and any questions or concerns about the research project have been addressed. All information collected in this survey will be kept strictly confidential. Interview can be ended anytime if the interviewee is feeling uncomfortable answering.

1. Background Information

   Do you mind telling me your age, education level and your place of origin?
   Are you a full-time caregiver? If not, what’s your other job?
   How long have you cared for this person? How did you get this caregiving job? Have you received any training before the caregiving job?

2. Care work

   What kinds of care work you do? How long are you working as a caregiver in a week? Where is you caregiving job taken place? How do you perceive this place? How long do you have to be at this place for within a week?

3. Challenges and barriers

   How do you find yourself coping with this job? What are the challenges you feel as a caregiver? Do you feel any barrier/problem between you and your care receiver? How do you like your current position in general? From a caregiver perspective, what do you think need to be done in terms of elderly care in the community?
Appendix D

Letter of Information

My name is Jie Yu and I am a PhD candidate from Queen’s University, Canada. I am here for my PhD project on aging and elderly care. This survey asks the elderly who choose to age at home from all districts of metropolitan Beijing about their health, care experience and service use. One of the main goals of the survey is to gather information to help improve health programs and services provided for the increasing elderly community in your region.

This questionnaire will take 40 minutes. At the end of the questionnaire, you will be asked whether you are interested in participating another interview session. The interview will take an hour to two hours.

During the questionnaire survey and interview, some questions about your physical and emotional well-being will be asked. Also some questions may touch your family and social networks. If any of these questions cause you discomforts, inconvenience or you don’t feel like talking, please inform the interviewer.

Participating in questionnaire survey and interview are voluntary that participants are free to withdraw at any time. Questions can be skipped if participants do not feel like answering. Interview can be ended anytime if the interviewee is feeling uncomfortable answering. Electronic recorder maybe used for interview only under participants’ consent.

Questionnaire survey will be anonymous. For any identifying information that may appear during interview, the main investigator is the only one who has access to it. All information collected in this survey will be kept strictly confidential in dissertation, future publication and overall research procedures. Raw data pertaining to individuals' involvement in the study will be disposed when data analysis is done. Research results will be accessible through Qspace, Queen’s University library and potentially through journals that publish the papers.
A compensation of some gifts will be given to participants. If participants have any
corns concerns about the research procedure, here are the contact information of the main
investigator and the General Research Ethics Board: Jie Yu, 8jy6@queensu.ca or
862087110574; Chair of the General Research Ethics Board at chair.GREB@queensu.ca
or 613-533-6081.

This study has been granted clearance according to the recommended principles of
Canadian ethics guidelines, and Queen's policies.
Appendix E

Consent Form

The participant's name_______

I have read the Letter of Information and have had any questions answered to my satisfaction;

I understand that I will be participating in the project of Aging at Home and Supportive Community-Based Care in China: a Case Study of Metropolitan Beijing, that I have been informed that my involvement consists of questionnaire survey and interview which will be recorded by electronic recorder, that I understand that the purpose of the study is to understand the current aging pattern and elderly care in Beijing;

I am aware that I can contact Jie Yu and the Unit REB or the General Research Ethics Board with any question, concern or complaint that I have.

I understand that my participation is voluntary and that I am free to withdraw at any time.

I have been assured that all the information I provided during the research is strictly confidential.

Name: __________________________
Date: __________________________
Signature: ______________________

By initialing this statement below,

_____ I am granting permission for the researcher to use a tape recorder (and/or)
_____ I am granting permission for the researcher to attribute my name to any quotes
Appendix F

Confidentiality Agreement

Name:____

I acknowledge that Queen's University at Kingston (hereinafter called "Queen's") has in its possession, and with the authority to disclose, in confidence, certain information ("Confidential Information") relating to specific research projects being conducted by Jie Yu in the field of Human Geography. Confidential Information includes, without limitation, computer programs, discoveries, inventions, techniques, documents, data and information concerning the study or other research programs of Jie Yu, and of information with respect to Jie Yu’s assistant.

The Confidential Information will be given to me in order to perform duties as a research assistant (RA) related to the Jie Yu’s project. In consideration of working on such project(s), I agree that I will keep in confidence and trust all Confidential Information and will not directly or indirectly use the Confidential Information, nor disclose any Confidential Information to any person or entity, except in the course of performing duties assigned with respect to the studies. I agree that I shall be free to use information that:

a. is known to me prior to the receipt of the said Confidential Information from Queen's as evidenced by written documentation; or
b. lawfully is or becomes public knowledge through no default of this Agreement; or
c. is provided to me by any third party with a bona fide right to do so; or
d. is approved for release by written permission of the Vice Principal (Research) of Queen's University

Upon the termination of the Work, I undertake to return all Confidential Information pertaining there to which has been provided by Queen's and all copies thereof or to destroy the same at the option of Queen's.
This agreement is to be effective upon the date of signing, and shall be interpreted and construed in accordance with laws of the Province of Ontario, Canada.

By: __________________________

Dated at _________________ this _______ day of ________________, 200__.

Witness: _________________________

Please retain a copy of this agreement for your records and provide one to the Researcher.
Appendix G

Ethic Clearance Letter

January 27, 2014

Ms. Jie Yu
PhD Candidate
Department of Geography
Queen's University
Kingston, ON, K7L 3N6

Dear Ms. Yu:

RE: Amendment for your study entitled: G GEO-148-13 Aging at Home and Supportive Community-Based Care in China: a Case Study of Metropolitan Beijing; ROMEO# 6007904

Thank you for submitting your amendment requesting to add Dr. Yang Cheng as a Co-investigator of this project.

By this letter you have ethics clearance for this change and the Romeo/traq file has been updated accordingly.
Good luck with your research.

Sincerely,

Joan Stevenson, Ph.D. Chair

General Research Ethics Board

c.: Dr. Mark Rosenberg, Faculty Supervisor  
   Dr. Yang Cheng, Co-investigator