RESIDENTIAL CARE FOR ELDERLY PEOPLE IN BEIJING, CHINA:
A Study of the Relationship between Health and Place

by

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the degree of Doctor of Philosophy

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Abstract

This thesis is a study of the residential care for elderly people in Beijing, China. First, a set of statistical indicators are developed for mapping the spatial distribution of the elderly population and residential care facilities (RCFs). Secondly, in-depth, semi-structured interviews are used to understand the socio-cultural meanings of access, the decision making process in relocation, the well-being of elderly residents, as well as the challenges of residential care and social welfare reform. In total, 27 elderly residents, 16 family members, and five RCF managers were interviewed in six RCFs in Beijing. The constant comparative method is used to analyze all the transcribed interview materials.

There are several major findings resulting from the research: the distribution of the elderly population and residential care resources is geographically uneven across the districts of Beijing and the supply of resources does not match the potential need. Elderly people and their family members choose residential care because of the shortage of community and home care resources and/or the advantages of residential care. The decision making process is a process of balancing geographical factors, quality of services, and financial affordability. Access to residential care is an interactive process influenced by geographical, economic, and social-cultural factors. The physical and socio-cultural environments of RCFs and individual’s sense of place play important roles in their adaptation and well-being after the relocation from the home to a RCF. Building up the active aging model with joint efforts from governments, society, RCFs, and individuals is helpful and effective for promoting the well-being of elderly residents in
RCFs. At the end, the study also provides suggestions for the government, organizations, and RCFs on aspects such as administration, policy making, planning, volunteering, and management of RCFs to meet the challenges of residential care in China.

The study confirms the importance of healthy living environments to the well-being of elderly residents. It also provides knowledge for understanding the reconfiguration of filial piety in decision making processes and utilization of residential care in current Chinese society. From a health geography perspective, this thesis is one of the first studies on residential care in China.
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# Table of Contents

Abstract .................................................................................................................................................. i

Acknowledgements ............................................................................................................................... iii

Table of Contents ................................................................................................................................... vi

List of Tables ........................................................................................................................................... xii

List of Figures ........................................................................................................................................... xiii

Chapter 1 Introduction ............................................................................................................................. 1

1.1 Introduction ....................................................................................................................................... 1

1.2 Population Aging ............................................................................................................................... 2

1.3 Elder Care ......................................................................................................................................... 6

1.4 Research Goals, Questions, and Significance ................................................................................ 9

1.5 Outline of Thesis Chapters ............................................................................................................ 12

Chapter 2 Literature Review .................................................................................................................. 15

2.1 Introduction ....................................................................................................................................... 15

2.2 Theoretical Studies in English-speaking Countries ........................................................................ 18

2.2.1 Life course ................................................................................................................................... 18

2.2.2 Active aging ............................................................................................................................... 18

2.2.3 Continuity theory ....................................................................................................................... 19

2.2.4 Public finance and social welfare ............................................................................................. 20

2.2.5 Theoretical studies in geography .............................................................................................. 22

2.2.5.1 Concept of access .................................................................................................................. 23

2.2.5.2 Aging, place, and health ....................................................................................................... 24

2.3 Empirical Studies in English-speaking Countries ........................................................................... 25
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.3.1 Characteristics of residents</strong></td>
<td>25</td>
</tr>
<tr>
<td><strong>2.3.2 Decision making process</strong></td>
<td>26</td>
</tr>
<tr>
<td><strong>2.3.3 Access to residential care and service use</strong></td>
<td>28</td>
</tr>
<tr>
<td><strong>2.3.4 Adjustment to relocation</strong></td>
<td>30</td>
</tr>
<tr>
<td><strong>2.3.5 Empirical studies in geography</strong></td>
<td>31</td>
</tr>
<tr>
<td><strong>2.4 Studies in China</strong></td>
<td>34</td>
</tr>
<tr>
<td><strong>2.4.1 Traditional culture patterns</strong></td>
<td>34</td>
</tr>
<tr>
<td><strong>2.4.2 Challenges of elder care</strong></td>
<td>35</td>
</tr>
<tr>
<td><strong>2.4.3 Studies on residential care</strong></td>
<td>37</td>
</tr>
<tr>
<td><strong>2.5 Relevance of the Existing Literature to My Thesis Research</strong></td>
<td>39</td>
</tr>
<tr>
<td><strong>2.6 Chapter Summary</strong></td>
<td>40</td>
</tr>
<tr>
<td><strong>Chapter 3 Research Design and Methods</strong></td>
<td>42</td>
</tr>
<tr>
<td><strong>3.1 Introduction</strong></td>
<td>42</td>
</tr>
<tr>
<td><strong>3.2 Conceptual Framework</strong></td>
<td>42</td>
</tr>
<tr>
<td><strong>3.3 Methods</strong></td>
<td>47</td>
</tr>
<tr>
<td>3.3.1 Mapping</td>
<td>48</td>
</tr>
<tr>
<td>3.3.2 In-depth, semi-structured interview</td>
<td>49</td>
</tr>
<tr>
<td><strong>3.4 Data Collection and Analysis</strong></td>
<td>51</td>
</tr>
<tr>
<td>3.4.1 Statistics</td>
<td>51</td>
</tr>
<tr>
<td>3.4.2 Government policies and documents</td>
<td>52</td>
</tr>
<tr>
<td>3.4.3 Questionnaire design, recruitment of participants, and interview process</td>
<td>53</td>
</tr>
<tr>
<td>3.4.4 Data analysis</td>
<td>58</td>
</tr>
<tr>
<td><strong>3.5 Limitations, Challenges, and Ethical Issues</strong></td>
<td>59</td>
</tr>
<tr>
<td><strong>3.6 Chapter Summary</strong></td>
<td>62</td>
</tr>
</tbody>
</table>
Chapter 4 Financial Security of Elderly People in China ................................. 64

4.1 Introduction ........................................................................................................ 64

4.2 Current Financial Security of Elderly People in China ................................. 66

4.2.1 Financial security of elderly people in urban areas of China .................. 66

4.2.2 Financial security of elderly people in rural areas of China .................... 70

4.3 Challenges for Greater Financial Security of Elderly People in China .......... 72

4.4 Chapter Summary .............................................................................................. 75

Chapter 5 Population Aging and Residential Care Resources in Beijing ........ 77

5.1 Introduction ........................................................................................................ 77

5.2 Demographic Changes in the Chinese Population ....................................... 78

5.3 The Demography of the Elderly Population in Beijing ............................... 82

5.4 Residential Care in Beijing .............................................................................. 91

5.5 Chapter Summary .............................................................................................. 97

Chapter 6 Access to Residential Care by Elderly People in Beijing ............ 99

6.1 Introduction ........................................................................................................ 99

6.2 Choosing Residential Care ............................................................................. 100

6.3 Access to RCFs .................................................................................................. 108

6.3.1 Geographical access .................................................................................... 108

6.3.2 Information access ...................................................................................... 112

6.3.3 Economic access .......................................................................................... 113

6.3.4 Socio-cultural access .................................................................................. 115

6.3.5 The socio-managerial environment ............................................................... 119

6.4 Chapter Summary .............................................................................................. 120

Chapter 7 Well-being of Elderly Residents in Residential Care Facilities .... 122
7.1 Introduction .................................................................................................................. 122
7.2 Well-being of Elderly Residents in RCFs ................................................................. 123
7.3 Health and Place in RCFs .......................................................................................... 127
  7.3.1 Physical environment .......................................................................................... 127
  7.3.2 Social environment ............................................................................................ 131
  7.3.3 Individual factors - elderly residents ................................................................. 137
  7.3.4 Individual factors - family members ................................................................. 142
7.4 Chapter Summary ....................................................................................................... 144

Chapter 8 Challenges of Residential Care in Beijing ..................................................... 147
8.1 Introduction ............................................................................................................... 147
8.2 Challenges in the Management of the Residential Care Industry ......................... 148
  8.2.1 Government policies and support mechanisms ................................................. 149
  8.2.2 RCF planning and design ................................................................................. 156
    8.2.2.1. Geographical location .............................................................................. 156
    8.2.2.2. Built environment and facilities ............................................................. 157
  8.2.3 Management of RCFs ....................................................................................... 158
    8.2.3.1. Management of the staff members .......................................................... 158
    8.2.3.2 Management of residents ........................................................................ 159
8.3 Suggestions for Improvements and Policy Implications ......................................... 160
  8.3.1 Administration .................................................................................................... 160
  8.3.2 Policies, regulation and laws ............................................................................. 166
  8.3.3 Planning ............................................................................................................... 169
  8.3.4 Management of elderly residents ..................................................................... 172
  8.3.5 Social activities ................................................................................................... 173
Appendix 13. Information of interviewed family members................................. 273
Appendix 14 Sample of transcripts .................................................................... 276
Appendix 15 Ethics certificate ........................................................................... 277
List of Tables

Table in Chapter 1
Table 1-1 Proportion of the Population Aged 60 and Over in 2006 .................................. 3

Table in Chapter 3
Table 3-1 Inter-linkages between the Conceptual Framework and Methodology .......... 50

Table in Chapter 4
Table 4-1 The Multi-pillar Pension System by the World Bank. ............................... 66

Table in Chapter 5
Table 5-1 The Age and Sex Structure of the Population in China in 2006 and 2050 ...... 82
List of Figures

Figures in Chapter 1

Figure 1-1. The trends of population aging ................................................................. 3

Figure 1-2. The proportion of the population aged 60 and over at the provincial level in China in 2000 and 2005 ........................................................................... 5

Figures in Chapter 3

Figure 3-1. A conceptual model of residential care for elderly people ....................... 43

Figure 3-2. Framework for the design of the questionnaires ........................................ 57

Figures in Chapter 5

Figure 5-1. China’s population pyramid in 2006 ........................................................... 80

Figure 5-2. China’s population pyramid in 2050 .......................................................... 80

Figure 5-3. The self-reported health status of elderly people in The One Percent Population Sample Survey of Beijing in 2005 .................................................. 83

Figure 5-4. Income sources of elderly people in The One Percent Population Sample Survey of Beijing in 2005 ................................................................. 83

Figure 5-5. Marital status of elderly people in The One Percent Population Sample Survey of Beijing in 2005 ................................................................. 84

Figure 5-6. The spatial distribution of the population aged 60 and over in Beijing in 2006 .................................................................................................................................................. 86

Figure 5-7. The spatial distribution of the population aged 80 and over in Beijing in 2006 .................................................................................................................................................. 87

Figure 5-8. The spatial distribution of elderly families in Beijing in 2006 ................. 88

Figure 5-9. The trends for the elderly population in next 50 years in Beijing .............. 90

Figure 5-10. Residential care resources and occupancy rate in Beijing in 2006 ........ 94

Figure 5-11. The spatial distribution of residential care resources in Beijing in 2006 .... 94
Figure 5-12. The occupancy rate of RCFs in Beijing in 2006 ........................................ 95
Figure 5-13. The ownership of RCFs in Beijing ............................................................ 97
Chapter 1 Introduction

Aging is not only an embodied process but is emplaced as well.

(McHugh, 2003, p.169)

1.1 Introduction

Age is the most important variable associated with limitations on one’s ability to carry out activities (Kovar, 1977). Aging can be interpreted both at an individual level and at a population level. Individual aging refers to one’s biological, psychological, and social changes as one’s age increases. Population aging refers to the process a population experiences with an increasing proportion of the population who are elderly. Individual aging is associated with one’s life course, and each person’s life course is different and unique, whilst a generation experiences common life stages and social changes at a population level (Hodge, 2008). Transitions to old age and choices of place for aging are concerns at an individual level. At the same time, demographic changes, social welfare, and policies related to the elderly population are concerns at a population level. The two levels interact in elderly people’s everyday lives, and also in research and policy making.

This thesis aims to understand residential care for elderly people in Beijing, China both at individual and population levels within the broader Chinese economic and socio-cultural context. The following parts of this chapter consist of an introduction to population aging at the international, national and local levels in China and Beijing; elder

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1 In English speaking countries, aged 65 and over is usually used to define elderly people. In China, aged 60 and over is usually used to define elderly people, and the same definitions are used throughout this thesis except in citing research from other sources.
care systems in China; research goals and questions of this study; and chapter structures of this thesis.

1.2 Population Aging

The challenge of population aging has aroused attention at the international level. Both the Vienna International Plan of Action on Aging and the Madrid International Plan of Action on Aging called attention to the rapidly increasing number and proportion of elderly people in the world, especially in developing countries. The two plans also advocated that all countries take action to meet the approaching challenges of population aging (United Nations, 1983, 2002). In 2006, the global population reached 6.58 billion and the population aged 60 and over was 10 percent of the total population (Population Division, United Nations, 2007). The proportion of the population aged 60 and over reached 11 percent in China, 17 percent in the U.S., 18 percent in Canada, and over 20 percent in some European countries. Among all countries, Japan is the one with the highest proportion (27%) of an elderly population (see Table 1-1). The population of most countries of the world is aging.

Forecasts by the U.N. show that the population aged 60 and over is expected to be 21.8 percent of the total population of the world by 2050, 31.1 percent in China, 31.9 percent in Canada, 37 percent in Germany, and 44 percent in Japan (Figure 1-1). Another important trend of population aging is that the increase of the elderly population will be greatest and most rapid in developing countries such as China (Population Division, United Nations, 2001).
Table 1-1

Proportion of the Population Aged 60 and Over in 2006 (Population Division, United Nations, 2007)

<table>
<thead>
<tr>
<th>Country</th>
<th>World</th>
<th>India</th>
<th>China</th>
<th>U.S.</th>
<th>Canada</th>
<th>France</th>
<th>Spain</th>
<th>Germany</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of population aged 60 and over</td>
<td>10%</td>
<td>8%</td>
<td>11%</td>
<td>17%</td>
<td>18%</td>
<td>21%</td>
<td>22%</td>
<td>25%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Figure 1-1. The trends of population aging (Population Division, United Nations, 2007).

Population aging has profound influences on the world population. First, “population aging is unprecedented”. The number of elderly people (60 years or older) exceeded the number of the young (under age 15) in the more developed regions in 1998 for the first time in history, and by 2050, it will take place in the world as a whole. Secondly, “population aging is pervasive”. It is a global phenomenon affecting intra-generational and inter-generational equity and solidarity. Thirdly, “population aging is
“population aging is enduring”, and this trend is expected to continue to the middle twenty-first century (Population Division, United Nations, 2001, p. xxviii).

In China, the proportion of the elderly population is increasing rapidly mainly for two reasons: first, fertility rates have declined to a low level because of the “one family one child” policy, which has been in place since the late 1970s; and secondly, age-specific mortality rates have been in decline and are now lower because of health care improvements since the establishment of People’s Republic of China in 1949. As a result of the large population in China and the above two reasons, China now has the largest elderly population in the world in absolute terms. The results in *The One Percent Population Sample Survey* in 2005 show that the population aged 60 and over was 144 million, which was 11.03 percent of the total population (National Bureau of Statistics of China, 2006). The forecast by the U.N. shows that from 2010 to 2030, these two decades will be the period with the most rapid population aging in China (Figure 1-1) (Population Division, United Nations, 2007).

Population aging also shows great regional difference among all the provinces in China. The number and proportion of the elderly population in east coast areas are higher than in the central and west areas. Shanghai, Jiangsu, and Beijing were the top three provinces (metropolitan areas) with the highest proportions of the elderly population in China (14.98%, 12.62 %, and 12.54% respectively in 2000) (National Bureau of Statistics of China, 2001). The distribution pattern of the elderly population in 2005 changed compared to the pattern in 2000. Chongqing, Sichuan, and Shanghai were the provinces
The proportion of the elderly population increased most rapidly in Chongqing, Sichuan, Hubei, and Anhui provinces (metropolitan areas) (Figure 1-2). One of the important reasons is that young and mid-age populations from central and western areas migrated to the east coast areas for work and educational opportunities during 2000 to 2005 (National Bureau of Statistics of China, 2006).

Following the same population aging process as in other parts of the world, the developed areas in China have also been the first areas to age, such as Beijing, Tianjin, and Shanghai metropolitan areas. The Household Registered Population Survey of Beijing in 2006 shows that the population aged 60 and over was 2,024,000, which was 16.9 percent of the total population of Beijing (Committee on Aging of Beijing, 2007). The population aged 60 and over is expected to be 30 percent of the total population in 2025.
(Beijing Municipal Bureau of Statistics, 2000). As a result of the demographic changes, the challenges of elder care provision will be faced by both the government and individual families with the dramatic socio-economic changes in Beijing in the next few decades (More details of the demography of population aging in Beijing are covered in Chapter 4).

1.3 Elder Care

Elderly people need more care giving resources than other age groups because of the degradation of self-care abilities as their ages increase (Johnson & Grant, 1985). According to where care is offered, elder care can be divided into home, community, and residential care. According to whom caregivers are, elder care can also be divided into informal care and formal care. The increasing demand for elder care is a challenge faced by both governments and individual families in countries with a growing elderly population.

Historically, Confucian principles played important roles in providing elder care in China. Normally, the eldest son and his family were responsible for taking care of his parents and filial piety was thought to be the obligations of adult children (Chen, 1996). In the last two decades, the combination of a rapidly aging Chinese population and dramatic socio-economic transformations, however, has decreased the potential of family caregivers to provide continuous support for their elderly family members (Gu, Dupre, & Liu, 2007; Joseph & Phillips, 1999; Zhang & Goza, 2006). These transformations include the increasing involvement of women in the paid workforce and the changing geographic
distribution of family members resulting from work-related migration. The impact of demographic changes on the Chinese kinship system and socio-economic inequalities between China’s urban and rural populations also challenges the care for elderly people, especially for those in rural areas (Jiang, 1995; Joseph & Phillips, 1999). Lack of care resources available in private homes facilitates the development of residential care facilities (RCFs) as an alternative choice for elder care in China (Bartlett & Phillips, 1997).

Residential care has existed in China for several decades; however, the services and the eligible residents of RCFs only began to increase and improve in recent years. Prior to the establishment of the People’s Republic of China in 1949, RCFs were almost nonexistent. In the 1950s, the government united charitable homes into social welfare homes. At this stage, social welfare homes were for the relief of vulnerable groups. In the 1980s, the Chinese government decided to turn social welfare homes from a relief policy into a welfare policy. It expanded services to all elderly people and the disabled for their living, health care, education², exercise, and amusement. At the end of 1990s, the Chinese government encouraged the private sector, organizations, and non-profit corporations to invest in developing RCFs (Wei, 2007). The data show there were 38,000 RCFs with 1.2 million beds in 2006 in China, which provided 8.6 beds for per 1000 elderly people (China National Committee on Aging, 2006).

Different types of RCFs developed in China, such as social welfare homes, respected senior homes, rest homes, and seniors apartments and the services and

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² For example, the Third Age University.
functions vary by type. Both social welfare homes and respected senior homes provide services for the “Three-No" elderly people: those who have no living children or relatives, little or no income, and no physical ability to work in urban areas. They also provide the basic needs of food, clothes, shelter, health care, and funerals, which is called “Five Guarantees”; for childless elderly people and the disabled in rural areas with funding from local governments. Social welfare homes are owned by local governments, whereas respected senior homes are owned and funded by communities and local governments. Rest homes provide services for elderly people who look for residential care and are able to pay for care. Rest homes may be owned by governments, the private sector, or other organizations. Seniors apartments are similar to retirement homes in some countries such as Canada. These settings enable residents to live as independently as possible and provide certain services and social activities. Some social welfare homes, respected senior homes, and rest homes also offer 24-hour nursing care and supervision for the elderly (Wei, 2007).

Residential care in China faces many challenges. On the one hand, the current RCFs resources are unable to meet the demands of the increasingly elderly population. For example, in Beijing, 12.7 percent of elderly people are willing to be institutionalized, but only 1.25 beds are available per 100 elderly people and there are even fewer resources (0.29 beds per 100 elderly people) in the central districts (Zhao, 2006). In Shanghai, one sixth of the elderly people want to move into RCFs, but only one bed is available per 100 elderly people (Pan, 2003). Generally speaking, the 1.2 million beds in around 38,000 RCFs in China were only enough for 0.86 percent of the total elderly population in 2006 (China National Committee on Aging, 2006). In more developed
countries such as Canada, there was five percent of the elderly population living in RCFs in 2006 (Statistics Canada, 2008). On the other hand, existing RCFs resources are not efficiently utilized. Some RCFs have long waiting lists to get in, whereas some RCFs are likely to be closed down because of low occupancy rate. Normally, the revenues and expenses of RCFs can be balanced when the occupancy rate is over the range of 60 to 70 percent depending on the facility. Geographical location is one of the important factors that determines occupancy rates of RCFs (Li, Huang, & Dong, 2007; Shi & Li, 2003; Xie, 2006). For example, in Beijing, the occupancy rate of RCFs in the central districts is over 75 percent, 52 percent in suburban districts, but only 49 percent in exurban districts. Many of the RCFs in exurban districts are facing financial difficulties and highly depend on the funding from local governments and communities because of their low occupancy rates (Li et al., 2007). The situation is no better in Shanghai, where the occupancy rate in central districts is over 90 percent, but much lower in suburban and exurban districts (Shi & Li, 2003).

1.4 Research Goals, Questions, and Significance

Who cares for elderly people and where are basic questions of interest to both political and academic communities (Milligan, 2006). Various disciplines such as gerontology, sociology, and geography all contribute to the knowledge of aging and elder care from different perspectives. Population geography contributes an understanding of the geographical distribution and variation of the elderly population. The geography of public finance and restructuring contributes in understanding social welfare system
reform, financial security for elderly people, and inequity of distribution and utilization of care resources. In health geography, at the macro-scale, such as regional and national levels, research interests focus on the distribution and allocation of residential care resources in space. At the micro-scale, research interests focus on the relationship between body, health, and place within RCFs (Andrew, 2005).

Most research on residential care, however, has been carried out in English-speaking countries. Research on residential care is limited in China because of its short history of development. Current research in China focuses on social welfare system reform (Bartlett & Phillips, 1997; Huang, 2003), the challenges of population aging and elder care, and availability of family and community care resources (Bartlett & Phillips, 1997; Davis-Friedmann, 1991; Jiang, 1995; Joseph & Phillips, 1999; Leung, 1997; Zhang & Goza, 2006). A few researchers have started to study the characteristics of residents in RCFs (Gu et al., 2007), the willingness to choose residential care and its availability (Guan, Zhan, & Liu, 2007; Zhan, Liu, & Guan, 2006). Little, however, is known about the geography of aging and residential care, well-being of RCF residents, and the relationship between health and place in RCFs in China.

Beijing, the capital of China, is one of the cities with the highest proportion of an elderly population and the most rapid socio-economic development in China. Residential care as an alternative choice to traditional family care has developed quickly in Beijing in recent years. Therefore, this study takes Beijing as the study area with the following research goals:
G1. To understand the spatial distribution of the elderly population and residential care resources in Beijing and to visualize the spatial match between service needs and resources.

G2. To understand the decision making process of choosing residential care and access to residential care of elderly people and their family members.

G3. To understand the “sense of place” for elderly people living in RCFs and the relationship between body, health, and place for elderly people in RCFs.


Specific research questions are asked to achieve the above goals:

Q1. What is the spatial distribution of the elderly population and residential care resources in Beijing? Do service needs geographically match residential care resources?

Q2. How is the decision of residential care being made instead of traditional home care?

Q3. What are the factors that affect access to residential care?

Q4. How does the relocation to RCFs affect elderly people’s everyday activities and health compared to when they lived at home?

Q5. What current and future challenges of residential care do government and RCFs face?

Q6. What changes are needed for policy to meet the current and future challenges in residential care?

Answering the above research questions will help researchers and policy makers to understand the relationship of service demand and supply, the equity of access to
residential care, the quality of life in RCFs, and the developments and challenges of residential care in the Chinese socio-economic, political, and cultural context. The unique perspective from health geography will emphasize the importance of place on access to residential care and the influence of place on one’s health. It will also provide suggestions for the improvement of service quality, future planning, and policy making. This research will fill the gaps in research on residential care in China and shed light on future research on elder care in China.

1.5 Outline of Thesis Chapters

Chapter 1. Introduction. In the first chapter, the background of aging at international, national, and local levels and elder care in China were introduced in the second and third sections. In the fourth section, the research goals, specific research questions, and the significance of the research were presented.

Chapter 2. Literature Review. This chapter reviews the theoretical and empirical studies of residential care in English-speaking countries, especially the research on the elderly population, access to elder care, and the relationship between health and place in health geography. The following part reviews research on population aging and elder care in China. In the last part of this chapter, it summarises the relevant existing literature with this research inside and outside of geography in both English-speaking countries and China.
Chapter 3. Research Design and Methods. This chapter explains the conceptual model and methods (Geographic Information System [GIS] techniques and in-depth, semi-structured interviews) of this research. Based on the conceptual model, how quantitative (GIS) and qualitative methods (in-depth, semi-structured interviews) are used to answer the research questions is also explained. In addition, the challenges, limitations, and ethical issues of the research are presented at the end of this chapter.

Chapter 4. Financial Security of Elderly People in China. This chapter introduces the current social welfare system locally and nationally in China. The World Bank’s multi-pillar pension model is used to explain the financial security of elderly people in China, which includes the current pension and health care systems in urban and rural areas respectively. The important issues of financial security of elderly people which the Chinese government should address in the near future are discussed at the end of this chapter.

Chapter 5. Population Aging and Residential Care Resources in Beijing. Data from official statistics and government reports are used to understand the characteristics of the elderly population and residential care resources in Beijing. Maps developed by GIS methods are used to present the spatial distribution pattern of the elderly population and RCFs, and the geographical relationship between service demands and resources. The findings help in the understanding of the demography of the elderly population and provide information for future planning on elder care in Beijing.

Chapter 6. Access to Residential Care by Elderly People in Beijing. Results from in-depth, semi-structured interviews are used to explain the reasons why elderly
people and their family members choose residential care and how they access residential care in Beijing. The findings presented in this research help to understand the new phenomenon of choosing residential care instead of traditional home care for Chinese elderly people and the accessibility of residential care within the contemporary Chinese socio-cultural and economic context.

Chapter 7. Well-being of Elderly Residents in RCFs. This chapter uses the results from the interviews to understand the well-being of elderly residents in RCFs, the factors which affect residents’ physical and mental health, and the relationship between health and place. It also provides suggestions for improving the quality of life of elderly residents in RCFs.

Chapter 8. Challenges in Residential Care in Beijing. This chapter uses the results from the interviews to understand what kinds of challenges are faced by elderly residents, RCFs managers, and the government. Based on the challenges identified, suggestions are made for future planning and policy making, as well as to RCF managers and elderly residents respectively.

Chapter 9. Conclusion and Discussion. This chapter provides the final conclusions and contributions in its first part. In the second part, the results from this research are compared to the existing research in English-speaking countries to show the similarity and differences. In the last part, the limitations of the research and directions for potential future research are provided.
Chapter 2 Literature Review

2.1 Introduction

In English-speaking countries, the majority of research on aging, health, and place has focused on the experience, meaning, and construction of two locales: private homes and RCFs (Cutchin, 2003). Studies show both positive and negative sides of residential care, and the “residential care versus community care” debate has been going on for years (Andrews & Phillips, 2002). RCFs provide an alternative option for elderly people and their family members who lack caregiving resources in their private homes.

The proportion of institutionalized elderly people reached five percent of the total elderly population in the U.K., U.S., and Australia in 1970s and 1980s (Gibson & Rowland, 1984; Ikegami, 1982). Before the 1990s, one of the most prevalent beliefs regarding residential care, however, was that home is the best place for the healing and care for the frail elderly. Residential care was often seen as a last resort (Johnson & Grant, 1985; Salamon & Rosenthal, 1990). The criticisms about RCFs focused on the inability of RCFs to provide independence and choice for the residents and to protect residents’ civil liberties (Andrews & Phillips, 2002). In the 1990s, governments in many countries advocated developing community care because of the increase in the elderly population and residential care budget. In the U.K., the 1990 National Health Service and Care in the Community Act was implemented in 1993 and aimed to maintain elderly people in their own homes as long as possible and to be supported by community services (Great Britain, Department of Health, 1989). In Canada and New Zealand, a number of policies were also implemented leading to the development of community-based care (Hodge, 2008; New Zealand, Ministry of Health [MoH], 2001, 2002; Raphael et al., 2001). Some
research, however, offered an alternative view of maintaining elderly people in their homes through community care. For example, Oldman and Quilgars’ (1999) research showed that elderly people experienced their home not as a place where they found self-expression and autonomy, but as a lonely and bleak place.

At the same time in the 1990s, new types of residential care such as retirement communities and assisted living residences (ALRs) were developed to provide different levels of care and supports to elderly people (Bernard, Bartlam, Sim, & Biggs, 2007; Cutchin, 2003). These types of residential care have been described as “a promising new model of long-term care that blurs the sharp and invidious distinctions between nursing homes and community-based care and reduces the chasm between receiving long-term care in one’s own home and in an institution” (Hawes, 2001, p.2). The new residential model of care is able to provide adequate care and a satisfying environment for elderly people with varying levels of care needs (Aminzadeh, Dalziel, Molnar, & Alie, 2004). Empirical research provides evidence to show that some elderly people enjoy the lifestyle and independence in RCFs and take comfort in that they are not burdens on their families (Kearns & Andrews, 2005).

The study of residential care is inter-disciplinary. Concepts and theories, such as life course, active aging, continuity theory, access, therapeutic landscapes, and equity of accessibility and utilization, have been proposed to explain how elderly people adapt to the changes during the life course, how place affects people’s health, and equity in access to public services (Anderson, 1995; Atchley, 1989; Kearns & Gesler, 1998; Rosenberg, 1983; WHO, 2002). There is also theoretical research focusing on financial security of long-term care (Everett & Anthony, 2002, 2003; Everett, Anthony, & Burkette, 2005;
Hancock & Wright, 1999; Stum, 2000; Wright, 2003), the co-existence of for-profit and non-profit RCFs (Andrews & Phillips, 2000a, 2000b, 2002; Phillips & Vincent, 1988), and the role of government in supporting elder care (Comas-Herrera et al., 2006; Skinner & Rosenberg, 2006). A great deal of empirical research focuses on the characteristics of RCF residents (Ness, Ahmed, & Aronow, 2004; U.S. Federal Interagency Forum on Aging Related Statistics [FIFARS], 2004), the decision making process of choosing residential care (Caron, Ducharme, & Griffith, 2006; Davies & Nolan, 2003; Funk, 2004; Johnson & Grant, 1985), the adjustment after relocation (Joiner, 1991; LaRue, Dessonville, & Jarvik, 1985; Reed, Cook, Sullivan, & Burridge, 2003), well-being of the elderly residents (Arnetz & Theorell, 1983; Bland, 1999; Froggatt, 2001), and care delivery in RCFs (Aminzadeh, Dalziel, Martell, & Amos, 2001; Aminzadeh et al., 2004). From both inside and outside geography, studies increasingly explore elderly people’s experiences and meanings associated with RCFs as places of care and their implications for well-being (Kearns & Andrews, 2005).

The research on residential care in China is relatively limited compared to the studies in English-speaking countries. Existing research focuses on the demography of an aging population, the social welfare system for elderly people, challenges of providing elder care, and characteristics of elderly residents in RCFs. The following parts of this chapter will review the theoretical and empirical research in English-speaking countries both inside and outside geography, and also the research in China. The last part of this chapter will emphasize the relevance of the literature to this research.
2.2 Theoretical Studies in English-speaking Countries

2.2.1 Life course

The concept of life course was developed in the social sciences to explain “the interaction of biological, psychological, and social aspects of individual development” as one’s age increases, and how an individual life is connected to developments and changes in social structure (Settersten & Mayer, 1997, p.233). Smelser and Halpern (1978) defined life course as “triangularization of life” which is composed of three distinct segments – an early part of devoted to education and training, a middle part devoted to work, and a final part devoted to retirement (Kohli, 1994). Mayer and Tuma (1990, p.3) interpreted the life course as “the way in which social institutions shape and institutionalize individual lives in the interconnected domains of education, family, and work”. The life course is also shaped by “cultural beliefs about the individual biography, institutionalized sequences of roles and positions, legal age restrictions, and the decisions of individual actors” (Mayer & Tuma, 1990, p.3). Hence, from the definitions of life course, it can be viewed at an individual level or a cohort level, and can also be compared between different cultures, nation-states, and historical periods (Settersten & Mayer, 1997).

2.2.2 Active aging

Theoretical frameworks have been developed to deal with the outcome of the aging process since 1960s. The concept of “active aging” has been developed recently in
response to rapid population aging and elderly people’s quality of life (WHO, 2002). There are several similar terminologies such as “successful aging” (Rowe & Kahn, 1997) and “healthy aging” (Bartlett & Peel, 2005) being used in various contexts. The concept of “active aging” was developed by WHO in 2002 and refers to “the process of optimizing opportunities for health, participation, and security in order to enhance quality of life as people age” (WHO, 2002, p.12). The new models of active and successful aging posit that the quality of life of elderly people does not only depend on their physical and mental health but also on their morale, life satisfaction, and engagement with life (Kristjanson, McDowell, Aylesworth, & Karam, 2003; Menec, 2003). The framework of active aging is conceptualized from various perspectives. For elderly people, active aging means the ability for self-care, the capacity to adapt to the outcomes of aging, active involvement in community and society, and a positive attitude in aging (Bartlett & Peel, 2005; Bowling, 1993). For policy making and RCF management, the concept of active aging places new requirements on the long-term care of elderly people. It means to create a secure and supportive environment for healthy lifestyles, to provide educational and health-rated activities and opportunities for elderly people, and to encourage their continuous participation and involvement in society (Findlay, 2003; Rowe & Kahn, 1987; WHO, 2002).

2.2.3 Continuity theory

Continuity theory uses a life course perspective to argue that elderly people usually maintain the physical, mental, and social status, activities, and Behaviors as they
did in their earlier life (Atchley, 1989). This theory was first developed by Atchley in his article entitled “Retirement and Leisure Participation: Continuity or Crisis?” in 1971 and further developed in his other article entitled “A Continuity Theory of Normal Aging” in 1989 (Atchley, 1971; 1989). In the second article, he outlined two types of continuity: internal and external. Internal continuity refers to elderly people’s inner structure such as temperament, preferences, and interests, whereas external continuity refers to elderly people’s social activities, relationships, and roles (Atchley, 1989). Later, Becker (1993) criticized Atchley’s theory as only applicable in understanding “normal aging” and expanded the theory to understand elderly people who experienced health disruptions. Based on Atchley and Beaker’s research, Elliott (1995) interpreted continuity as personal and cultural continuity to explain how elderly people in nursing homes structure physical space and social opportunities to maintain cultural connections between their pre- and post-institutionalization lives.

2.2.4 Public finance and social welfare

Residential care as a part of social welfare concerns criteria of equity, equality, and efficiency of its distribution and utilization. The concept of equity can be defined in terms of horizontal and vertical equity. Horizontal equity also means equality which suggests equal shares of resources, whilst vertical equity suggests matching needs with resources. When needs cannot be met, equity is interpreted as unequal or “certain population groups with a particular need are denied the care offered to the rest of the population with that need” (Rice & Smith, 2001, p. 259). Efficiency suggests providing
maximum use with the minimum cost (Bloom, 2001; Rice & Smith, 2001). In health care accessibility and utilization, equality is not economically efficient and equitable to meet variable needs. “Equitable access occurs when demographic and need variables account for most of the variance in utilization”, and “efficient access is shown when the level of health status or satisfaction increases relative to the amount of health care services consumed” (Andersen, 1995, p. 4, 6).

Research on residential care, policy orientation, and government expenditures on residential care documents the effects on the development and distribution of residential care resources. Studies show that health care system restructuring have effects on service utilization by elderly people living in different communities. Research in New Zealand showed that after the service restructuring and privatization of the long-term care system, urban areas benefited from an expansion of the private sector, while rural communities suffered a depletion of services (Joseph & Chalmers, 1995, 1996). In the U.K., the change from substantial financial support for the care of residents in the 1980s to withdrawal of support in the 1990 National Health Service and Care in Community Act, resulted in many RCFs experiencing financial hardships in management (Andrews & Phillips, 2000b). Research in Canada showed that the restructuring of the long-term care system downloaded the responsibilities of elder care onto communities and individual families (Cloutier-Fisher & Joseph, 2000; Skinner & Rosenberg, 2006). Comas-Herrera et al. (2006) have forecasted potential long-term care expenditures in Germany, Italy, Spain, and the U.K. in a European Commission funded study for better planning of long-term care in the future. Regarding the public administration of long-term care, new agencies have been developed to provide better access and efficient use of resources. The
creation of Community Care Access Centers (CCACs) in Canada is an example. Research also shows the effects of RCF ownership on their performance and efficiency-effectiveness. In theory, non-profit operators reinvest their revenues in initiatives to improve performance and to provide charity care and less profitable services, while for-profit organizations theoretically hold their revenues in service and facility improvements, which indicates that the ownership of RCFs may have an effect on RCFs’ performance and efficiency, and also on the well-being of the residents (Berta, Laporte, & Valdmanis, 2005; Lemke & Moos, 1989).

2.2.5 Theoretical studies in geography

There were two branches in medical geography before the 1990s, one focusing on “geography of disease”, and the other on “geography of health care” (Litva & Eyles, 1995; Kearns, & Joseph, 1993, p.712). The research interests in “geography of disease” are the ecological and environmental association of particular disease and the diffusion of diseases, whereas the research interests in “geography of health care” are distribution, accessibility, utilization, and planning of health care resources (Litva & Eyles, 1995; Kearns & Joseph, 1993; Rosenberg, 1998). In the 1990s, a significant transformation started from “medical geography” to “geography of health” with changes in research interests (Rosenberg, 1998, p.211). The new geography of health emphasizes the importance of place in the study of health, involving social theories (e.g., feminism and postmodernism) and methodological approaches (e.g., qualitative methods) (Cutchin, 1999, 2007; Dyck, 1999; Kearns & Andrews, 2005; Kearns & Moon, 2002; Laws, 1993,
1995, 1996; Rosenberg, 1998). In this section, the theoretical research on access to care resources and interactions of aging, health, and place in the geography of health will be reviewed.

2.2.5.1 Concept of access

In medical geography before the 1990s, the concept of access was broadly applied in the study of health care delivery. The early studies emphasized distance decay in health care utilization. Various ways to measure distance were developed, such as map distance, road distance, time distance, socio-cultural distance, and economic distance. Mobility of people was considered to be more important for health care utilization than physical distance. Later, medical geographers became aware of the limitations of distances measures and sought for a better understanding of how distance interacts with other non-spatial factors in health care accessibility and utilization (Meade, Florin, & Gesler, 1988). For example, Penchansky and Thomas (1981) divided access into five components: availability, accessibility, accommodation, affordability, and acceptability. Rosenberg (1983) interpreted access as two components: economic and physical access. The former is the ability to purchase health care service, whereas the latter is the ability to overcome the cost of distance for using health care service. The former is thought to be the prime important factor in the study of health care delivery. Joseph and Phillips (1984) divided accessibility into locational accessibility (physical distance) and effective accessibility (e.g., whether a facility is always available or open, and whether it is socially or financially accessible). In Andersen’s revised Behavioral Model of Health Services Use,
access is measured as: potential access (enabling resources), realized access (actual use of health service), equitable access (occurring when demographic and need variables account for most of the variance in utilization), and inequitable access (occurring when social structure, health beliefs, and enabling resources determine who gets medical care) (Andersen, 1995). All of these definitions indicate that access is not only affected by geographical factors, but is also affected by economic, social, and cultural factors.

2.2.5.2 Aging, place, and health

During the transformation from medical geography to health geography, both theoretical and empirical research shows increasing interests in the relationship between the well-being of elderly people and the environment in which they live (Golant, 1972; Reed et al., 2003; Rowles, 1978; Warnes, 1982). Two concepts - “sense of place” and “therapeutic landscapes” are broadly used to examine the relationship between health and place, and put an emphasis on well-being in place (Duncan, 1990; J. Duncan & N. Duncan, 1988; Kearns & Gesler, 1998). Sense of place indicates “a person’s socio-economic status helps shape their experience of places at the same time as place of residence influences opportunities for activity and experience” (Kearns & Joseph, 1993, p.716). Therapeutic landscapes are a concept first developed by Gesler (1992) and defined by Kearns and Gesler as “places that have achieved lasting reputations for providing physical, mental, and spiritual healing” (Kearns & Gesler, 1998, p.8). At the beginning, the concept of therapeutic landscape was applied to places with the function of healing, whereas later it was applied to places which promote well-being and maintain
health (Gesler, 2005). Besides the above two concepts, Laws’ (1993, 1995, 1996) research contributes theoretically to understand how the elderly body is represented and what it is supposed to represent by using post-structuralist theories of representation and the body. She argued that identities are both embodied and emplaced and the politics surrounding identity formation is spacialized. Paralleling the argument for the shift from empirical and positivist medical geography to critical health geography, Harper and Laws (1995) called for a similar shift to a critical geography of aging.

2.3 Empirical Studies in English-speaking Countries

Empirical researchers across various disciplines have studied characteristics of residents, the decision making process of choosing residential care, access to RCFs, and adjustment after relocation. There is also research studying service use, financial security of residents in RCFs, and the roles family members play in elder care in RCFs. In health geography, research interests focus on the distribution and allocation of residential care resources at the macro-scale, and the relationship among body, health, and place at the micro-scale.

2.3.1 Characteristics of residents

Research shows that the characteristics of residents in retirement communities and long-term care homes vary because of the different levels of care provision in the two settings. In terms of residents in retirement communities, studies in the U.K. show that
the residents generally come from a wide geographical area, have good incomes, are home owners, have been well educated, and are mostly at good or reasonable health status when they move (Bayley, 1996; Croucher, Pleace, & Bevan, 2003; Oldman, 2000). Studies in North America indicate that such communities tend to be provided by the private sector rather than the public or voluntary (non-profit) sectors, and that their residents are principally white and relatively affluent (S. Sherwood, Ruchlin, C. C. Sherwood, & Morris, 1997; Streib, 2002). In terms of residents in long-term care homes, research in the U.K., Netherlands, and the U.S. shows that females, whites, the oldest-old (aged 80 and over) and those with high levels of physical, functional, and cognitive impairment are more likely to be institutionalized than other groups (Cuijpers, Lammeren, & Duzijn, 1999; Gosney, Tallis, & Edmond, 1990; Ness et al., 2004; Quinn, Johnson, Andress, McGinnis, & Ramesh, 1999; Spore, Mor, Hiris, Larrat, & Hawes, 1995; Sturgess, Rudd, & Shilling, 1994; U.S. FIFARS, 2004). Married persons and those with a greater number of living children and higher education are less likely to enter a long-term care home than persons with fewer family caregiving resources and lower education (Aykan, 2003; Couch & Kao, 1998). Those with affluent economic resources have greater accessibility to residential care (Wallace, 1990).

2.3.2 Decision making process

Research shows that the decision making process of choosing residential care is influenced by many factors, either singly or in combination, and are related to the elderly person and his/her family caregivers (Caron et al., 2006; Cohen et al., 1993; Gaugler,
First, factors related to health status of the elderly person and care burden on caregivers are important for choosing residential care. These factors include advancing age, deteriorating health status, and problematic behaviors of the elderly person, and insufficient formal and informal care resources and increased level of stress and sense of burden on caregivers. Secondly, financial security from both public and family sources affects the decision-making process. For example, Stum (2000) examined later life financial security goals for potential long-term care expenses from the perspective of elderly people and involved family members. Research in China shows that elderly people’s willingness to choose residential care relates to their financial ability and the affordability of residential care is likely to be a major factor that affects their decision making (Zhan, Liu, & Guan, 2006; Zhan, Liu, Guan, & Bai, 2006). Thirdly, other factors, such as physicians’ suggestions and changes in the community situation, are also reported. Lastly, studies show that the expectation of an active and healthy life-style provided by RCFs attracts elderly people to move. Many elderly residents report that retirement communities provide them opportunities for making new friends and sharing interests. Living in retirement communities helps combat loneliness, improve morale, and encourage the development of healthy life-styles (Kupke, 2000; Madigan, Mise, & Maynard, 1996; Siegenthaler & Vaughan, 1998). In many instances, elderly people are, however, unable to make the decision or they are forced into a passive status in the decision-making process, such as elderly people with dementia, those who are too sick or too disoriented to make the decision, and those who are financially dependent on their families (Caron et al., 2006). Research also shows that the elderly people’s participation
in the decision making process directly and indirectly influences their adjustment and well-being in RCFs (Johnson & Grant, 1985).

2.3.3 Access to residential care and service use

Geographers use statistics, mapping, and more recently GIS to study the population distribution, location of health care facilities, transport links, and other factors. These methods help provide information on resource locations and availability, and visualize the spatial match between service needs and resources. The results also help analyze access to health care resources and equity in their provision (Cromley & Shannon, 1986; Gatrell & Loytonen, 1998; Joseph & Bantock, 1982; Joseph & Cloutier, 1990, 1991; Love & Lindquist, 1995; Morrison, Alexander, Fisk, & McGuire, 1999). For example, Joseph & Poyner (1982) and Joseph & Cloutier (1990) studied health and social service consumption by elderly people in rural communities in Ontario, Canada. Hugo and Aylward (1999) used GIS methods to identify elderly people and areas that are disadvantaged in their access to residential care in non-metropolitan South Australia. Fortney, Chumbler, Coby, and Beck (2002) studied how geographical access influences service use by elderly people in Arkansans, U.S., and the results showed that elderly people in rural areas receive fewer home/mental health services because of less geographical access to care resources, and they may be at greater risk for hospitalization or nursing home placement than elderly people in urban areas.

Empirical research provides evidence to prove that the concept of access is a multidimensional term. Socio-cultural and economic factors influence access to
residential care besides geographical factors (Falcone & Broyles, 1994; Netten & Darton, 2003). Financial security of residents is one of the important factors in access to residential care. A group of studies aim to develop a retirement income projection model to deal with the impact of possible long-term care expenses (Everett & Anthony, 2002, 2003; Everett et al., 2005). Some research discusses the equity in access to residential care by elderly people. Wright (2003) reported that self-funded elderly people can be admitted directly to RCFs without a need for assessment in the U.K. As a result, those self-funded people who are relatively physically independent are likely to receive preferential access to residential care resources compared to publicly funded elderly people. Research also shows possible unequal financial security, financial complexities, and consequences among the residents in RCFs and their spouses who continue to live in the community (Hancock & Wright, 1999).

Residents in RCFs are registered in three categories according to their dependency levels in the U.K.: active elderly (AE), elderly mentally infirm (EMI), and elderly physically disabled (EPD) (Phillips & Andrews, 1996; Andrews & Phillips, 2000a, 2000b, 2002). Empirical research shows that RCFs offer different levels of services and health care for the residents according to their health status, especially for those with chronic and mental health diseases. For example, Aminzadeh et al. (2004) examined the health/functional profiles, patterns of service use, and health care needs of a representative sample of 178 older adults in RCFs in Ottawa, Canada. Researchers have also studied the challenge of service provision from RCF managers’ perspectives. A research project conducted by Aminzadeh et al. (2001) shows that many senior managers
indicate that their facilities are not adequately equipped to meet the care needs of an increasingly frail elderly population, as well as the professional training of their staff.

2.3.4 Adjustment to relocation

Each elderly resident experiences a process of adaptation to a new life in RCFs when they first relocate. Joiner’s research (1991) shows that on the one hand they need to deal with the separation from a familiar home, family, friends, and their social networks. On the other hand, they need to adjust to group living in RCFs. In earlier research, removal from the home and placement in a nursing home was thought of as “social surgery” and the adjustment that follows as healing (Rosen & Kostic, 1957). The adaptation process of relocation is influenced by a number of factors such as desirability to move, participation in the decision making process, environment of the facility, quality of services, degree of disruption of the person’s social network, and the person’s health status (Joiner, 1991; LaRue et al., 1985; Reed et al., 2003). A group of researchers have also studied the psychological, sociological, and health Behavior of institutionalized elderly people (Arnetz & Theorell, 1983; Froggatt, 2001; Hertzsprung & Konnert, 2004; Hubbard, Tester, & Downs, 2003; Joiner, 1991). The results show that psychological adaptation is thought to be more difficult and important than physical adaptation.

Family members usually continue to provide supports for elderly residents after their relocation and play important roles in helping them adapt to the relocation. Research shows family members undertake a wide range of tasks within RCFs. They continue to
provide physical care such as feeding, laundering, and bathing. They engage in emotional supports such as visiting to RCFs and taking residents on outings or to family events. They also undertake an important monitoring role to check on the quality of care (Keating, Fast, Dosman, & Eales, 2001; Milligan, 2006).

2.3.5 Empirical studies in geography

Urban geographers first started to relate aging and place to each other in the 1970s. They were concerned about housing, transportation, and mobility of elderly people from the perspective of urban and economic geography. For example, Golant’s (1972) work *The Residential Location and Spatial Behavior of the Elderly: A Canadian Example* first examined how the process of human aging is reflected in the residential mobility and daily activities of late middle-aged and elderly people. Rowles’ (1978) well-known work *Prisoners of Space?: Exploring the Geographical Experience of Older People* focused on elderly people’s emotional attachments to place by writing about the lives of five elderly people who lived in the same neighbourhood for many years. This research studied their varying uses and geographical experiences within the same setting, emotional attachments to place, and various activities in other environments (Rowles, 1978). A later book edited by Rowles and Ohta’s (1983), *Aging and Milieu: Environmental Perspectives on Growing Old* emphasizes the relationship between elderly people and their environments at various scales, experiences of aging in rural environments, the meanings of place, place memories, and adaptation to environment in an old age.
Research combined aging and health care together in 1980s, with a focus on health care, social services, uneven geographical distribution of care resources, care delivery, and accessibility for elderly people. In the U.K., researchers studied the geographical distribution of RCFs with various types of ownership nationally and locally. For example, Larder, Day, and Klein (1986) provided a national geographical picture of the distribution of RCFs. Smith (1986) examined the distribution of local authority residential homes, independent residential care, and nursing homes in the area served by Nottingham District Health Authority. Bochel (1987) studied the change in distribution patterns of public, private, and voluntary RCFs across local authority areas between 1981 and 1984. Phillips and Vincent (1988) studied the geographical distribution of RCFs, the overwhelming growth of private RCFs in the 1980s, and the influences of related policies on the development of private RCFs. Corden (1992) investigated the geographical development of the long-term care market for elderly people in North Yorkshire during 1985 to 1988 in relation to changes in social security arrangements. In Canada, Joseph and Bantock (1982) studied physical accessibility to general practitioners in rural areas. Joseph & Poyner (1982) and Joseph & Cloutier (1990) studied service provision and utilization of elder care in rural areas.

More recently, a group of researchers have focused on long-term care reform and the geography of aging and long-term care. With the transformation from medical geography to health geography, the research tends to use qualitative methods and “critical thinking”. For example, Joseph and Chalmers (1995, 1996) examined the contact between the restructuring of long-term care and the geography of aging in Waikato, New Zealand. The results showed that almost all the urban centers benefited from an
expansion of long-term care driven by private-sector initiatives, while rural communities suffered a broad-based depletion of services. Cloutier-Fisher and Joseph (2000) studied long-term care restructuring in rural Ontario, and concluded that the restructuring of public-funded community services made certain groups of elderly people more vulnerable to institutionalization. Milligan (2003) explored the different forms of care giving by both formal and informal caregivers within the home space and RCFs in the U.K. Skinner and Rosenberg (2006) discussed managed competition in the private delivery of health care services by for-profit and non-profit providers of long-term care in rural and small town settings in Ontario, Canada.

Another growing body of literature in geography considers the role of the psychological, social, and cultural aspects of place in care provision. Cutchin (2003) used empirical evidence from qualitative fieldwork in adult day centers (ADCs) and assisted living residences (ALRs) to support a model of aging in place. Martin, Nancarrow, Parker, Phelps, and Regen (2005) used qualitative methods (i.e., interviews and focus groups) to examine the relationship between place and practice in the care and rehabilitation of elderly people across a range of settings, and reached the conclusion that the therapeutic environment is not a straightforward notion, but crucially dependent on the social, symbolic, and policy context of care provision, and the ways they interact. Wiles (2003) used qualitative methods to study the informal care provided by families and friends to elderly people living in the community, and she has critically examined the home as a new site for provision and consumption of informal and formal elder care in her later work (Wiles, 2005). A group of researchers in the U.S. studied elderly migrants and their attachments to places under the concept of active and successful aging. Sun City in
Arizona is used as a case study area to understand the relationships between the identity of elderly people and the spaces and places they inhabit (McHugh, 2000, 2003, 2007; McHugh & Larson-Keagy, 2005; McHugh & Mings, 1996).

2.4 Studies in China

Current research on population aging in China focuses on social welfare system reform (Bartlett & Phillips, 1997; Huang, 2003), the challenges of population aging and elder care with decreased family care resources, the existing family and community care resources, and alternative ways of caregiving for elderly people both in urban and rural areas of China (Bartlett & Phillips, 1997; Davis-Friedmann, 1991; Jiang, 1995; Joseph & Phillips, 1999; Leung, 1997; Zhang & Goza, 2006). A few studies have examined the characteristics of residents in RCFs (Gu et al., 2007) and the willingness and availability of residential care among Chinese elderly people (Zhan, Liu, & Guan, 2006). Little, however, is known about the well-being of residents in RCFs and the relationship between their health and the environment of RCFs within the interactions of the Chinese social, economic, and cultural context.

2.4.1 Traditional culture patterns

The traditional cultural pattern of family care is important for understanding elder care in China. The Chinese family structure is traditionally clustered around relatives who support one another financially, and elderly parents who generally live with their eldest
son. Blood tie relationships and family resources have been and will continue to be the main source of financial and social support for elderly people in China (Bartlett & Phillips, 1997; Goldstein & Ku, 1993; Joseph & Phillips, 1999; Streib, 1987; Zhang & Goza, 2006). Not only constricted by morality, the law also requires adults to care for their elderly parents (Bartlett & Phillips, 1997; Goldstein & Ku, 1993; Huang, 2003; Joseph & Phillips, 1999; Palmer, 1995; Streib, 1987). Article 49 in the “Constitution of the People’s Republic of China” states that “parents have the duty to rear and educate their minor children, and children who have come of age have the duty to support and assist their parents” and “maltreatment of old people, women, and children is prohibited” (The National People’s Congress of China, 2004). These obligations pass to grandparents and grandchildren in the absence of the middle generation. The “Criminal Law” states that an adult child can be imprisoned for up to five years for refusing to support an aged family member (The National People’s Congress of China, 1979). With such moral obligation and regulation, elderly people are traditionally cared for by their family members at home.

2.4.2 Challenges of elder care

The rapid population aging process, lack of community and home care resources, and the impact of dramatic socio-economic transformations challenge traditional elder care in China. Lin (1995) carried out research on the issues relating to the burden of supports to elderly people and family formation in China. The results showed that the impact of demographic changes on the Chinese kinship system and socio-economic
inequalities between China’s urban and rural population has challenged the care for elderly people, especially for those in rural areas. Bartlett and Phillips (1997) discussed national and local issues on aging and elder care in China. Guangzhou was used as a case study to understand the urban responses to change in elder care in times of socio-economic change. The development of RCFs in China is thought of as an alternative approach to elder care because of smaller family size and the disruptions of population migration. The results from Joseph and Phillips’s (1999) research showed that the increasing involvement of women in the paid workforce and the changing geographical distribution of family members resulting from work-related migration reduced the ability of families to care for their elderly relatives.

The interconnections between population aging and modernization present numerous challenges to caregiving for elderly people in contemporary rural China. Researchers have studied the impact of “one family one child” policy on population aging in China, focusing on the sandwich generation\(^3\) (Zhang & Goza, 2006). The current Household Registration System and social welfare systems in China challenge the financial security of elder care in rural areas. The Household Registration System limits social welfare benefits to rural residents because of the different social welfare systems in rural and urban areas. Existing research also brings attention to the few rights and strictly limited access to formal health care and welfare services for the floating population (labour migration from rural to urban areas) and their accompanying families in the cities where they work (Joseph & Phillips, 1999).

\(^3\)The sandwich generation is generally defined as those who often care for both the younger and older generations (Grundy & Henretta, 2006).
The Chinese government started to create a multi-pillar pension system for the urban elderly in 1991, and finished unifying the pension insurance system for urban employees in 1997. In terms of the health care system, the Chinese government promulgated “establishment of the basic medical insurance system for urban employees” in 1998. However, in rural areas, pension and health care systems are still under reform (Ministry of Labour and Social Security of China, 2007; State Council Information Office of China, 2004).

2.4.3 Studies on residential care

Existing research on residential care in China focuses on the characteristics of institutionalized elderly people and the willingness and availability of residential care. Gu et al. (2007) compared the characteristics of RCFs’ residents with community elderly residents in China. The research used three waves of the Chinese Longitudinal Healthy Longevity Survey (CLHLS) to analyze the demographic characteristics, family and social caregiving resources, health status, and mortality risk of the institutionalized and community-residing oldest-old in China. The results showed that the institutionalized oldest-old in China were more likely to be younger, male, live in urban areas, have lower family caregiving resources, and poorer health compared to the oldest-old living in communities. The oldest-old were less likely to be institutionalized with increasing age and that men were more likely than women to live in an institution. A survey by the Ministry of Civil Affairs of China (2005) showed that most health care institutions were
established to house elderly people who lack sufficient family caregiving resources regardless of the individuals’ functional status.

In terms of relationships with families after relocation and satisfaction with the quality of residential care, Pei’s (2000) research showed that 80 percent of elderly people thought their relationships with their families stayed the same after their relocation, 10 percent of elderly people thought they got closer to their families, and only five percent of elderly people thought they were isolated from their families after their relocation. A survey in Tianjin showed that 58.3 percent of elderly people thought RCFs should be able to provide health care, 48.3 percent of elderly people cared about the physical environment of RCFs, 41.1 percent cared about the professional training to caregivers, and 27.6 percent elderly people cared about assistance with their activities of daily living (ADL) and food services (Pang, Fu, & Kui, 2005). Furthermore, Zhan, Liu, and Guan (2006) studied both elderly people’s and their families’ evaluation of the quality of services offered by RCFs, elderly people’s willingness to stay in RCFs, and families’ willingness to continue to place elderly parents in RCFs. The results showed that elderly residents’ attitudes toward RCFs were overall positive. The majority actually reported emotional and physical improvements after moving into the RCFs. Among the adult children, those who had more siblings tended to have a more positive view of residential care than those who had fewer siblings. Females were less willing to place elderly parents in an institution than males.
2.5 Relevance of the Existing Literature to My Thesis Research

Existing research in China is relatively limited compared to the research in English-speaking countries, therefore, concepts and theories developed in research within the context of English-speaking countries and related empirical evidence is needed to shed some light on the studies in China. Based on the research goals and research questions of this study (see Chapter 1), concepts such as life course, active aging, equity, equality and efficiency in service provision and utilization, access, sense of place, and therapeutic landscapes will contribute in building the conceptual framework for this research (see Chapter 3). Regarding the empirical evidence, existing research on decision making processes of entering residential care, access to residential care, impacts of place on health, and policy making on residential care will contribute in understanding the accessibility and utilization of residential care in Beijing. Existing research in China also helps to understand the demography of population aging, challenges of elder care, and use of residential care.

Elder care in China, however, is profoundly influenced by Chinese culture such as Confucian principles and filial piety. The gap between research in English-speaking countries and China is the lack of theoretical and empirical research considering socio-cultural differences in access and utilization of residential care. Theories and results in the context of English-speaking countries are not directly transferable to research in China without considering the socio-cultural differences between countries.

This research on residential care in the developed areas of Beijing will shed light on future research on residential care in China, especially the development of residential
care in less-developed areas in China. First, it will help us to understand the reasons for choosing residential care among elderly people in Beijing and how socio-cultural factors affect decision making processes. Secondly, it will expand the meaning of access beyond geographical access in a Chinese socio-cultural context. Thirdly, it will help the public understand the well-being of elderly residents in RCFs and contribute knowledge in understanding the relationship between health and place in RCFs. Besides the above aspects, the research on restructuring of residential care in English-speaking countries will help provide suggestions for challenges to residential care and future policy making in China.

2.6 Chapter Summary

This chapter reviews the existing theoretical and empirical research on residential care in English-speaking countries and in China. The first part of this chapter reviews the theoretical research in English countries both inside and outside of geography, including the concept of the life course, active aging, continuity theory, public finance and social welfare, the concept of access, and the relationship between health and place. The following part reviews empirical studies in English-speaking countries: characteristics of residents, decision making processes, access to residential care and service use, adjustment after relocation, and related empirical studies in geography. The third part of the chapter reviews the existing research on Chinese traditional culture patterns and challenges of elder care and residential care in the Chinese context. At the end of this chapter, it relates the existing research to this study and identifies the gaps between the
two. In reviewing the existing literature, this chapter demonstrates that there is limited amount of research that studies residential care of elderly people in China. Little is known about the meaning and use of place by elderly people in RCFs and the importance of place on their physical and mental health. It is a lack of studies, especially geographical studies, which consider the traditional conceptions of elder care and challenges of residential care under current local and national social welfare policies in Beijing and China that is a strong motivation for carrying out the research in this thesis. The literature reviewed in this chapter helps to develop the conceptual framework and methodology for this research, which will be presented in the following chapter.
Chapter 3 Research Design and Methods

3.1 Introduction

The process of elderly people’s relocation from their homes to RCFs involves individual families, RCFs, and governments. This process includes the willingness to institutionalize, access to RCFs, the decision making process in choosing a specific RCF, the adjustment after relocation, and the well-being of elderly residents in RCFs. This chapter develops a conceptual framework to understand this process and achieve the research goals presented in Chapter 1. The literature reviewed in Chapter 2 provides a base for the conceptual framework. The second part of this chapter explains the conceptual framework in details. The methods used in this research, specifically how quantitative and qualitative research methods contribute to understanding the research questions are explained respectively in the third part of this chapter. The fourth part of this chapter discusses the challenges, ethical issues, and limitations of the research and study methods.

3.2 Conceptual Framework

The existing literature helps provide the ideas to build a conceptual framework for this research (see Figure 3-1). It considers the residential care process as five components at the individual level: willingness to institutionalize, accessibility, decision making, adjustment, and well-being. Instead of a linear process, the five components of residential
care compose an intersectional process. They interact with each other under the social, economic, political, and cultural structures and the characteristics of individuals and their family members in Chinese society. Elderly residents, their families, RCFs, and the government are all involved in this process at different levels.

*Figure 3-1. A conceptual model of residential care for elderly people.*
Traditionally, elderly people are cared for by their families in China; however, the “one family one child” policy and changing women’s roles in families have decreased the available family resources for elder care. The number of elderly people who choose residential care has increased in China in recent years, especially in developed areas such as Beijing. The first part of the conceptual framework--“willingness to institutionalize”--is related to the second research question: “How is the decision of residential care being made instead of traditional home care?” This component aims to explain how socio-cultural change affects elderly people’s willingness to consider residential care. Family care resources, socio-economic determinants of the elderly person, and traditional notions all possibly influence their willingness.

The second component is “accessibility to residential care”. Once the decision of choosing residential care is established, elderly people and their families must consider how to access residential care. Existing literature shows that the concept of access is an important component in studying health care delivery. Studies on health care delivery in the 1980s and 1990s define access as a multidimensional term of geographical access, economic access, and socio-cultural access. In this research, geographical, information, economic, and socio-cultural access are taken into consideration to understand the meanings of access to residential care. This component is related to research question one – “What is the spatial distribution of the elderly population and residential care resources in Beijing? Do service needs geographically match residential care resources?” and research question three – “What are the factors that affect access to residential care?” The first question focuses on geographical factors and the third question aims to understand

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4 See the Chapter 2 literature review part p. 23-24.
socio-cultural and economic factors. In this research, economic and socio-cultural access includes factors such as the different social welfare systems in rural and urban areas, the expenses of residential care, the lack of informal care resources, and the Confucian culture in China.

The third component in the model is “decision making”, the selection of a specific RCF. To find a suitable RCF for relocation is different from the first stage of the decision making process, which is choosing residential care instead of home care. This stage of the process happens after gathering some information on residential care, comparing different RCFs, and finding a balance between one’s expectations, needs, affordability, and RCF supply. This component includes factors such as willingness of elderly people to relocate, willingness of family members, environment and quality of the RCF, and affordability. It builds upon the concept of access together with the second component and helps us understand research question three.

The fourth component is “adjustment” after relocation. Relocation to a RCF is a major physical and emotional change for elderly residents. The length of the process depends on factors such as attitudes on aging, environment of the RCF, and family support. This component contributes to understanding the first part of research question four – “How does the relocation to RCFs affect elderly people’s everyday activities?”

The last component is “well-being” of residents, which focuses on a relatively stable stage after the adjustment to relocation. In the model, “well-being” refers to the health status of elderly residents, including their physical and mental health. The concepts of “sense of place” and “therapeutic landscapes” are used to understand how place affects one’s health and how elderly residents experience the place and adapt to the new lives in
RCFs after their relocation. Together with the fourth component, this component aims to answer research question four – “How does the relocation to RCFs affect elderly people’s everyday activities and health compared to when they lived at home?”

As an intersectional process, any of these five components cannot be studied separately. They are structured as a complex process involving individual families, RCFs, and governments at different levels. Willingness to institutionalize is the precondition of one’s access to residential care. It also affects one’s later participation in the decision making process and plays important roles in the adjustment stage and the well-being of residents after relocation. Accessibility to residential care affects all the other four components. It influences the decision making for a suitable RCF and the relocation and adjustment process. The affordability to services and cultural conceptions of residential care play important roles in access to residential care besides geographical and information access. Who participates in the decision making process of a specific RCF is related to elderly people’s willingness to relocate and their accessibility to the RCF. The level of elderly people’s involvement in the decision making process affects their adjustment process and well-being in the RCF. Social interactions within community and society continue to influence elderly people’s well-being after their relocation. The adjustment process influences the well-being of elderly residents and also relates to the willingness to relocate, accessibility to the RCF, and participation in decision making with interactions of factors such as health status, sense of place, and satisfaction with residence and services. All of the components contribute to one’s well-being in RCFs, and the well-being of elderly residents also influences other elderly people’s willingness to utilize residential care and access to residential care.
Equity, equality, and efficiency are determinant factors in health policy making. At the RCF and government levels, the three concepts are used to analyze critically social reform in residential care and related social welfare reforms, and explore the current and future challenges in residential care planning. They contribute to answering research question five – “What current and future challenges of residential care do government and RCFs face?” and provide suggestions for the question six – “What changes are needed for policy to meet the current and future challenges in residential care?”

Either at an individual level or a cohort level, the concept of “life course” is used to explain the decision making process of residential care of elderly people, their “sense of place” in RCFs and impacts of social welfare reform. It is taken as the theoretical base for developing the conceptual framework of this research with the concept of “access”, “sense of place”, “therapeutic landscapes” and “equity, equality, and efficiency”.

### 3.3 Methods

Both quantitative and qualitative methods are used in this research to contribute to understanding the six research questions. To study the distribution of residential care resources and needs at the macro-level, quantitative research methods such as statistical indicators and GIS mapping are helpful, particularly in regards to research question one. A qualitative approach can provide rich and detailed sources of information from an individual’s perspective (Silverman, 2005). In this research, the use of the in-depth, semi-structured interview as a qualitative method helps explain the socio-cultural meanings of access, the decision making process in relocation, and the well-being of elderly residents.
at the micro-level, as well as challenges of residential care and social welfare reform at the meso-level and macro-level. The interview provides detailed information for research questions two to six. The mixing of both quantitative and qualitative methods results in a more powerful means of understanding social phenomena (Gatrell, 2002). Table 3-1 shows the kinds of methods used to collect and analyze data, and how these methods relate to research questions and research goals under the designed conceptual framework.

3.3.1 Mapping

GIS has been applied in public health, epidemiology, and health planning since the end of the 1970s (Bracken, Higgs, Martin, & Webster, 1989). It is used for providing and managing information about health service location and distribution patterns and investigating how well the distribution of services fits the distribution of populations in need. The use of GIS in public health plays an important role in improving the performance of health care services and promoting community health. GIS can also be a spatial decision support system in the health services planning process, allowing decision makers to explore complex and multi-objective problems (Cromley & McLafferty, 2002; Hodge, 2008). For instance, Cromley and Shannon (1986) used GIS to analyze accessibility to ambulatory medical services among elderly residents in communities. Love and Lindquist (1995) used cumulative distributions to describe the geographical accessibility of elderly population to hospital-based geriatric services in Illinois, U.S. Morrison et al. (1999) developed a GIS model to provide welfare recipients with
information on the locations of essential health and social services, including job centers, childcare facilities, and primary health care centers.

### 3.3.2 In-depth, semi-structured interview

The in-depth, semi-structured interview is one of the methods in common use in qualitative research. “Semi-structured interviews allow both structured responses and the opportunity to investigate certain issues in depth and it is the most suitable method for gaining both macro-scale and micro-scale perspectives and eliciting complementary qualitative and quantitative data” (Andrews & Phillips, 2002, p.69). In semi-structured interviews, the interviewer typically has only a list of topics or issues. The style of questioning is usually informal. The interviewee is allowed to respond freely, and the interviewer may just simply respond to the points which seem worthy of being followed up. The interview is usually audio-recorded and transcribed. Researchers are frequently interested not only in what people say but also in the way they say it (Bryman, 2004; Silverman, 2005). In-depth, semi-structured interviews can provide detailed information about relevant topics and are broadly used in social science research and increasingly used in qualitative research in health geography. For example, Bartlett and Phillips (1997) interviewed policy-makers and government officials in Guangzhou to discuss the change in care of elderly people and the policies on elder care. Stum (2000) used semi-structured interviews to explore later life financial security when coping with long-term care from the perspective of involved family members. Davies and Nolan (2003) interviewed 48
Table 3-1

*Inter-linkages between the Conceptual Framework and Methodology*

<table>
<thead>
<tr>
<th>Conceptual framework</th>
<th>Research goals</th>
<th>Research questions</th>
<th>Methods, data, and analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willingness to institutionalize</td>
<td>To understand the access to residential care (Goal 2).</td>
<td>How is the decision for residential care being made instead of traditional home care (Question 2)?</td>
<td>Statistic indicators and GIS mapping (Question 1 and 3)</td>
</tr>
<tr>
<td>Accessibility to residential care</td>
<td>To understand the spatial distribution of elderly population and residential care resources (Goal 1).</td>
<td>What is the spatial distribution of elderly population and residential care resources in Beijing? Do service needs geographically match residential care resources (Question 1)?</td>
<td>Review of government policies and documents (Question 3, 5, and 6)</td>
</tr>
<tr>
<td>Decision making of a specific RCF</td>
<td>To understand the decision making process of choosing residential care (Goal 2).</td>
<td>What are the factors that affect access to residential care (Question 3)?</td>
<td>In-depth, semi-structure interviews of elderly residents, family members, and RCFs managers, and analysis of transcripts of interviews using the constant comparative method (Question 2 to 6)</td>
</tr>
<tr>
<td>Adjustment after relocation</td>
<td>To understand the “sense of place” for elderly residents and the relationship between health and place within RCFs (Goal 3).</td>
<td>How does the relocation to RCFs affect elderly people’s everyday activities and health compared to when they lived at home (Question 4)?</td>
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<tr>
<td>Well-being of residents</td>
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</table>
people who had assisted close relatives to move into a nursing home, in order to understand the decision making process of institutionalization. Zhang and Goza (2006) used interviews to study the challenges of providing elder care by the sandwich generation experiencing the effects of “one family one child” policy on China’s population aging.

3.4 Data Collection and Analysis

3.4.1 Statistics

At the international level, both population and economic data on social welfare systems were collected. Population data are derived from World Population Prospects (Population Division, United Nations, 1999), The World Fact Book (Central Intelligence Agency [CIA], U.S., 2007) and data provided by Population Division/International Programs Center (U.S. Census Bureau, Population Division, 2007). Economic data are derived from Social Security Programs throughout the World: Europe, 2004, Social Security Programs throughout the World: Asia and the Pacific, 2004 and Social Security Programs throughout the World: The Americas, 2005 (U.S. Social Security Administration, 2004, 2005, 2006).

are provided by the *Report on Elderly Population Information and Development of Elder Care of Beijing in 2006* (Committee on Aging of Beijing, 2007). This report provides data on the population aged 60 and over, population aged 80 and over, and the number of elderly families in Beijing. The data on self-reported health status, income sources, and marital status of elderly people are from the *One Percent Population Sample Survey of Beijing in 2005* (Beijing Municipal Bureau of Statistics, 2007). The research conducted by Ma (2003) provides data on the trends in the elderly population for the next 50 years in Beijing. Data on RCFs are provided by the Beijing Municipal Bureau of Civil Affairs on its website\(^5\). RCF resources, occupancy rates, ownership, and standard charges are all taken into account (Beijing Municipal Bureau of Civil Affairs, 2008).

Indicators such as percentage of population aged 60 and over, percentage of population aged 80 and over, the proportion of elderly people within elderly families to the population aged 60 and over, and number of beds per 1000 elderly people aged 60 and over were developed based on the above statistical data. These data were used in ArcView GIS software to map the demographic characteristics of the elderly population and geographic distribution of residential care resources and occupancy rates of RCFs in Beijing.

### 3.4.2 Government policies and documents

Government documents are good resources for studying the change of government policies. This research collected government policies and documents for

\(^5\) [http://bjfl.bjmzj.gov.cn](http://bjfl.bjmzj.gov.cn)
critical review of social welfare reform and the current and future challenges related to residential care at the national and local levels in China and Beijing.

At the international level, *Old-age Income Support in the 21st Century: An international perspective on pension systems and reform* (Holzmann et. al., 2005) provides information on the multi-pillar pension system created by the World Bank. The information on the pension system in Canada is from *Canada’s Retirement Income System – What’s in it for you?* (Human Resources Development Canada, 2001). At the national and local levels in China and Beijing, government documents on the retirement system, pension system, health care system, elder care, related laws, RCFs design, and quality of residential care were collected for this research (see Appendix 1).

### 3.4.3 Questionnaire design, recruitment of participants, and interview process

For this research, three questionnaires were designed for the three groups involved in the decision-making process of residential care: elderly residents, family members, and RCF managers. Besides the questions asked about background information, each questionnaire has a list of topics or issues based on the research goals and questions. The list of topics in each questionnaire aims to provide answers for the specific research questions under the designed conceptual model of this research. For example, questions in the questionnaire for elderly residents, such as “how did you find this facility?” and “why did you choose this facility? What factors were most important?” aim to elucidate how elderly people and their family members accessed residential care resources and
their decision making process in choosing a specific facility. They are also asked about “what roles their families played in the decision making?” and so on. Questions for family members, such as “how often do you come to visit her/him? Do you provide some financial support?” and “do you provide some other types of support?” help elucidate the types of family support and the role of family members in caring for elderly residents. RCF managers were asked “what is the eligibility of elderly residents?”, “what kind of support do you get from the government and other organizations?” and “what kind of challenges do you face in the management of RCF?” (See the detailed questionnaires in Appendices 2-4). The framework of the questionnaire design is presented in Figure 3-2.

In the English-speaking countries, many researchers have used health service utilization models which are often based on Andersen’s Behavioral Model of Health Services Use (Andersen, 1995). One of the concerns with these models for this research is that they are western culturally based. Therefore, the literature from English-speaking countries is helpful in building the conceptual framework of this research, but an original model is presented which takes into account Chinese culture.

In examining the questionnaire for elderly residents, the reader will note that none of the well-known quality of life measures (e.g. SF-36 Health Survey), was used because the questionnaires in this research were designed for a qualitative research project instead of a population health survey. Also the commonly used quality of life measures are based on a series of questions not a single question which might be difficult for the elderly participants to answer. Instead, I used a single simple question which is similar to the
self-perceived health status question used in Canadian Community Health Survey which well-known to provide a good measure of health status.

Interviews were carried out in six RCFs. A research group in the Institute of Geographical Sciences and Natural Resources Research at Chinese Academy of Sciences recommended a RCF to me, and the other five RCFs were recommended by the manager from the first RCF I contacted. All six RCF managers were contacted by phone first. After permission was given by the managers, time to visit the RCFs was arranged. RCF managers helped recruit elderly residents who were willing to participate, taking into account their health status. Elderly residents were only included if they were without cognitive impairments or severe functional problems. Managers and residents helped recruit family members as interviewees (see the information letters in Appendices 5-7). The interviews were carried out in private and quiet rooms or outdoors in the six RCFs. The interviewees were asked questions based on the questionnaires and were allowed to respond freely. The interviewer took notes and the interviews were audio recorded at the same time. The interviews varied from 30 to 90 minutes. Mandarin was the language used during the interviews. Before each interview started, the purpose of the study was explained and the interviewees were assured that their comments would be kept anonymous and confidential (see the consent forms in Appendices 8-10).

Ethics approval for the study was obtained from the General Research Ethics Board of Queen’s University.

In total, 27 elderly residents, 16 family members, and 5 RCF managers were interviewed in the six RCFs. Three of the RCFs are located in central districts and the other three are
located in suburban districts. In terms of ownership and size, one is a private facility with 102 beds, one is a community facility with 80 beds operated by a village committee\(^6\) (see Chapter 5 for a more detailed explanation of the political geography of Beijing), two are community facilities operated by neighbourhood committees (one with 25 beds and the other with 32 beds), and two are publicly-owned and privately-run facilities\(^7\) (one with 76 beds and the other with over 100 beds and still expanding). The occupancy rate is over 80 percent in all six facilities. The average age of the elderly residents is 80. The standard charge of each facility varies from 1000 to 4000 Yuan\(^8\) per month. Among the 27 elderly interviewees, 17 of them are female and 10 are male. Three of the elderly participants are in their 60s, 11 of them are in their 70s, 10 of them are in their 80s, and three elders are over 90. Among the 16 interviewed family members, 14 are female and two are male. Eleven of the 16 family members are the children of the elderly residents, three of them are siblings of the elderly residents, one is a granddaughter, and one is a nephew (see more details about participants in Appendices 11-13).

\(^6\) Currently, the constitution of China provides for five levels of local governments: the province, prefecture (city), county (district), township, and village. At the village level, neighbourhood committees serve for residents in urban areas, whilst village committees or villager groups serve for residents in rural areas.

\(^7\) Publicly-owned and privately-run facilities are a new type of ownership developed in recent years in Beijing, which is a model of public-private partnerships (PPPs) in the residential care industry in China. They are set up and funded by government, but managed by the private sector. The private sector does not own the properties or need to pay rent, but assumes sole responsibility for the profits or losses. In this way, this model reduces the cost of running RCFs and also takes advantage of more efficient management by the private sector. Chapter 8 will explain more about this type of ownership.

\(^8\) The current exchange rate between Yuan and Canadian dollars is: 1 Canadian dollar≈6.56 Yuan (January, 2010). 1000-4000 Yuan is equivalent to 152-610 Canadian dollars.
Figure 3-2. Framework for the design of the questionnaires.
3.4.4 Data analysis

The content of the audio recordings was fully transcribed. The analysis of the data is based on the constant comparative method developed by Glaser and Strauss (1967). It is composed of four stages: 1) comparing incidents applicable to each category; 2) integrating categories and their properties; 3) delimiting the theory; and 4) writing the theory (Glaser & Strauss, 1967, p. 105). Open coding, as the first step, requires a detailed, slow, and careful reading of the transcripts to examine the data in detail. During the open coding process, the transcripts were read line-by-line several times in order to mark the key points with a series of codes, and the similar codes were grouped into a concept. As new transcripts were read, either new concepts were identified or text was coded according to the developed concepts. The transcripts were read and re-read to ensure that nothing was missed and that the codes and concepts fit the data. Concepts were checked against each other. Inaccuracies and misinterpretations were gradually discovered and resolved. As concepts accumulated and their descriptions became more detailed, similar concepts were rearranged and grouped into conceptual categories. The conceptual categories were organized according to theoretical significance, and core categories emerged as central themes of the study. Finally, the thematic categories were used to define concepts and find associations between themes. Together the thematic categories, concepts, and resulting associations were used to provide explanations for the findings (Fox, Solomon, Raina, & Jadad, 2004; Grbich, 1999; Reed et al., 2003; Strauss & Corbin, 1990, 1998; Tannenbaum, Labrecque, & Lepage, 2005).
3.5 Limitations, Challenges, and Ethical Issues

The major limitation of GIS mapping in this research is its inability to provide in-depth understanding of the decision making processes of residential care and the relationship between health and place at the micro-level. In-depth, semi-structured interviews make up for the limitations of GIS mapping and provide details from an individual perspective. Qualitative research, however, is thought to be subjective. There are concerns regarding the researcher, the recruitment of participants, the responses of participants in the interview, the interpretation of data, and the number of interviewees. For instance, the researcher is the main instrument of data collection. What the researcher observes and hears and also what the researcher decides to focus on influence the conclusions the researcher makes. The recruitment of participants may have bias to those who are willing to participate in the research. The responses of participants to the researcher are likely to be affected by the characteristics of the researcher. Interpretation of data is influenced by the subjective leanings of a researcher because of the characteristics of qualitative data. In addition, the number of interviewees is limited, and the people who are interviewed cannot represent the whole group, so the generalizability of the findings should be considered in qualitative research (Bryman, 2004; Silverman, 2005). Understanding the limitations of each research method helps in the correct use of the methods and in using each method most advantageously. Professional training in using qualitative methods helps mitigate the subjective influence on interview process and on data analysis. The purpose of qualitative research, however, is not for generalizability based on a large number of participants. It is for a deeper understanding of social phenomena from individual perspectives. The combination of quantitative and qualitative
methods supplements the limitation of each and helps elucidate the research topic from multi-perspectives at various levels.

There were some challenges during the recruitment of participants. First, all the elderly participants are registered as urban households, one of the reasons being that residential care in the participating six RCFs is relatively expensive for rural elderly people (the differences in social welfare benefits between urban and rural households will be explained in Chapter 4). All the elderly participants have self-care abilities because only those who were without cognitive impairments or severe functional problems were eligible to participate. These characteristics of the elderly participants limit the understanding of the residential care of rural elderly people and those who have partial or no self-care abilities. Secondly, there are challenges in recruiting family members to participate. Elderly participants felt it was hard to recruit their family members because of their busy schedules or privacy concerns. The original research plan was to recruit one manager, five residents, and five matched family members in each RCF. It was, however, difficult to recruit matched family members, so family members who went to visit the elderly residents and were willing to participate in this research were recruited as the research participants. This factor limits our understanding of the perspectives of both elderly residents and matched family members in the same case. Thirdly, the fact that RCF managers helped recruit residents and that managers and residents helped recruit family members potentially influences the results generated from the collected qualitative data. It was, however, necessary to take the suggestions from the RCF managers due to the

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9 The household registration system is used to identify a person as a resident of an area and record information such as the name of the person, date of birth, and the names of the parents, spouse, and children. The system registers families as either urban or rural households. The current social welfare system is tied to the urban or rural household registration.
difficulty in recruiting participants and the lack of familiarity of the researcher with the elderly residents’ health status. Fourthly, the original plan was to interview policy makers in order to understand the challenges of developing residential care faced by the government. Unfortunately, no policy makers participated. The fieldwork was carried out right before the 2008 Olympic Games in Beijing and it is presumed that they were unavailable because of the preparations for the Olympics.

The research is focused on residential care, which is a relatively sensitive topic in Chinese culture and elderly people are considered a vulnerable group in China. Therefore, ethical issues must be taken into consideration when designing and carrying out the research. Elderly residents can be physically and emotionally vulnerable, and the interview process had the potential to remind them of negative experiences. A situation such as visible upset was considered before carrying out the interviews. If visible upset happened during an interview, the interview was terminated. Fortunately, this occurred zero times\(^\text{10}\).

Before each interview started, the purpose of the study was explained and the interviewees were assured that their comments would be kept anonymous and confidential. Participation in the research was completely voluntary and participants were free to withdraw from the research at anytime. During the interview, the participant could refuse to answer any question if he/she was uncomfortable. Participants had the right to stop or pause the audio recording at anytime. Not agreeing to be involved in the research or withdrawing at anytime did not affect any services elderly residents received or the evaluation of RCFs. The interviews were audio-recorded, but if the interviewee objected,

\(^{10}\) Protocols had been planned to refer issues to the managers and/or the participant’s close relatives, or in the case of physical or mental abuse to legal authorities.
only notes were taken. Any of the above situations occurred zero times. Parts of the interview could be erased if the participant wished. The information up until the withdrawal of consent was maintained, but the entire interview was destroyed at the participant’s request. This occurred zero times.

If participants had no questions, consent forms were signed and collected, and the interviews commenced. Participants were also informed about who would have potential access to the data and then participants’ permission was sought concerning how their data could be used. All the data were accessed only by the author, her supervisor, and the research assistant who helped transcribed the interviews.

All data are used only for the purposes of this research project. All the personal information identifying specific respondents is kept confidential and anonymous when using it. All electronic files are password protected and all field notes are kept in a locked cabinet. All electronic files and field notes will be destroyed after seven years.

3.6 Chapter Summary

This chapter explains the conceptual framework designed for this research. The conceptual framework divides the process of institutionalization into five components at the individual level: willingness to institutionalize, accessibility to residential care, decision making for a specific RCF, adjustment after relocation, and well-being of the elderly resident. It is an intersectional process involving individual family, RCFs, and the government. Methods in this research are introduced in the third part of this chapter. Both
quantitative and qualitative methods are used in this research for in-depth understanding of the research topic at various levels. How research goals and specific research questions fit the conceptual framework and which method is used to understand the specific research questions are also explained in this section. The fourth part of this chapter talks about data collection and the analysis process, including quantitative and qualitative data collection, questionnaire design, the interview process, and transcription analysis. The limitations of research methods, challenges in fieldwork, and ethical issues of the research are discussed in the last part of this chapter. The next chapter introduces the financial security system of the Chinese elderly people, which is a key factor in determining economic access to residential care.
Chapter 4 Financial Security of Elderly People in China

4.1 Introduction

As demographic changes in a population and socio-economic development evolve, population aging and financial security for elderly people is becoming one of the most important issues for countries in the 21st century. A great deal of research aims to understand financial security of elderly people, some of which is focused on understanding retirement security. The existing literature suggests that the primary focus has been on aggregation and objective measures of retirement security, and on actions which family members take in preparation for retirement and possible long-term care costs (Everett & Anthony, 2002, 2003; Everett et al., 2005; Hanna, Fan, & Chang, 1995; Hatcher, 1997, 1998; Li, Montalto, & Geistfeld, 1996). Later life financial security revolves around the goal of using private family resources to meet current and future long-term care demands (Stum, 2000). In this research, financial security is defined as the basic cost of one’s living, such as housing, clothing, food, transportation, and health care. This concept mainly focuses on the financial benefits for elderly people provided by the current social welfare system in China.

Within various systems, the contents of financial security may vary among different countries according to their socio-economic and political structures. For example in Canada, the pension system and health care system are two separated systems. Old Age Security (OAS), the Guaranteed Income Supplement and the Guaranteed Income Supplement Allowance aim to provide basic financial security and poverty alleviation for
elderly people (Human Resources Development Canada, 2001; Tamagno, 2005). Whereas in China, the expense for health care usually costs a great part of elderly people’s incomes, especially in the rural areas. Therefore, the cost of health care is considered as an important part of financial security of elderly people in China, which is different from the situation in Canada (State Council Information Office of China, 2004).

Pension systems, as an important component of financial security of elderly people, also vary among different countries. The World Bank has supported the creation of pension systems around the world in recent years, and proposed countries consider a multi-pillar pension system (Holzmann et al., 2005). The World Bank’s multi-pillar pension system combines five basic elements (Table 4-1), which can then be used to analyze the financial security provided by social welfare systems for elderly people.

The remainder of the chapter is organized into three parts. Part Two introduces the multi-pillar pension model developed by the World Bank and explains the current financial security of urban elderly people in China based on this model. The financial security of rural elderly people is also briefly explained. Financial security of rural elderly people is relatively different from that of the urban elderly people because of the different social welfare systems in urban and rural areas of China. Part Three discusses the current and near future challenges of providing financial security for elderly people faced by the Chinese government, especially for elderly people with rural household registration. Demographic and socio-economic changes, such as changes resulting from population aging, the unbalanced sex ratio of elderly population, and urbanization, challenge the government’s social welfare policies. The fourth part is a summary of the key points of this chapter.
Table 4-1.

*The Multi-pillar Pension System by the World Bank (Holzmann et al., 2005)*

<table>
<thead>
<tr>
<th>Pillar</th>
<th>Contribution</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero pillar</td>
<td>Universal</td>
<td>Basic or social pension; providing a minimal level of protection.</td>
</tr>
<tr>
<td>First pillar</td>
<td>Mandatory</td>
<td>Public pension plan. Contributions, perhaps with some financial reserves.</td>
</tr>
<tr>
<td>Second pillar</td>
<td>Mandatory</td>
<td>Occupational or personal pension plans. It can be constructed in a variety of ways.</td>
</tr>
<tr>
<td>Third pillar</td>
<td>Voluntary</td>
<td>Occupational or personal pension plans.</td>
</tr>
<tr>
<td>Fourth pillar</td>
<td>Voluntary</td>
<td>Intra-family or intergenerational sources of both financial and non-financial support to the elderly, including access to health care and housing.</td>
</tr>
</tbody>
</table>

4.2 Current Financial Security of Elderly People in China

4.2.1 Financial security of elderly people in urban areas of China

China is presently a developing country with an “arguably” weaker economic foundation and less development compared to the developed countries (Cai & Gu, 2006). During the last quarter century, China's economic system has changed from a centrally planned system to a more market-oriented economic system with a rapidly growing private sector. The Chinese government has been trying to improve its social security system since the People’s Republic of China was founded in 1949 and has had some successes over the years. Economic development has generally been more rapid in coastal provinces than in the interior provinces. Therefore, large gaps in per capita income exist among different
regions. The difference in regional economies also differentiates the current financial security of the elderly people among the various regions of China, especially between the elderly people with urban and rural household registration.

Before the 1990s, there was only one level in China’s old pension system, and it was only for employees in urban areas. After 1991, the Chinese government started to create a multi-pillar pension system for urban elderly people, and finished unifying the basic pension system for urban employees in 1997. The current pension system in China forms three hierarchies: a basic pension system on the basis of social pooling and individual accounts; a supplementary pension system by establishing Enterprise Annuity (EA); and voluntary individual pension insurance or saving (Ministry of Labour and Social Security of China, 2005). The basic pension system enables employees to get a monthly pension after retirement if they meet the retirement age and paid for their individual pension accounts for more than 15 years. In China, the retirement age is 60 for male employees, 55 for female cadres\(^\text{11}\), and 50 for female workers. The sources of funds are from government, employers, and employees. Employers provide no more than 20 percent of employees’ total salaries and employees provide eight percent of their salaries. The part employers contribute goes into social pooling and the part employees contribute goes into individual accounts. The ones who are self-employed pay 20 percent of local average salaries, eight percent of which goes into individual accounts. When elderly people get their monthly pensions after retirement, the pension is composed of two parts: one part is provided from social accounts, which is 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

\(^{11}\) Here, cadres refer to leaders in their working places, such as corporations, institutions, and enterprises.
individual accounts (Ministry of Labour and Social Security of China, 2005, 2007; State Council Information Office of China, 2004). The EA was proposed in *Trial Rules on Enterprise Annuity* and *Trial Measures for Enterprise Annuity* issues by the Ministry of Labour and Social Security of China in 2004, which refers to “the supplementary endowment insurance system established voluntarily by enterprises and their employees after they have bought basic endowment insurance” (Ministry of Labour and Social Security of China, 2004, Article 2). The individual pension insurance systems have various forms and are totally voluntary. The per capita retirement pension in 2005 was 10,761 Yuan. The annual per capita disposable income of urban households in 2005 was 10,493 Yuan, whereas the annual per capita disposable income of rural households in 2005 was only 3,255 Yuan, which was less than 1/3 of the income of urban households (National Bureau of Statistics of China, 2005). The pension is higher than disposable income in China because only a certain proportion of elderly population with urban household registration receives pensions after they retire. Compared to many developed countries, China has a high contribution rate for its basic pension system, which is eight percent by individuals and 20 percent by employers. In Canada, the U.S., Japan, and Germany, the contribution rate is 4.95 percent, 6.20 percent, 6.79 percent, and 9.75 percent respectively by both individuals and employers (U.S. Social Security Administration, 2004, 2005, 2006). The contribution rate by employers in China is relatively high and much more than the part contributed by individuals.

After ongoing pension reform for more than a decade, China created a multi-pillar pension system based on the model proposed by the World Bank (Ministry of Labour and Social Security of China, 2007; State Council Information Office of China, 2004).
• Zero pillar: the minimum living standard guarantee, which is an allowance for low-income people with urban household registration. It does not belong to any of the three hierarchies of the China’s pension system mentioned above, but it plays a role as a minimal level of protection for the low-income urban elderly people in China.

• First pillar: the pension from social pooling and individual accounts, which is the basic pension system for employees in urban areas. This part of the pension is mandatory and contributory to employers and employees.

• Second pillar: EA, which is designed as the second pillar of the pension system in theory. It is voluntary for eligible enterprises to participate and has only just been issued since 2004. Only six percent of elderly people with basic pensions are enrolled in EA program by 2005 (Qi, 2005).

• Third pillar: other individual voluntary pension insurance systems. This level is a voluntary part for employers and employees. It can be a lump sum or a monthly pension for individuals after their retirement.

• Fourth pillar: family supports. For thousands of years, the Confucian tradition of filial piety has long been the essential ingredient holding together the Chinese family system of elder care (Gu & Liang, 2000; Ikels, 1993). The informal intra-family or intergenerational sources of supports, such as financial support and informal caregiving, are important parts of the financial security of elderly people in China, especially for those living in rural areas.
Regarding the health care system, the Chinese government promulgated *Establishment of the Basic Health Insurance System for Urban Employees* in 1998. The funds are from employers and individuals. Employers contribute six percent of their salaries, and employees contribute two percent. Retired elderly people do not need to contribute. All the payments by employees and 30 percent of the payments by employers are assigned to individual accounts, and the remaining 70 percent of the payments by employers are assigned to a social fund. The medical expenses of outpatients are paid from individual accounts, and the medical expenses of hospitalization are paid from the social fund. The social fund has minimum and maximum limits for payment, which are about 10 percent and four times local average annual salaries (State Council Information Office of China, 2004). Some provinces, cities, enterprises, and institutions create supplementary health insurance systems to supplement individual expenses on health care. This kind of health insurance aims partly to cover the hospitalized expenses which are above the maximum fund limit and medical expenses which are not covered by the basic health insurance. The government also tries to provide basic health care for special groups who are not covered by the basic health insurance system (State Council Information Office of China, 2004).

### 4.2.2 Financial security of elderly people in rural areas of China

The social welfare system of rural areas is quite different from the system of urban areas in China. A weaker economic foundation, large population, and great regional differences in rural areas challenge the social welfare system. Compared to the urban areas,
the system in rural areas is weak and incomplete. It only covers a small proportion of the population and most people still depend on their families in rural areas. Social welfare reform has continued for years. The process, however, is slow and success is limited, and many measures are still experimental.

Regarding the pension system in rural areas, elder care by family members was the only way to support the elderly people in rural areas for a long time. At the end of the 1980s, some more developed rural areas spontaneously created their own community pension systems. However, there was no guarantee of the funds in the long run. Only those elderly people without children and relatives are eligible to receive an allowance and some social welfare benefits which are called “Five Guarantees”\(^\text{12}\) (Bartlett, 1994; Kallgren, 1992). In 1991, the central government started to create a social pension insurance system in rural areas. Funds are from individuals and governments at all levels (Duan, 2001; Song & Chen, 2006). In 2009, *Guidance on Creating New Rural Social Pension System for Rural Areas* by the State Council aims to implement the 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). Regarding the health care system in rural areas, before the 1980s, the health care system in rural areas was composed of clinics and “bare foot” doctors. After the 1980s, this system faced a lot of challenges because of the socio-economic changes in Chinese society. The old health care system was gradually collapsing, and people in rural areas returned to a system of paying their health care expenses individually. In 1991, the central government started to rebuild the cooperative medical system in rural areas. Funds are contributed by different levels of governments, and

\(^\text{12}\) See p.8.
communities, and individuals (State Council Information Office of China, 2004). Currently, the health care system is still under reform in rural areas, and residents continue to pay the majority of their health care expenses individually.

The current pension and health care systems play important roles in providing financial security for elderly people in urban areas. The two systems have improved as a result of social welfare reforms in the past two decades. Health care expenses, however, can be a major expense for elderly people in China, especially for those with chronic diseases or disabilities and limited income. The current social welfare benefits still cannot meet all of the needs for health care expenses of the elderly people, especially elderly people in rural areas of China.

4.3 Challenges for Greater Financial Security of Elderly People in China

China’s pension system reform uses the strategy of developing a multi-pillar pension system. The government encourages people to save money individually or to enrol in individual pension insurance plans. Family support still plays an important role in providing income security for elderly people in China because of Chinese traditions, especially in the current situation in rural areas where a pension system has not been fully created. How to find a long-term financial equilibrium is a challenge for China’s pension system.

First, the reform of China’s pension system needs to place more effort on reducing poverty and increasing the covered population. The implementation of pension systems to
cover the rural elderly people and floating population in this regard is urgently needed. Economic development brings rapid urbanization and increased labour migration between cities, as well as between urban and rural areas. The floating population and their families who move with them have few rights and strictly limited access to formal health and welfare services in the cities where they are working. The Household Registration System has more effects on rural residents than on urban residents because of the different social welfare systems in rural and urban areas (Joseph & Phillips, 1999). Transferable individual accounts only work in theory and face some challenges under the current system. A large numbers of migrants are not enrolled in any pension system.

Second, the current retirement age in China is 60 for male employees, 55 for female cadres, and 50 for female workers. It is much younger than that of developed countries. In China, men over 60 were 5.43 percent of the total population in 2006, and will be 14.89 percent in 2050; and women over 55 were 7.97 percent of the total population in 2006 and will be 20.57 percent in 2050. If elderly people receive pensions at the current retirement age, there will be a larger proportion of pensioners (35.46% of the total population) in China in 2050 (Gillin, MacGregor, & Klassen, 2005; Lbbott, Kerr, & Beaufot, 2006; U.S. Census Bureau, Population Division, 2007). With increasing life expectancy, rapid population aging, and other outcomes of the “one family one child” policy, adjustment in the retirement age is an option to keep the pension system sustainable. However, issues like job opportunities for younger generations also need to be considered.
Third, with the rapid population aging process, some measures should be adopted to maintain the long-term financial equilibrium of the pension system. The proportion of terminated, retired, and resigned, to staff and workers was 1:2.3 in 2004 in China. The Chinese government spent 481.5 billion Yuan on the social welfare system, including 425 billion Yuan on pensions and 37.3 billion Yuan on health care (National Bureau of Statistics of China & Ministry of Labour and Social Security of China, 2005). As the population grows older, the proportion of the elderly population will be larger and government expenses on the social welfare system will increase. How to build a sustainable pension system is a great challenge for the Chinese government. The individual accounts under the current pension system in China are still a kind of pay-as-you-go system as opposed to an individual account system. The money for individual accounts is used for the payout of social security at the same time, which brings great pressure on the finances of the Chinese government and makes it difficult to maintain a long-term financial equilibrium (Cai & Gu, 2006). Based on the multi-pillar system that the Chinese pension reform tries to create, EAs and individual pension insurances should be encouraged to diversify the sources of retirement income and reduce the pressure on the government.

Fourth, individual families are under pressure from increasing health care expenses for elderly people as they age, especially for elderly people with rural household registration. Under the urban health care system, some health insurance systems are tied to appointed hospitals, which limit elderly people’s choices of hospitals if they want to receive refunds for their health care expenses. The appointed hospital system also brings some challenges for elderly people to access health care resources if their residences are
far away from their appointed hospitals. Regarding residential care, access to health care is one of the determinants in the decision making process and the appointed hospital system becomes the barrier to access health care resources by elderly residents in RCFs in some cases. Rural elderly people who are not enrolled in any health care insurance system and pay for their health care expenses individually face more challenges to access health care resources.

Fifth, gender equality and equity are seldom considered in China’s pension system. As Zeng (1991) suggested that, if the current low level of fertility persists in urban areas, elderly females will make up 36 percent of the female population and 40 percent of them will live alone. Elderly women are more likely to live longer and have worse health status at their old age than elderly men. The income security for elderly women needs to be considered in the social welfare system (Zheng, 2005), especially for those who live alone (widows, divorced or separated, and never having married). More research to show the social and economic differences caused by gender are needed in China.

4.4 Chapter Summary

This chapter introduces the multi-pillar model of pension system developed by the World Bank. It explains the current pension system and health care system of people with urban and rural household registrations in China respectively. In conclusion, the Chinese government has already taken action in reforming the social welfare system to improve financial security for elderly people. The large elderly population, its rapid growth, and
relatively weak economic foundation, however, create many challenges for the Chinese government.

Financial security is one of the determinants for understanding accessibility to residential care and one’s well-being. Current pension and health care systems in China provide insights into explaining the decision making process of residential care and the choice of a specific RCF. Inequities created by two different pension and health care systems for urban and rural residents contribute to understanding how one’s financial status affects his/her Behavior and quality of life. The appointed hospital health care insurance also provides some explanations for the interaction between geographical access and socio-economic access to residential care. Basic knowledge of the current pension and health care systems in China is important for understanding the following results chapters (Chapter 5 to 7).
Chapter 5 Population Aging and Residential Care Resources in Beijing

5.1 Introduction

China is one of the countries with the fastest growing elderly populations in the world because of the decline of fertility rates and mortality rates. The demography of the elderly population has changed dramatically since People’s Republic of China was founded in 1949. The elderly population has constantly increased after a steep drop in the 1960s because of natural disasters and political factors (Wang et al., 2005). By 2005, the population aged 60 and over was 144 million or 11.03 percent of the total population (National Bureau of Statistics of China, 2006). In the developed areas of China, the elderly population has reached a higher proportion than 11.03 percent and continues to increase rapidly. In Beijing, the elderly population was 2,024,000 in 2006, which was 16.9 percent of the total population (Committee on Aging of Beijing, 2007). The proportion of elderly population is expected to be 20 percent of the total population in China (Population Division, United Nations, 2007) and 30 percent of the total population in Beijing by 2025 (Beijing Municipal Bureau of Statistics, 2000). The rapid aging process in China has many implications for the future development of Chinese society, economy, and culture.

The elderly population needs more care resources than any other age group. “Who are the elderly population and where can elder care be provided?” are questions being asked by both researchers and policy makers. Residential care becomes an alternative choice for elder care in the absence or shortage of community or home care. In China, elderly people are traditionally cared for by their families at home. The combination of a
rapidly aging Chinese population, the “one family one child” policy, and the increased need for geographical mobility of adult children, however, has decreased the potential of family members to provide day-to-day care for elderly people (Gu et al., 2007). In this situation, residential care has developed quickly in Beijing in recent years. By the end of 2007, there were 333 RCFs in Beijing, and 23,283 beds were occupied among the 36,736 beds in total. The occupancy rate reached 63.38 percent (Beijing Municipal Bureau of Civil Affairs, 2008), and around one percent of the elderly people in Beijing were living in RCFs in 2007.

This research used statistical indicators and GIS mapping to study the characteristics and spatial distribution of the elderly population and residential care resources in Beijing. Indicators include: percentage of the population aged 60 and over, percentage of the population aged 80 and over, the proportion of elderly people within elderly families to the population aged 60 and over, number of beds per 1000 elderly people aged 60 and over, and occupancy rate. ArcView GIS software is used for the mapping. The second part of this chapter elucidates demographic change of Chinese population at the national level. The demographic characteristics of the elderly population in Beijing are presented in the third part. The results of the analysis of residential care resources are presented in the fourth part.

5.2 Demographic Changes in the Chinese Population

China is one of the largest countries in the world in terms of both geography and population size. In 2005, the total population was 1.3 billion, with 0.54 billion (41.7%)
urban population and 0.76 billion (58.3 %) rural population (National Bureau of Statistics of China, 2006). Historically, China has had relatively low economic levels compared to the developed countries and great regional differences. GDP per capital in China was $7,600 (in comparison to $35,200 in Canada) in 2006 (Central Intelligence Agency [CIA], U.S., 2007).

The population in China is experiencing a rapid aging process due to rapid socio-economic changes in recent decades. Fertility rates have declined to a low level because of the “one family one child” policy beginning in the late 1970s, whilst mortality rates have been in decline because of health care improvements since the liberation in 1949. According to the demographic transition model (DTM) developed by Warren Thomson (Demeny & McNicoll, 2003, pp.939-940), the age structure of the Chinese population is quickly passing through stage three to stage four as Figure 5-1 and 5-2 show.

Initially, as the fertility rate fell, the proportion of the labour force increased and continued to do so. Under such a “balanced” population structure, the current burden of care for the elderly population and children is low. As the process of population aging gains momentum in the coming decades, this kind of advantage will disappear in the near future (Zeng, Li, Gu, & Lin, 2006). Based on this population aging trend, the elderly population will increase quickly, and the speed of population aging will be faster in China than in any other country in the next 50 years.
The proportion of the oldest old is increasing more rapidly than the elderly population overall. The oldest old was 1.2 percent in 2005 (U.S. Census Bureau, Population Division, 2007). By forecasting how the proportion of population aged 60 and
over will change, the oldest old will be 31.1 percent of the elderly population and 7.2 percent of the total population by 2050 respectively (U.S. Census Bureau, Population Division, 2007). The increasing speed of the relative growth of the oldest old is two times that of the elderly aged 60 and over (Zeng, 2004). The more oldest old there are, the more services and resources have to be provided.

The increasing age dependency ratio (the ratio of the population aged 65 and over divided by the population aged 15-64) and unbalanced sex ratio (the ratio of males to females in a population) of elderly population will also increase the challenges for elder care provision in the near future. The age dependency ratio will rise to 17 to 19 percent in 2020 and 37 to 45 percent in 2050, which means each elderly person aged 65 and over will be supported by every 2.2 to 2.7 people aged between 15-64 by 2050 (Zeng, 2004). Statistical data also show that sex ratio favours elderly women over elderly men (see Table 5-1). Women over 65 were 4.12 percent of the total population, while men over 65 were 3.81 percent of the total population in 2006. However, women over 65 will be 14.75 percent and men over 65 will be 12 percent of the total population by 2050 (U.S. Census Bureau, Population Division, 2007). Elderly women need more care resources because they are more likely to live longer and alone with chronic disease in their later life (Andrew & Phillips, 2005).

Regional difference is a challenge for elder care in addition to the above factors. The regional difference is great among the various regions in China, especially between rural and urban areas. More and more young people in rural areas migrate to urban areas, resulting in the proportion of the elderly population and the speed of population aging are
higher in rural areas than in urban areas. From 1982 to 2000, the proportion of the population aged 65 and over rose from 4.54 percent to 6.42 percent in urban areas, whilst the proportion rose from 5.0 percent to 7.5 percent in rural areas (Zeng, 2004).

Table 5-1.

*The Age and Sex Structure of the Population in China in 2006 and 2050 (U.S. Census Bureau, Population Division, 2007)*

<table>
<thead>
<tr>
<th>Percentage to total population</th>
<th>Age≤15 (%)</th>
<th>Age: 15-64 (%)</th>
<th>Age≥65 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2006</td>
<td>2050</td>
<td>2006</td>
</tr>
<tr>
<td>Male</td>
<td>10.66</td>
<td>7.08</td>
<td>37.13</td>
</tr>
<tr>
<td>Female</td>
<td>9.22</td>
<td>6.63</td>
<td>35.06</td>
</tr>
<tr>
<td>Total</td>
<td>19.88</td>
<td>13.71</td>
<td>72.19</td>
</tr>
</tbody>
</table>

5.3 The Demography of the Elderly Population in Beijing

Beijing is one of the cities with the largest and the most rapidly aging populations in China. By the end of 2006, the registered population in Beijing was 11,976,000. The population aged 60 and over was 2,024,000, which was 16.9 percent of the total population. The population aged 65 and over was 1,529,000, which was 12.8 percent of the total population, and the population over 80 was 258,000, which was 2.2 percent of the total population (Committee on Aging of Beijing, 2007).
Figure 5-3. The self-reported health status of elderly people in *The One Percent Population Sample Survey of Beijing in 2005* (Beijing Municipal Bureau of Statistics, 2007).

Figure 5-4. Income sources of elderly people in *The One Percent Population Sample Survey of Beijing in 2005* (Beijing Municipal Bureau of Statistics, 2007).
The One Percent Population Sample Survey of Beijing in 2005 provides details on the health status, income sources, and marital status of elderly people in Beijing. According to the survey, 61.65 percent of the elderly population aged 60 and over self-report their health status as healthy, 23.67 percent have the ability to self care and work, 13.95 percent are unable to self care or work, and 0.73 percent did not provide a clear answer. Health status is better for men than women and better for those aged 60 and over than the oldest old, demonstrating gender and age differences are also important to consider (Figure 5-3). Regarding income sources, 70 percent of elderly people aged 60 and over receive pensions, 23 percent are supported by their family members, 5 percent earn salary from work, and 2 percent have other income sources. Elderly men are more likely to

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13 The survey categorized marital status as unmarried, first married, remarried, divorced, and widowed (Beijing Municipal Bureau of Statistics, 2007). In this report, the category with spouse includes first married and remarried, and the category without spouses includes unmarried, divorced, and widowed.
receive pensions than elderly women, and the male oldest old are most likely to receive pensions. Women are more likely to be supported by their family members than men, and the female oldest old are most likely to be supported by their family members. The likelihood increases with age (Figure 5-4). Concerning marital status, 77 percent of the elderly people aged 60 and over have spouses. Men are more likely to have spouses than women, and elderly people aged 60 are more likely to have spouses than the oldest old. Elderly men aged 60 and over are most likely to have spouses, and the female oldest old are most likely to live without spouses (Figure 5-5) (Beijing Municipal Bureau of Statistics, 2007). To sum up, elderly people aged 60 and over are in a better position than the oldest old in all aspects of health, economic, marital status, and education. Meanwhile, the male elderly population are healthier, more financially independent, more likely to have a spouse, and more likely to have higher education than the female elderly population. Both the age and gender differences among elderly people enhance the vulnerable position of the female oldest old, which indicates that the female oldest old may be the group who needs the most elder care resources among all elderly population.

The maps developed using some of the statistical indicators from above show that the spatial distribution of the elderly population is uneven across the districts of Beijing (see Figures 5-6, 5-7, and 5-8). The 11th Five-Year Plan on Functional Area Development of Beijing Municipality (Beijing Municipal Commission of Development and Reform, 2006) divides Beijing into four functional areas: Capital Core Functional Area (Dongcheng, Xicheng, Chongwen, and Xuanwu Districts), Urban Functional Extension Area (Chaoyang, Fengtai, Shijingshan, and Haidian Districts), Urban New Developing Area (Fangshan, Tongzhou, Shunyi, Changping, and Daxing Districts), and Ecological
Protection Area (Mentougou, Huairou, Pinggu Districts, and Miyun and Yanqing Counties) (see Figure 5-6). The Capital Core Functional Area and the Urban Functional Extension Area are the two areas with the highest proportions of population aged 60 and over, which was 19.3 percent and 17.8 percent respectively. In the other two areas, the Urban New Developing Area and the Ecological Protection Area, the proportion was 14.5 percent and 15.1 percent respectively. Among all 18 districts (counties) in Beijing, Xuanwu (20.3%), Chongwen (19.6%), and Chaoyang (19.4%) were the three districts with the highest proportion of elderly population aged 60 and over, while the districts with the lowest proportions were Daxing (13.8%) and Fangshan (14%) Districts (Figure 5-6) (Committee on Aging of Beijing, 2007).

Figure 5-6. The spatial distribution of the population aged 60 and over in Beijing in 2006 (Committee on Aging of Beijing, 2007).
The spatial distribution of the oldest old was different from the population aged 60 and over (Figure 5-7). The Capital Core Functional Area and the Urban Functional Extension Area were also the two areas with the highest proportion of the oldest old, which were 3.6 percent and 2.0 percent respectively. In the Urban New Developing Area and the Ecological Protection Area, the proportions were 1.6 percent and 1.7 percent respectively. Among all 18 districts (counties), Chongwen (3.9%), Xuanwu (3.6%), and Xicheng (3.5%) in the Capital Core Functional Area are the three districts with the highest proportions of the oldest old.

Figure 5-7. The spatial distribution of the population aged 80 and over in Beijing in 2006 (Committee on Aging of Beijing, 2007).
Two interesting points should be addressed when comparing Figure 5-6 and 5-7. First, the proportion of the elderly population aged 60 and over and the proportion of the oldest old are both higher in the Ecological Protection Area than in the Urban New Developing Area. An important factor in understanding this distribution pattern is that the labour force migrates from the Ecological Protection Area to the other three areas for better pay, leaving the elderly population back at home. Second, the districts with the highest proportion of the oldest old are different from the distribution of the elderly population aged 60 and over. For example, in Chaoyang District, the proportion of the elderly population aged 60 and over is one of the highest, whereas the proportion of the
oldest old is not. This distribution pattern indicates that Chaoyang District will become the area with highest proportion of the oldest old if the pattern does not change in the next 20 years (Committee on Aging of Beijing, 2007).

By the end of 2006, the number of elderly people in elderly families was 331,000, which was 16.4 percent of the total elderly population in Beijing (Figure 5-8). As an indicator to elucidate the family structure of elderly population in Beijing, “elderly family” refers to the family with all of its members aged 60 and over, including: 1) elders who live alone; 2) elderly couples aged 60 and over; and 3) elders who live with his/her parents or elderly relatives (Committee on Aging of Beijing, 2007). Chaoyang, Haidian, and Fengtai are the three districts ranked in the top three for the largest number of elderly families. The indicator, the proportion of elderly people within elderly families to the population aged 60 and over is used to show the spatial distribution of elderly families and help elucidate the need for elder care resources because elderly people in elderly families are more likely to lack caregiving resources. In the Capital Core Functional Area, the Urban Functional Extension Area, the Urban New Developing Area, and the Ecological Protection Area, the value of the indicator was 10.9 percent, 17.5 percent, 13.7 percent, and 26.6 percent respectively. Mentougou, Yanqing, and Miyun districts (counties) were ranked the top three Districts (Counties) with the highest proportion of elderly families (Committee on Aging of Beijing, 2007). The distribution pattern of elderly families is quite different from the distribution of the elderly population. The proportion of elderly families is higher in the Urban New Developing Area and the Ecological Protection Area than in the Capital Core Functional Area and the Urban Functional Extension Area because the distribution of elderly families is highly related to the effects of urbanization. The labour force in
suburban and exurban areas migrates to central areas with their children and leaves elderly family members at home. The migration of younger generations changes the population structure at the local level. Figure 5-8 also shows that in the central areas of Beijing, a high percentage of elderly people still traditionally live with their children, even though elderly people are becoming more and more financially independent and live by themselves or with their spouses (Zhan, Liu, & Guan, 2006). This kind of distribution pattern of elderly families and the elderly population reinforces the pressure of population aging and elder care in suburban and exurban districts.

Figure 5-9. The trends for the elderly population in next 50 years in Beijing (Ma, 2003).

The number and proportion of elderly people has rapidly increased and will continue to increase in Beijing. The proportion of the population aged 60 and over is expected to be 30 percent of the total population by 2025 and 40 percent by 2050 (Figure
A survey shows that 12.7 percent of elderly people are willing to choose residential care in Beijing, but only 15 RCF beds were available per 1000 elderly people in 2005 and even fewer in the central areas (The People’s Government of Beijing Municipality, 2006; Zhao, 2006). With the demographic changes and shortages of caregiving resources at home and in the community, the need for residential care resources will increase in Beijing.

5.4 Residential Care in Beijing

The history of residential care is short in China, and the public has negative perceptions of residential care because of Confucian conceptions in Chinese culture. Traditionally, most Chinese live in multigenerational families and the elderly people receive care from their adult children and extended family (Chen, 1996). Prior to the establishment of the People’s Republic of China in 1949, RCFs were almost nonexistent. In the 1950s, the government turned charitable homes into “social welfare homes” for “Three-No” elderly people in urban areas (Zhan, 2000). In rural areas, similar facilities were built for the childless elderly, orphans, and the disabled who were unable to work. The government provided the “Five Guarantees” services with funding from various local, municipal, and governmental agencies (Bartlett & Phillips, 1997). At this stage, “social welfare homes” were for the relief of vulnerable groups.

In the 1980s, the Chinese government began to take notice of the challenges of population aging and take action to improve elder and residential care systems. In 1984, a social welfare conference organized by Ministry of Civil Affairs in Zhangzhou was an
important milestone for the development of residential care in China. Two changes were advocated for residential care at the conference: one to increase care receivers from traditional “Three-No” and “Five Guarantees” elderly people to all elderly people, the disabled, and abandoned children; and the other to change the relief system into a welfare system and provide all-round services in residential care such as daily care, health care, education\textsuperscript{14}, physical training, and leisure activities for elderly residents (Wei, 2007). At the end of the 1990s, the Chinese government encouraged private sector and non-profit organizations to invest in developing RCFs (Wei, 2007).

In 2000, the Central Committee of the Communist Party and State Council of China put forward a guide for the development of elder care: “elder care should be based on home care and community care with the support of residential care” in order to fulfill the Chinese filial piety tradition and in accord with the level of socio-economic development (The Central government & State Council of China, 2000). In the same year, the Beijing local government planned to create a city-district-street (village)-home four-level social welfare system. With the combination of public and private provision, the residential care system aims to gradually form a network to cover both rural and urban areas of Beijing (State Council of China & Ministry of Civil Affairs of China, 2000). After five years’ effort, the network reached 15 RCF beds per 1000 elderly people, and 171 villages reformed their elder care institutions into social welfare centers by 2005. The goals for 2006 to 2010 are to build up to 23 beds for per 1000 elderly people, continuously to improve the four-level social welfare system, and further to develop publicly-owned and

\textsuperscript{14} For example, the third age university.

The indicator: number of beds per 1000 elderly people aged 60 and over is used to map the spatial distribution of residential care resources. The figures (Figure 5-10 to 5-12) show that the Capital Core Functional Area is the area with highest proportion of elderly people, but with relatively few residential care resources. Changping District has the most abundant resources with 55 beds per 1000 elderly people aged 60 and over, whereas Dongcheng District has the fewest resources with less than 4 beds per 1000 elderly people aged 60 and over. As a result of the distribution pattern of the elderly population and residential care resources, the occupancy rate of RCFs is highest in the Capital Core Functional Area and lower in the Urban New Developing Area and the Ecological Protection Area (Beijing Municipal Bureau of Civil Affairs, 2008; Committee on Aging of Beijing, 2007). On the one hand, the residential care resources cannot satisfy the demands of the elderly people, with a long waiting list to move into some RCFs in central areas. On the other hand, the occupancy rate of RCFs in the Capital Core Functional Area and the Urban Functional Extension Area is over 75 percent, 52 percent in the Urban New Developing Area, and only 49 percent in the Ecological Protection Area of Beijing. Research shows RCFs can only balance the revenues and costs if the occupancy rate is over 60 to 70 percent (Li et al., 2007). One reason for the inefficient utilization of residential care resources is the mismatch between the elderly population and residential care resources in Beijing.
Figure 5-10. Residential care resources and occupancy rate in Beijing in 2006 (Beijing Municipal Bureau of Civil Affairs, 2008; Committee on Aging of Beijing, 2007).

Figure 5-11. The spatial distribution of residential care resources in Beijing in 2006 (Beijing Municipal Bureau of Civil Affairs, 2008; Committee on Aging of Beijing, 2007).
Experience from developed countries shows that one way to meet the increasing demands for residential care is through private sector provision allocated by a market system (Andrews & Phillips, 2002). As mentioned above, the Chinese government has encouraged private sector and non-profit organizations to invest in developing RCFs since the end of the 1990s, which has diversified the development of the residential care industry. Currently, ownership of RCFs in Beijing is divided among government operated facilities, community facilities, private facilities, and publicly-owned and privately-run facilities. Government operated facilities include those facilities operated by local governments. Community operated facilities include those facilities operated by city neighbourhood
committees and village committees. Facilities operated by persons, companies, enterprises, and organizations are categorized as private facilities. Besides these three types of facilities, there is a new type of ownership called publicly-owned and privately-run facilities, which are set up and funded by government, but managed by the private sector. The private sector does not own the properties nor need to pay rent, but assumes sole responsibility for the profits or losses. In this way, the model reduces the cost of running RCFs and takes advantages of efficient management by the private sector. The proportions of community facilities, private facilities, government operated facilities, and publicly-owned and privately-run facilities are 60 percent, 31.6 percent, 4.5 percent, and 3.9 percent respectively. The ownership of facilities is more diverse in the Urban Functional Extension Area and the Urban New Developing Area than in the Capital Core Functional Area and the Ecological Protection Area. Most of the RCFs in exurban areas are traditional community facilities (Figure 5-13).

In Beijing, only government operated facilities and community facilities accept the “Three-No” and “Five Guarantees” elderly people for free. Other elderly residents are charged admission and service fees. The standard charge for most RCFs is below 2,000 Yuan per month, whereas some upscale facilities charge over 2,000 Yuan per month. Generally, the standard charges are higher in central areas than in suburban and exurban areas (Beijing Municipal Bureau of Civil Affairs, 2008). The average income of elderly people was 1,338 Yuan per month in Beijing in 2006, with 1,643 Yuan per month (719 Yuan per month in 2000) for elderly people in urban areas and only 316 Yuan per month (244 Yuan per month in 2000) for elderly people in rural areas (Li, 2007). For more than half of the elderly people, residential care is an expensive option for elder care. Some
research indicates that financial affordability is likely to be the major factor that influences future elders’ decision making about residential care (Zhan, Liu, & Guan, 2006).

![Graph showing the ownership of RCFs in Beijing](image)

**Figure 5-13.** The ownership of RCFs in Beijing (Beijing Municipal Bureau of Civil Affairs, 2008).

### 5.5 Chapter Summary

This chapter helps in understanding: who are the elderly population and where can care be provided? What is the spatial distribution of elderly population and residential care resources in Beijing; and do service needs geographically match residential care resources? The results show that the proportion of elderly population is high in Beijing, and both the number of elderly people and the proportion will continuously increase in the near future. Elderly women are more likely to need elder care resources and there will be more challenges to provide care for the female oldest old. The distribution of the elderly
population and residential care resources is geographically uneven across the districts of Beijing and the needs do not match the resources. Central areas have the highest proportion of the elderly population but inadequate residential care resources to meet the demands. Exurban areas have the highest proportion of elderly families because of the migration of younger generations. Elderly people in elderly families are more likely to lack care resources than elderly people who live with their adult children. The distribution pattern reinforces the pressure for elder care in suburban and exurban areas. However, statistical data show that the resources are inefficiently used with lower average standard charges of RCFs in suburban and exurban districts. It is obvious that geographical access is only one aspect of access to care resources and equity in their provision. Social, economic, and cultural factors are also significant for access to residential care by elderly people. The next chapter examines how is the decision for residential care being made instead of traditional home care and what are the factors that affect access to residential care?
Chapter 6 Access to Residential Care by Elderly People in Beijing

6.1 Introduction

In the 1980s, research in North American showed that most elderly people held negative views of nursing homes (Johnson & Grant, 1985). Recent studies have supported and opposed residential care in what is known as the “residential care versus community care debate” (Andrews & Phillips, 2002, p. 64). The criticisms of residential care have focused on the inability of RCFs to provide independence and choice for the residents (Andrews & Phillips, 2002). The alternative views on RCFs argue that some elderly people experience their home not as a place where they find self-expression and autonomy, but as a lonely and bleak place. Instead, some elderly people enjoy the lifestyle and independence in RCFs and take comfort in that they are not being a burden on their families (Kearns & Andrews, 2005; Oldman & Quilgars, 1999).

In China, informal home care is the most likely and traditionally the choice for both elderly people and their family members. The public has conceptions of the elderly who choose residential care as being alone without any family members or being badly treated by their families. Not only the elderly people, but also their families see residential care as the last choice. As a result of the rapid socio-economic development in recent decades, the shortage of community and home care resources facilitates residential care as an alternative choice for elderly people in China. The negative perceptions and social stigma associated with residential care facilities are breaking down.
Based on the conceptual framework and qualitative data collected by in-depth, semi-structured interviews, this chapter presents results to understand why elderly people choose residential care and how they access residential care resources. The second part of this chapter analyzes the reasons that elderly people choose institutionalization instead of aging at home. The findings on the access to residential care resources and the decision making process for a specific RCF are presented in the third part of this chapter. The last part summarizes the results presented in this chapter. This chapter aims to answer research questions two and three: “how is the decision of residential care being made instead of traditional home care?” and “what are the factors that affect access to residential care?” The results will provide suggestions on improving access to residential care by the elderly people in Beijing, which will be discussed later in Chapter 8 of this thesis.

6.2 Choosing Residential Care

Existing research in North America and Europe shows that singles, females, whites, frail elderly people, those with lower education, and the oldest old are more likely to be institutionalized than other groups of elderly people. Some research shows that elderly people with abundant economic resources have greater access to residential care than elderly people with less financial resources (Bernard et al., 2007; Longino, Perzynski, & Stoller, 2002). Studies in East Asian societies also show that advanced age, females, and living alone are strongly associated with the use of residential care (Phillips, Siu, Yeh, & Cheng, 2005). In general, elderly people and their families choose residential care because of a combination of health, housing-related, security, and independence concerns. In the Chinese context, significant socio-economic changes have happened in recent decades, the
size of the Chinese family is declining and geographical distance between elderly parents and adult children is increasing. Lack of family care resources is the main reason for elderly people and their families to choose residential care. In addition, elderly people are more and more financially independent in urban areas in China (Qin, 1994). Many of them prefer to live independently either with their spouse or alone instead of living with their adult children. The elderly play an increasingly important role in the decision making process. The results from this research show that reasons for choosing residential care come from the push factors (the challenges of providing informal home care) and pull factors (the advantages of residential care).

Several challenges of providing home care were addressed by both elderly residents and family members during the interviews. First, lack of caregivers providing day-to-day care for elderly people in their private homes is the most important reason for them to choose residential care. Similar results are found in English speaking countries and Japan (Grundy & Henertta, 2006; Ikegami, 1982; Johnson & Grant, 1985). Family caring capacity is the key factor in decision for placement of elderly people (Ikegami, 1982). The self care ability of elderly people gradually decreases as their age increases, and the housekeeping becomes a heavy burden for them, as well as the challenges of transportation and grocery shopping. Meanwhile, adult children are more likely to live separately with their parents and less likely to provide daily care for their parents than before. Some elderly people may move to live with one of their children’s families, especially after their partner passed away. Some adult children, however, are unable to provide enough caregiving resources at private homes for various reasons, such as busy working schedule, and lack of living space in their homes. Additionally, some caregivers are becoming
elderly people themselves. The shortage of informal family caregiving resources facilitates elderly people to choose residential care.

I lived with my son after my partner passed away. After a while, I moved out of his home to live by myself . . . . Doing grocery shopping and cooking meals are really challenges for me . . . . I have three sons and a daughter. My oldest son has diabetes, so my daughter-in-law needs to care for him. I used to live with my second son, but his wife passed away a few years ago, and the nanny who used to care for me went back to her own home. My little son is still at work. He is busy. My daughter’s home is a two-bedroom apartment, and it will be crowded if I move in . . . . Here is the best choice for me. (An elderly resident)

My mother-in-law needs more caregiving as her age increases, and we are all aged over 60. We are elderly people now. We feel that we are not able to care for her at home anymore . . . . (A family member)

Hiring temporary informal caregivers is an option to keep elderly people living at home. The study results, however, show that there are other challenges in hiring temporary informal caregivers. For example, elderly people sometimes cannot get along well with hired caregivers. Hired caregivers can help elderly people with physical care tasks such as cleaning, laundering, cooking, and grocery shopping. They are less likely to offer emotional care and elderly people still feel lonely and isolated by living at home.

It is hard to find a good nanny . . . . I asked her to do the chores. She always put them off or too lazy to do it . . . . She only cared about the money, not me, and she was not responsible for the housework . . . . She became a burden for me and I fired her eventually. (An elderly resident)

A second factor in choosing residential care is the loneliness elderly people feel living at home, especially those who are widowed or single. Some elderly people feel they lost their social connection and self values after their retirement. They are not used to the changed daily routine after their retirement. They feel lonely and isolated living at home,
and their physical health status declines with their mental health. Even living with their adult children’s family, some elderly people feel lonely staying at home during the daytime when other family members go to work or school. To change the situation, some elderly people chose to move into RCFs to live with other elderly people, make new friends, and to share their interests.

I used to hire an hourly worker. She came to help me with my housework. But there is no one I can talk with after she finished her chores and left my home every time. I watched TV programs at home every day. TV talked to me, but I cannot talk to TV . . . so lonely . . . . (An elderly resident)

They (the children and grandchild) leave home in the morning. I am alone to stay at home with the nanny, and I don’t know what to say to her. I feel lonely staying at home . . . . I prefer to live with other elderly people . . . . We can chat, play games, and do some exercises together . . . . (An elderly resident)

Some widowed elderly people move into RCFs soon after they lose their partners. The home environment reminds them of memories of living with their partners for many years. It is difficult for them to rid themselves of the sorrow for the loss of their loved ones. Some of the elderly people and their family members choose a RCF as a new environment.

Some of the elderly people and their family members choose a RCF as a new environment.

Thirdly, some elderly people lack a sense of security by living alone at home. “The sense of security includes less worry about being cared for and about daily life, such as illness and emergency, and the ability to have a sense of future planning” (Ng, Phillips, & Lee, 2002, p.144). Elderly people are physically vulnerable with critical and chronic diseases. Heart attacks, strokes, falls, and other accidents may happen to them when they.
are alone at home. The results of this research show that many elderly people worry about
critical illness such as heart attacks or strokes and what will happen to them without
anybody around. Once such accidents happen, both elderly people and their family
members have concerns about reoccurrences. This type of concern leads elderly people
and their family members to choose residential care.

I had several heart attacks when I was alone at home. My children are worried
about me. I am also afraid of a heart attack happening to me without anyone around . . . . I don’t even have the strength to call an ambulance when it happens . . . so I decide to move into a RCF. (An elderly resident)

Fourthly, undesirable urban, community, and home environments are important
factors for elderly people who choose to relocate to a RCF with a pleasant environment.
Elderly people are sensitive to the quality of the physical environment, especially the
crowded and noisy environment in the city. With the changes in the housing market in
Beijing, more and more elderly people are moving into residential quarters in tall and
dense apartment buildings. To go up and down stairs and carry daily groceries is a
challenge for them if an elevator is not accessible in the building. They are not familiar
with their neighbours and the new community. The apartment buildings lack open space as
do the neighbourhoods. The lack of friends and open space in the new communities and
neighbourhoods decrease elderly people’s opportunities for social interactions with others.
Some elderly people think RCFs offer them better physical and social environments than
their home communities, and residential care is a better choice for them than aging at
home.

I like the natural environment. I love it. I am tired of the living environment in
city. City is the place for working, not for living. (An elderly resident)
My apartment is on the fifth floor. I have some problems with my right leg and there is no elevator in the building. I find it is difficult for me to climb up and down the stairs. (An elderly resident)

I moved to a new residential quarter after my former home was torn down. My old neighbours moved away as well. I don’t know anyone in my new community, and I cannot find people to talk with . . . . I cannot sleep well and eat well at my new home . . . . I decide to move here. (An elderly resident)

As already discussed, some elderly people moved to live with their children because of their inability to care for themselves in their own homes. A shortage of living space at their children’s home, however, forced the elderly people to choose residential care. In some other cases, the elderly people decided to move into RCFs and leave their own homes for their children’s families. For example, some elderly people leave their home to their children since their children cannot afford a new apartment when getting married and others leave their home for their children’s family since their grandchildren are grown-up and need space at home.

My mom lived with my brother’s family for a few years after my dad passed away. She cannot get along well with my sister-in-law. She was unhappy sometimes, so she came to my place for a few days. But my apartment only has two bedrooms. It becomes a little crowded when she comes . . . . She owns the apartment she lived with my brother. She feels like a guest when she comes to live with me . . . . She made up her mind to move here (a RCF). (A family member)

Fifthly, family relationships are another factor to affect the decision making of moving into a RCF. The traditional cultural pattern of family care is that elderly parents live with one of their sons’ families, especially when the elderly parents have difficulties with self care. Family relationships are important for the harmony within such multi-generational families. The results show that elderly people face several challenges living in
a multi-generational family, such as loneliness after their families leave for work, the relationship with their daughters-in-law or sons-in-law, the different lifestyle of their children, and the generation gap between elderly people, their children, and even their grandchildren. Additionally, some elderly people view themselves as burdens to their children’s families. They are unwilling to be cared for by their children when they are aged.

Grandparents often spoil their grandchildren. It may cause conflicts between elderly parents and their daughter-in-law . . . . When the conflict happens, elderly parents want to leave the family and move into a place such as a RCF where they may feel free and enjoy their life. They don’t want to become a burden to their children and they are not willing to have conflicts with other family members . . . . They move here and live separately with their children’s family . . . . Families come to visit at the weekends and the relationship gets improved instead. (A RCF manager)

They (adult children) are tired when they come home after work, but I am not able to help them with the housework. I feel guilty to wait for them cooking the dinners . . . . Maybe being able to take care of myself offers them a great help, so I decide to move. (An elderly resident)

Sixthly, some elderly people move to RCFs for leisure opportunities and enjoyment of their elderly life in a friendly environment. The elderly people are active in arranging their lives. They rid themselves of the responsibilities of looking after a home and spend more time making new friends and sharing their interests with other elderly people in the RCF. They choose to move into RCFs with pleasant physical environments and high quality of services, as well as reasonable expenses. The elderly people who were interviewed were usually able to afford the expenses of residential care from their savings or pensions. Elderly people who are financially independent have more options for elder care. More details on financial access will be discussed in the next section.
The society is changing nowadays, and the traditional home care is a kind of out of date (for some of us) . . . . We should enjoy our elderly life. I feel now is the best time in my elderly life since I still have self care abilities, so I made a decision, to move into this RCF to enjoy my old life. (An elderly resident)

The advantages of residential care are pull factors in elderly people’s decision making to choose residential care. In English speaking countries, research shows that RCFs can provide adequate care and a satisfying environment for elderly people with varying levels of care needs, even though there is still a debate about whether to invest more in community care or RCFs (Aminzadeh et al., 2004; Hawes, 2001). The findings in this research show that, first, the pleasant environment in some RCFs, caregiving resources, and the rapid reaction to emergencies are attractive to the elderly people who lack caregivers at home. Secondly, relocation to RCFs provides elderly people an opportunity to rid themselves of the upkeep of their own homes and have more spare time to develop interests with their cohorts. Thirdly, some elderly people seasonally migrate between RCFs and their own homes. They usually stay in RCFs for summer and move back to their homes in winter. In this way, they take advantages of the pleasant physical environment in some RCFs in summer. Fourthly, some elderly people believe that maintaining a healthy life is the most supportive way to help their children, and residential care is able to provide them with a joyful and healthy lifestyle.

I am tired of the environment in the city. Here is good! The RCF is surrounded by hills and with a big orchard in the front. The air here is so fresh. We also grow vegetables in the yards. They are non-polluted vegetables, you know . . . . There is a park nearby. I often take a walk in the surrounding areas in the morning. (An elderly resident)

My physical and mental health gets improved after I moved here. My children are all happy with my health improvement. My enjoyment with living here and my health status are the most supportive thing for my children . . . . They don’t need
to worry about me and they can concentrate on doing other things . . . . (An elderly resident)

6.3 Access to RCFs

Existing literature shows that access is not only affected by geographical factors, but also relates to economic, social, and cultural factors (Anderson, 1995; Joseph & Phillips, 1984; Meade et al., 1988; Penchansky & Thomas, 1981; Rosenberg, 1983). In theory, each elderly person should have equal access to health care resources. Empirical studies in English speaking countries, however, show that access to health care services by elderly people is shaped by many factors, including elderly people’s health status, functional level, and socio-economic status (Aminzadeh et al., 2004). Results from this research divide access to residential care into five dimensions: geographical access, information access, economic access, socio-cultural access, and the socio-managerial environment. How elderly people evaluate their accessibility to RCFs plays an important role in their decision making for a specific RCF. The process of choosing a specific facility in which they would like to live is a process of balancing among factors such as geographical location, service quality, one’s demands, and affordability.

6.3.1 Geographical access

Geographical access to residential care is affected by factors such as location and distance at the macro-scale, and also by factors such as the physical environment and the facilities of RCFs at the micro-scale. The results of this research show that most elderly
people who originally lived in urban areas choose RCFs located in central districts or suburban districts instead of the ones located in exurban districts of Beijing. The importance of location and distance varies among individuals. Elderly people who choose RCFs located in central districts consider the geographical location of a RCF as one of the most important factors for their choice. The location of a RCF, convenience of public transportation, the time-distance for their families’ and friends’ visits, and access to health care play important roles in their decision making.

Transportation is interpreted as the access to health, recreation, and social services for elderly people in policy making (National Advisory Council on Aging, Canada, 1989). Later, Hodge (2008) added access to commercial facilities, family, and friends to the meaning of transportation for elderly people. In Beijing, few RCFs offer shuttle bus service to supermarkets, hospitals, and main public transport junctions. Elderly residents usually use public transportations, such as buses and cabs, or rides offered by their families to get to their destinations. Differently from the elderly in urban areas, elderly people who chose RCFs located in suburban districts considered factors such as the physical and social environments of the RCF as more important than the location and distance factors.

I chose this RCF because it locates close to where my children live. That is easier for them to come to visit. The public transportation here is convenient too. I can get to my appointed hospitals easily. (An elderly resident)

I live very close to here. I can stop by several times a day, on my way to work and way back home. I always stop by to talk to him (the interviewee’s father) for a while, check if everything is alright, and bring him some dishes he likes . . . I won’t be able to do so if he lives in a RCF far from me, (in that case) maybe I can only visit him twice a month. (A family member)

The physical environment including both the natural and built environment of a RCF is also important for elderly people’s choice. The results show that the open space
within and around a RCF, such as gardens, fields, parks, and green lands, is taken into consideration by elderly people when they look for a RCF to move into. Some elderly people prefer to choose RCFs with a particular housing style, such as bungalows and court yards, because bungalows and court yards are convenient for their daily activities and are traditional housing styles which they are used to. Elderly people also take the room distributions into considerations, such as single rooms or shared rooms, room location, room size, and the window direction of the room.

We (an elderly couple in the RCF) had visited several RCFs before we found this one. The room size in some RCFs is so small and the open space is limited. Compared to the ones we visited, this RCF has the best physical environment. Besides the garden, there is also a park nearby. We like to go there to enjoy the well cared plants and do some exercises using the equipments in the park. The complex we live in now is quite new. We have common rooms for reading, painting, playing cards, and exercising. We are very satisfied with the living environment here. (An elderly resident)

The elderly residents interviewed were most concerned about health care, communication, and sanitary facilities in the RCFs they chose. Elderly people need more health care resources than other age groups. Health care facilities such as a clinic and medical equipment are necessary for a rapid reaction to emergencies and routine physical examinations within a RCF. The availability of health care facilities in a RCF is important for elderly people and their family members’ decision making. Compared to the government operated RCFs, private and community RCFs have fewer health care facilities and medications.

The health care system is still under reform in China. Under some old health care systems, elderly residents are eligible to receive refunds of their health care expenses only if they visit their appointed hospitals. The health care services offered by their RCFs are
not accessible for elderly residents who are enrolled in the health care system with strict appointed hospitals. Therefore, to choose the facility close to their appointed hospitals is important for their access to health care. A new model to improve health care access aims to make the best use of health care resources within the community (e.g., having community clinics offer health care to RCFs). This model has not been successful in reality. The limited health care resources in community clinics are not sufficient for elderly residents because elderly residents are more demanding on health care resources than residents in other age groups in the community. Many RCFs only accept elderly people with self care abilities. As a result, current elderly residents in RCFs are worried about their future health and elder care needs since they gradually lose their self care abilities as they age.

Communication facilities such as telephones and alarms are required in a RCF. Not every RCF, however, installs a telephone and an alarm in each room of the RCF. In some RCFs, one or two telephones are shared by elderly residents living on the same floor. Some elderly residents use cell phones instead for convenience and privacy. Some elderly people report they are more used to use desk phones than cell phones for several reasons, such as the buttons of a cell phone and words on the screen are too small for them to read, they have challenges in learning the functions of a cell phone, and they occasionally forget to charge batteries on time. With regard to sanitary facilities, in some old RCFs, washrooms are shared by many people and located in the yard or at the end of the hall on each floor. The location of washrooms causes many concerns and complaints from elderly residents and their family members.
I have concerns about my mom in using the telephone. Mom uses a cell phone because there is no telephone in her room. She always complains that it is hard for her to press the buttons on the cell phone and read the small words on the screen because of her shaking hands and poor eyesight. She does not have many phone calls, so she forgets to charge the battery sometimes. We always get worried about her when we cannot reach her if the cell phone is out of battery and shut down automatically. (A family member)

I hope the sanitary facilities can be improved. You know, now all the residents share the washroom located in the yard. During the daytimes and in this season (summer), it is OK, but it will be a different situation at nights or in winter. It is not convenient for the elderly residents. (A family member)

6.3.2 Information access

Information access is important for elderly people and their family members to know the availability of residential care resources and help them choose a suitable RCF. The results show that information access to RCFs is relatively poor in Beijing. Currently, no official system has been set up to provide RCF information for elderly people in Beijing. Most of the elderly people and family members interviewed got information about RCFs from their friends and acquaintances. Elderly people and their family members usually visited the RCFs recommended by others and evaluated their suitability. Some of them reported that they got information from media such as newspapers, TV, radio, or from flyers by chance. A few of them got information from the retirement department or office of their former workplaces (e.g., through visits to RCFs organized by their retirement department or office, retirement magazines and consultations offered by their retirement department). Few participants mentioned they got information from the Internet or community services.
Investigation, visits, and temporary stays are helpful for elderly people to get detailed information about the environment, services, requirements, and amenities of the RCFs. All elderly participants and family members interviewed visited the RCFs before they decided to move in or have their parents move in. Some elderly residents had temporarily lived in the RCFs during different seasons to ascertain if the RCF is suitable for them before their final relocation. The criteria for choosing a proper RCF varies individually. Residents may have different opinions even on the same physical environment of a RCF. For example, when mentioning the RCF’s location among hills in a suburban area, some elderly residents evaluated the facilities as a good physical environment with fresh air and a beautiful landscape. Some others, however, thought the only advantage of the surrounding environment was that it was good for hiking.

I don’t want to make a decision without full consideration. I find it is important to do some investigations before making the decision. I first lived here in spring for a month, and I came back again in winter for another month. I’d like to try and experience the differences in different seasons . . . . Then I know if I can adapt the life here and make my final decision. (An elderly resident)

I had a lot of free time after I retired, so I visited almost all the well-known RCFs in Beijing within two years. I want to find a RCF with hills and waters. I visited here by chance and I really liked it, so I decided to live here temporarily. I came here to live for several times that year, and I stayed 10 days to half a month each time. After several trials, I finally decided to move in. (Another elderly resident)

6.3.3 Economic access

In developed countries, often a part of residents’ costs in RCFs is publicly funded and the other part is self-funded in both public and private RCFs (Wright, 2003). In China, the Chinese government has encouraged private sector and non-profit organizations to
invest in developing RCFs since the end of the 1990s. The ownership of RCFs in Beijing is divided among government operated facilities, community facilities, private facilities, and publicly-owned and privately-run facilities. Most of the residents in RCFs are self-funded. Only the “Three-No” and “Five Guarantees” elderly people are accepted by government and community operated facilities for free.

Financial affordability is one of the necessary conditions for elderly people’s access to residential care. Elderly residents need to make their decisions by balancing among their affordability, the service quality, and facilities provided by RCFs. As mentioned in the former chapters, the Chinese government started to create a multi-pillar pension system for the urban elderly people in 1991, and finished unifying the basic pension insurance system for urban employees in 1997. Regarding the health care system, the Chinese government promulgated “establishment of the basic medical insurance system for urban employees” in 1998. In rural areas, pension and health care systems, however, are still under reform (Ministry of Labour and Social Security of China, 2007; State Council Information Office of China, 2004). Financial security is not stable especially for elderly people in rural areas. In Beijing, the average income of elderly people was 1,338 Yuan per month in 2006, with 1,643 Yuan for elderly people in urban areas and 316 Yuan for elderly people in rural areas (Li, 2007). The average standard charge for RCFs in Beijing is below 2,000 Yuan per month (Beijing Municipal Bureau of Civil Affairs, 2008). In this situation, for many elderly people, residential care is a relatively expensive option compared to home care. Financial affordability is likely to be the primary factor that affects the choice for residential care (Zhan, Liu, & Guan, 2006).

Some new types of services are offered by insurance companies, commercial banks, and
RCFs for elderly residents to afford residential care in various ways. For example, one of the options is to mortgage one’s housing to agencies, or to find a housing agency to rent the housing out. The mortgage loan or rent can be used to pay for the expenses of residential care. Some elderly people take options to sell their housing and put the money into their saving accounts for future expenses of elder care (Yuan & Yang, 2006).

The results of my research also show the levels of elderly people’s participation in the decision making process of relocation is highly related to elderly people’s economic status. Most elderly participants who made their own decision for relocation receive pensions and are financially independent. The elderly residents who passively moved into RCFs are more likely to be supported by their adult children.

My mother-in-law does not receive any pension. She has four children, so we split all her expenses, including her living expenses and health care expenses . . . . Regarding those expensive RCFs, we cannot even think about it. (A family member)

I receive a monthly pension a little more than 1,000 Yuan . . . . I lived in a single bed room at the beginning, but my son persuaded me to switch to a three-bed room a month later because the single bed room is twice as expensive as the three-bed room. (An elderly resident)

6.3.4 Socio-cultural access

Socio-cultural access refers to the impacts of elderly people’s attitudes on aging, Chinese traditional values on elder care, and elderly residents’ characteristics on the utilization of residential care. The attitude on aging varies among elderly people. Andrews’s (2005) study divides the willingness of relocation into four types: preference relocations, strategic relocations, reluctant relocations, and passive relocations. This
research finds similar results. Some elderly people and their family members are in complete agreement on relocation which can be called preference relocation. Some elderly residents are very active with the attitude to enjoy one’s life. They are willing to move into RCFs and adapt to the relocation quickly. They move to RCFs based on their willingness which can be called strategic relocations. Some elderly people view themselves as burdens to their family. They feel valueless and become pessimistic about their lives. Some elderly residents move into RCFs as a result of negotiations with their families. They may disagree to be relocated, but still take action. This type of relocation can be called reluctant relocation. A few of the elderly people relocated according to their families’ will which can be called passive relocation.

According to Chinese traditional values, adult children have the obligation to care for their elderly parents both physically and emotionally. In an idealized form, adult children should show loyalty, respect, and devotion to their elderly parents (Ng et al., 2002). The public would think adult children do not fulfill their filial piety to their parents if the elderly parents live in RCFs. Under such a conception, family members would prefer to care for their elderly parents at home if they have a choice (Zhan, Liu, & Guan, 2006).

With the influence of traditional values, the attitudes of family members vary even though elderly people are willing to move into RCFs. Some family members support and respect the elderly people’s choice. Some family members have concerns about the elderly person’s decision on relocation at the beginning, but they change their minds after visits to RCFs and the elderly person’s relocation. Some family members reject the choice of residential care for several reasons. For example, they have concerns about the pressure from the public. They do not want to relocate their elderly family members to RCFs of
poor quality, but the costs of upscale RCFs are expensive. They think living with families provides a sense of security to elderly parents. Meanwhile, elderly people are likely to help their children organize family affairs even though they may not be able to help with the housework. Some family members admit that the relocation of their elderly family members to RCFs is not their favoured choice. They are not willing to tell others that their parents moved into RCFs. They keep their elderly family members’ relocation a secret from their neighbours and relatives. The tensions generated in the families related to traditional values and perceptions about the stigma associated with RCFs are breaking down. The influence of traditional values, however, is still strong and residential care has not been totally accepted by the public.

They don’t support my moving. They have concerns on Chinese traditional values and family affairs. She (the daughter) thinks her home is a better place for me than a RCF . . . the best RCF is expensive though. To live in such an expensive RCF will be an additional burden for the family . . . and I can help her organize family affairs if I stay with her. (An elderly resident)

My mom told us she wanted to move into a RCF to enjoy her elderly life . . . . We were not willing to do so . . . . She has five children, two supported and the other three rejected. We had concerns at the beginning. You know, the pressure from the public is strong . . . . We came to an agreement eventually, and we agreed to let her try, then she moved . . . . Only my families know that mom moved into the RCF. We still keep it a secret to our neighbours. We just tell them my mom went to visit her daughter for some time . . . . We still feel the pressure from the public. (A family member)

In addition, the size of families and the physical distance between parents and adult children affect the ability of adult children to practice and implement the traditional values of filial piety in today’s society (Ng et al., 2002). Some elderly people and their family members choose to use residential care passively because of the challenges in providing family care.
The other influence of Chinese traditional values is that elderly parents make decisions in consideration of their families. Elderly people are willing to take care of themselves as long as they can. Elderly couples usually support each other, followed by adult children, then the use of other resources (Ng et al., 2002). Some elderly people decide to move into RCFs because they do not want to be caregiving burdens for their families. When they choose a facility, they consider the location and convenience of transportation important for the time-distance for their families’ and friends’ visits. The relocation from home to a RCF is considered “social surgery” (Rosen & Kostic, 1957).

Elderly residents want to keep their social connections through the visits from their family members and friends. Time-consuming ways to visit will definitely reduce the potential of family members’ and friends’ visits and caregiving for the elderly residents.

The results also show that characteristics of elderly residents, such as their health status, life experiences, social economic status, and working experiences are important factors for elderly people to get along well with each other and share interests. Elderly residents prefer to live with healthy elderly people rather than those elderly people without self care ability. Old friends and acquaintances living in the same RCF helps to keep elderly residents’ former social connections. Various social activities, such as visits by volunteers, collective outgoings, and parties with high school and university students in and out of the RCF, help elderly residents keep their social connections.

The managers are really warm-hearted and care about us . . . . Most of the residents here were well educated and used to be cadres in their former workplaces . . . . We can get along well with each other because we have similar experiences . . . . Some of my old friends and colleagues also live here. (An elderly resident)
6.3.5 The socio-managerial environment

The socio-managerial environment of RCFs is also important for elderly people’s access to residential care resources. The reputation of the RCF, quality of services, management, social activities, and social connections affect elderly people’s decision making process of relocation and their well-being after the relocation. Many elderly residents consider the socio-managerial environment of a RCF more important than the built environment and amenities. RCFs provide services for elderly residents, such as food service, laundry, and room cleaning. Among all the services, the food services generate most consideration. The food service provided by RCFs is usually shared meals. Some elderly people are satisfied with the meals provided in RCFs, which saves their time and energy on food preparation. Some elderly people suggest the food services need to be improved. The shared meals limit elderly residents’ choice of food and the way food is cooked, especially for elderly people who have food allergies and health related limitations. Some elderly residents have strategies to buy some food or cook some simple meals to overcome the limitations of shared meals. In this case, cafeteria-style or buffet-style service works better for elderly residents, but the cost is more expensive than shared meals.

I am quite satisfied with the food services here. Staff work hard on the food preparation. They try to match vegetable and meat in each meal and they change the menu every week. We always have fresh meals on time . . . Before I moved to the RCF, I skipped my meals sometime because of being tired of cooking. (An elderly resident)

It is hard to satisfy everyone. Some elderly people may prefer rice to noodle and some may prefer soft cooked food to hard food because of their teeth problem. Food is wasted if someone cannot take certain kinds of food because of their health problem . . . . I cannot eat tofu, sea food, spinach, and beans . . . . For example, I cannot have two dishes out of three dishes provided yesterday. I ended up with going out to buy something else for my meal. (An elderly resident)
Management of staff members and elderly residents in RCFs play important roles in elderly resident’s access to residential care resources. Some elderly people have concerns about the security of the RCF because of the loose management at the RCF entrance. Some elderly residents find it is difficult to put forward suggestions and improve the service quality in large RCFs. Their suggestions are not taken into consideration sometimes because the suggestions do not reach managers. Lack of professional training to staff limits service quality and the variety of services being offered. The relationship between staff and elderly residents also affects elderly residents’ utilization of services. Elderly residents find it is difficult to get detailed information on management when they come to visit before they move in. Some elderly people chose to move to another RCF after a short stay in one RCF if they were not satisfied with management or the services being offered. For family members, good communication with care staff in RCFs and the extent to which they are kept informed of situations and changes in elderly residents are crucial to access residential care. Similar results are found in the study conducted by Milligan (2006).

6.4 Chapter Summary

The growing elderly population, the shortage of caregiving resources, and support from the government have all facilitated the development of residential care in Beijing. With the improvement of residential care in recent years, more and more elderly people choose residential care and the demand for residential care is increasing. Elderly people and their family members choose residential care because of the shortage of community
and home care resources and the advantages of residential care such as caregiving resources, and a better physical and social environment in RCFs. Elderly people’s relocation to RCFs helps them overcome their loneliness, shortage of caregivers and unpleasant physical and social environments in private homes. Access to residential care has more dimensions besides geographical access. Information access, economic access, socio-cultural access, and the socio-managerial environment of RCFs are also important to elderly people’s decision making.
Chapter 7 Well-being of Elderly Residents in Residential Care Facilities

7.1 Introduction

The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being” (1948, p.100). Later in the Ottawa Charter for Health Promotion, the WHO put forward a broader definition of health as “the ability to have and reach goals, meet personal needs, and cope with everyday life” (Center for Health Promotion, 2000, p.182). In the latter definition, emphasis is placed on the non-medical determinants of health as necessary for health (Raphael et al., 2001). Physical, social, and spiritual well-being, social connections, satisfaction in daily activities, and opportunities for leisure activities are determinants of the quality of life of elderly people (Center for Health Promotion, 2000).

Existing research shows that in some cases, elderly residents are satisfied with the care they receive. They enjoy a level of freedom, independence, and support that comes with living in RCFs. There are, however, some elderly residents who are dissatisfied with the care they receive. They often feel isolated from society living in such a restricted and constrained environment (Kayser-Jones, 1982).

Empirical studies confirm that the living environment is an important determinant of elderly people’s health and longevity (Gu et al., 2005). The concept of a “therapeutic landscapes” was first developed by Gesler (1992) to refer to “places that have achieved lasting reputations for providing physical, mental and spiritual healing” (Kearns & Gesler,
1998, p.8). Health geographers have argued for the importance of place with increasing attention for the meaning, experiences, and constructions of place and how place influence health (Kearns & Andrews, 2005). In a residential care setting, therapeutic landscapes play important roles in improving the well-being of elderly residents. The environment of RCFs and various social activities within the setting have profound subjective meanings for individuals and their health.

The last chapter explained the reasons why elderly people are more likely to choose residential care than before as well as the nature of their access to residential care resources in Beijing. Little is known, however, concerning the well-being of elderly residents in RCFs and how the environment of RCFs influences their health. This chapter aims to answer research question four: “how does the relocation to RCFs affect elderly people’s everyday activities and health?” The second part of this chapter focuses on the well-being of elderly residents in RCFs based on the interviews with them. The third part examines the factors which affect elderly resident’s well-being in RCFs and the relationship between elderly resident’s health and the environment in RCFs.

7.2 Well-being of Elderly Residents in RCFs

Existing research usually divides elderly people’s everyday activities into three primary types (Hodge, 2008). First are those basic personal maintenance and survival activities, such as bathing, dressing, eating, indoor transferring, toileting, and continence, termed as Activities of Daily Living (ADLs). The second type consists of those activities needed to support daily living, such as shopping, household chores, obtaining health care,
and walking or driving to these activities, which are called Instrumental Activities of Daily Living (IADLs). The third type is Leisure Activities, which include social, recreational, and spiritual activities both indoors and outdoors (Hodge, 2008).

Existing research also shows that the management and satisfaction of one’s everyday activities relates to quality of life. One’s well-being is affected by factors such as lifestyle, living conditions, and social networks (Gatrell, 2002). For elderly people, a life of quality is also affected by their personal capacity for self-care and a sense of security. They may choose to engage or disengage with particular activities and people to keep their past alive and adapt to the changes in their lives (Andrew & Phillips, 2004; Tornstam, 1989). Elderly residents in RCFs have multiple care needs, including physical care needs, social care needs, emotional needs, and spiritual needs (Milligan, 2006). A Chinese survey shows that elderly residents in RCFs are generally satisfied with the residential care services offered (Zhan, Liu, & Guan, 2006). Sixty-seven percent of elderly residents reported that their physical health improved after their relocation to RCFs. Almost 76 percent of elderly residents reported that their social and spiritual well-being improved after the relocation. Sixty-six percent of elderly residents expressed their preference for living in RCFs compared to at home (Zhan, Liu, & Guan, p.265).

In the interviews, the elderly RCF participants expressed similar views to those reported in the survey above. Most of the elderly residents interviewed are satisfied with their lives in the RCFs, with only a few residents expressing feelings of isolation and depression after their relocation. Some elderly residents even reported significant improvements to their health after their relocation.
My wife passed away almost 20 years ago. During these 20 years, I haven’t been feeling so well. I got anemia and heart disease, so I was sent to hospital every two or three months . . . . After moving here for one year and three months, I feel much better now. My anemia is gone. You know, my families and I are so happy with this. I guess, even 30,000 or 40,000 Yuan cannot exchange for my current health status if I stayed at home . . . . I am quite happy to live here. (An elderly resident)

Leisure activities organized by the RCFs and the well-scheduled daily life routine promote elderly residents’ physical, social, and psychological well-being. The leisure activities are diverse and elderly residents may choose to participate in the activities in which they are interested, such as singing, calligraphy, handcraft, reading group, writing group, gardening and so on. Collective life with other elderly people in RCFs provides elderly residents with more opportunities to communicate and share interests with their cohorts than living at home individually. In many ways, elderly residents involve themselves in various social activities and maintain their social connections within and out of the RCF. After the years of living in RCFs, some elderly residents have gotten used to the lifestyle in RCFs and have developed social connections and attachments to residential care life. These elderly residents view the RCFs as their new homes and are emotionally attached to the living environment of RCFs. Some elderly residents even spend the Chinese New Year in RCFs instead of going back to their original homes.

We (some family members of elderly residents) spent the Chinese New Year eve here (RCF) last year. We organized a potluck dinner with three elderly residents and the family members participated . . . . It was not a fancy dinner, but the atmosphere was lovely and comfortable. We were like a big family having New Year’s dinner together. (A family member)

During the interviews with the family members, they were asked about the changes of elderly residents’ daily lives after their relocation. Most family members reported that both their elderly parents (relatives) and themselves were satisfied with the services
provided in the RCFs. Some of the family members reported that the health of their elderly parents (relatives) improved and many were more likely to care about others than before after living collectively with other elderly people in the RCFs. The collective atmosphere in RCFs helps elderly residents build stronger personalities which enable them to cope with the changes and difficulties experienced in their older lives. Well organized leisure activities in RCFs and group living help elderly residents develop an active and healthy lifestyle.

We all can feel the change of my father. He gained some weight (he was too thin when he was at home). The most important thing is that his spiritual well-being has improved a lot. He used to avoid socializing with others because of his poor hearing and cataract. Now he starts to gain back the willingness to socialize with others after the relocation . . . . He reads newspapers and watches TV every day. It keeps him updated with the news and what is happening outside the RCF. (A family member)

The results from this research also show that a few elderly residents have low levels of interest in participating in any kind of social activities in the RCFs and have grown pessimistic about their futures with increasing anxieties about death. They feel lonely living in the RCFs because it is difficult for them to find emotional support there even from family and friends after relocation. The other change they mentioned is that their mobility has become restricted in some RCFs because of either the management or physical environment of the RCFs. They feel that they gradually lose their social connections with the outside world and with their former lives before relocation.

My wife and I lived in an apartment that belongs to my parents-in-law’s unit. After my wife died, I didn’t have place to live any more. If I have a home, I would not come here. Many residents come here because of the shortage of housing . . . . The space is limited here. It only provides a shelter for us, and I am scared to cross the
street outside of the RCF. I only walk around several times in the hall inside the RCF every day. (An elderly resident)

7.3 Health and Place in RCFs

Published work in English speaking countries shows that the effect of relocation is influenced by a number of factors such as their desirability to relocate, the physical and social environment of the RCF, the degree of disruption of the person’s social network, and the person’s health status (Joiner, 1991; LaRue et al., 1985; Reed et al., 2003). Forms of material and social deprivation such as poor physical environment, lack of participation in social activities, and a limited social network lead to poor health (Gatrell, 2002). The results from this research show that a RCF as a place with its “objective place characteristics and subjective place experiences” has significant influence on elderly residents’ physical, social, and spiritual well-being (Andrew & Phillips, 2004, p.192). Attachment to place involves physical, social, and psychological components (Rowles, 1983). Apart from the above, this research finds that the socio-economic status of elderly residents, their attitudes on aging and residential care, and family support also play important roles in their level of adaptation and well-being after the relocation from home to RCFs. These findings are elaborated on in the following sections.

7.3.1 Physical environment

First, certain kinds of natural and built landscapes within and around the RCF, such as Beijing courtyards, bungalows, gardens, parks, and green fields, are indentified as helpful for elderly residents to adapt to the RCF environment and promote their health.
Elderly residents mentioned how important physical landscapes are for their well-being. Mountain areas, gardens, water, and parks are reported as landscapes with positive meaning to elderly residents, whereas the noisy city environment, limited open space, and busy streets outside of the RCF are reported as places where they are more likely to have negative experiences. Some elderly residents view the pleasant natural landscapes in suburban areas as more likely to improve their well-being (especially psychological well-being) than at health care facilities within a noisy city environment.

I am tired of the noisy environment in the city. My home is very close to the hospital. I used to go to hospital frequently because I suffer from heart disease. Even I can easily access to the health care resources, I felt depressed and hopeless . . . I decided to move to a pleasant environment . . . The air is fresh, the water is clean, and the vegetables are organic here. I also enjoy the social environment of the RCF. I feel that my health gets improved. (An elderly resident)

Secondly, this research confirms the results from existing research, namely that building design influences residents’ well-being and the quality of care (Calkins, 2001; Keen, 1989; Netten, 1993). The micro-environment of private rooms, such as room location and design, also has effects on elderly residents’ well-being. Elderly residents reported that housing styles such as bungalows and Beijing courtyards are much easier for getting around and socializing with others as compared to apartment buildings. The results also confirm that elderly residents are more likely to use on-site common areas than separated facilities. Room distribution and design such as single rooms or shared rooms, including the room location and size, and the window direction of the room are reported as important determinants of elderly residents’ choice of relocation and well-being.

There are three rows of bungalows in the RCF. The hall of the first row faces the south (the windows of the rooms face the north), and the halls of the second and third rows face the north (the windows of the rooms face the south). I prefer my
room faced to the south, so I chose a room in the second row. Additionally, I chose my room in the middle of the row because the rooms which are close to the central hall are noisy when people are passing by, whilst the rooms at the end of the row which are close to the wall of the RCF have many bugs flying around . . . . (An elderly resident)

Not all RCFs in this study provided a positive environment. Some limited elderly residents’ mobility and have negative impacts on the experiences of their elderly residents. Lack of common areas and open space often reduces opportunities for interaction and socializing among elderly residents. For example, one of the study sites is a bungalow located in a residential quarters surrounded by tall apartment buildings. The RCF offers 32 beds within two-bed, three-bed, and four-bed units. The units are relatively small for sharing between two, three or four people. The lack of open space and the smell of disinfecting liquid often create discomfort for the elderly residents there. Elderly residents with and without self care ability are mixed and allocated in the same section in the bungalow because of limited space within the RCF. The hall is one of the few common spaces for residents, which is supposed to facilitate social interactions among elderly residents. Elderly residents sitting in the hall, however, seem reluctant to talk to others. Some of them spend hours every day sitting alone on the benches in the hall outside their rooms. The self-rated health status of elderly residents in this RCF is declining. Elderly residents feel isolated, depressed, and insignificant since their relocation. Upon seeing the significant limitations and challenges that entail with the incapacity to care for oneself, many elderly residents often feel discouraged and depressed thinking of their future. They view the RCF as a shelter in which to sleep and eat instead of a place for receiving care
and building a healthy lifestyle. They also show pessimism towards their later years and are often preoccupied with concerns about death.

Thirdly, common areas in RCFs facilitate social interactions among elderly residents. Research in English-speaking countries finds that one-site amenities and communal space enhances the opportunities for social interaction in a retirement community (Brenard et al., 2007). In this research, elderly participants also report places where they are more likely to engage in social interaction with other residents in the RCFs. For example, elderly residents report that the dining hall where they have meals together is a place for them to socialize. Sharing meals is a social and recreational activity and is thus an important aspect of care in residential life. The gardens and open space are also reported as places where elderly residents are likely to have positive experiences and social interactions. These places and the social activities in which they partake become an important part of elderly residents’ social life in the RCFs.

I prefer having meals with other residents in the dining hall to having meals alone in my room. Having meals with others breaks my loneliness. Having meals is a simple thing, but it can be quite different depending on where and whom you have meal with. People have appetite when they are happy . . . . Having meals together makes me quite happy. (An elderly resident)

We often get together at the corridor in the garden after lunch when the weather is good. Someone will volunteer to tell a story. It does not matter if you are professional or not, just for fun. We always have a good time there. After the story, we go back to our individual rooms, take a nap or do other things. (An elderly resident)
7.3.2 Social environment

The concept of “therapeutic landscapes” (Gesler, 1992, p.735) emphasizes the power of place, and specifically how place interacts with a combination of physical, social, and individual factors to shape the outcomes of health beliefs and the experiences of well-being (Gesler, 1992). The results from this research also confirm that therapeutic landscapes are not only influenced by natural and built environments, but are also related to the social environment of the RCFs, especially their subjective meanings to individuals (Andrews & Kearns, 2005). Therapeutic landscapes reflect both human subjectivities and social structures. The formation of therapeutic landscapes is thus a dynamic process interplayed by physical, social and individual factors (Gesler, 1982).

If one wants to gain longevity, he should acclimatize to the environment. The outer environment is nature, and the inner environment is one’s body. It is like a small universe. When the two environments syncretise and harmonise, one can achieve well-being . . . . Different people, however, have different preferences. People have different lifestyles and habits. Some residents care more about food, some care more about housing, whereas some care more about the natural or social environment. We came here for the fresh air and clean water. We take long walks . . . . The spiritual life is also important. I read and learn new things, and she studies her sutra . . . . The environment improves my health. (An elderly resident)

Apart from the physical environment, the social environment is also crucial to the well-being of elderly residents. The results show that social activities, management, together with service quality and utilization are important components of the social environment in a RCF. The well-being of elderly residents is related to the social connections between pre-relocation and post-relocation lives within a certain physical environment (Elliott, 1995).
The social activities organized within and outside of RCFs affect the well-being of elderly residents in RCFs. In general, existing research proves that social contacts and various forms of social support are important to the independence and well-being of elderly residents (Andrew & Phillips, 2004; Clark et al., 1996; Hodge, 2008). Activities are useful to enhance a resident’s quality of life and psychological well-being. This research confirms that social activities organized by RCFs are helpful for elderly residents to adapt to the relocation from home to RCFs. Diverse social activities, such as singing, calligraphy, painting, reading groups, discussion groups, performances, and weaving classes, are provided to enrich elderly residents’ daily life based on their interests. Morning exercises, such as tai-chi and dancing programmes, encourage elderly residents to keep fit daily. Certain activities are highly valued among elderly residents, such as performances during festivals, monthly mass birthday parties, and monthly newspaper publication. All these activities encourage elderly residents to participate actively and be involved in the social network of collective life in RCFs.

After several years of experience, we developed different activities and kept those popular ones going. For example, we have the monthly birthday party at the first weekend of each month to celebrate the birthdays of elderly residents in that month. We get together to share a birthday cake, make our best wishes and sing songs to them. Family members are also invited. The other special thing we do is to publish a monthly newspaper. All the manuscripts are written and submitted by our elderly residents. Some of them are really good writers. They write comments about news they heard of, about lives in the RCFs, all kinds of stuff. They are really happy to see their words printed out in the newspapers. (A RCF manager)

To meet the spiritual needs of elderly residents, some RCFs provide special rooms for practicing Buddhist and Christian religious activities. Volunteer groups from different organizations, universities, high schools, and primary schools also have connections with RCFs. Volunteers come to visit and perform for elderly residents in RCFs. Meanwhile,
elderly residents organize various symposia for the young people and tell them about their life stories. Some RCFs have agreements with communities and local governments to be education bases for young people.

The outcome of these activities, either through the crafts they make or the role they play in educating the young generation, make elderly residents feel valued and helps to boost their esteem levels. The social activities also help elderly residents maintain connections between their pre-residential life and post-residential life. It is the quality and not the quantity of activity that is important to the elderly residents. Social activities of poor quality can not only be boring but also demanding for elderly residents (Kayser-Jones, 1982).

Volunteers come to visit frequently. They come to talk to or perform for the elderly residents. We also organize visits for elderly residents to different universities and schools. Sometimes, we get invited to attend some big events at universities . . . . It is a kind of mutual communication. (A RCF manager)

Social activities outside of RCFs are highly valued by elderly residents. Restrictions to mobility and the lack of social connections were several concerns among elderly residents and their family members before relocation. As Rosen and Kostic (1957) suggested, institutionalization may be perceived as an act of “social surgery” on the part of elderly residents. Therefore, short trips, visits to schools or universities, and various other kinds of activities outside the RCFs help to keep elderly residents active in maintaining their social connections and not isolated and segregated within the RCFs. Some restrictions on elderly residents’ mobility are carried out for security reasons. RCFs have various rules related to their management which will be discussed in the later sections.
During the spring and fall, the RCF organizes some trips. We all enjoy such kind of activities. Last time, the RCF rented a bus and drove us around the second and third ring roads of Beijing. I was so excited about this. I lived in Beijing for several decades, and it was the first time for me to see the dramatic changes of Beijing during these years. (An elderly resident)

Existing research shows that as people get older, their activities possibly become increasingly restricted by health and/or other factors (Hodge, 2008). Especially, limitations to mobility have significant impacts on the well-being of elderly people. This research also found that the activities provided by RCFs are adjusted to the variation of elderly residents’ health status. Some elderly participants reported that the activities organized by the RCFs have changed over time as the proportion of residents became older, together with the increasing numbers of residents. Some activities were cancelled either because of poor health among the residents or the increasing costs of the activities. The intensity of engagement in activities is also affected by the changes in one’s health status. Some elderly residents may still be willing to participate in certain activities even as their health declines over time, but at a lower level of intensity.

In the first few years here, we had more exercises together as compared to now. We are getting old. Less and less people get up to join in the morning exercises. Some of us just walk around in the yard in the morning . . . . The RCF used to organize for us to go to the golf course and do fruit picking in orchards. This year we don’t have any trips like that. (An elderly resident)

Secondly, the management system constitutes an important part of the social environment of RCFs and has significant impacts on elderly residents’ well-being. The “residential care versus community care debate” (Andrews & Phillips, 2002, p. 64) indicates that the inability of RCFs to provide independence for the elderly residents is one of the main criticisms of residential care (Andrews & Phillips, 2002). The level of
restriction to elderly residents’ mobility is considered an important aspect of independence, which is one of the concerns of RCFs managers. As a vulnerable group, elderly residents are likely to encounter accidents such as fractures, falls, choking, becoming lost, or even sudden death in RCFs. In order to minimize the risks of accidents, some RCFs resort to taking precautionary actions that may have negative effects on elderly residents’ well-being, such as those which restrict their level of independence. For example, the staff may decrease the frequency of baths for elderly residents so as to avoid scalding. Elderly residents may have fish excluded in their meals to prevent accidents with fish bones. Staff may also discourage elderly residents with impairments from getting off their beds and moving around to avoid falls (Li et al., 2007). The results from this research are generally positive. Most elderly residents evaluate their lives in the RCFs as being well organized with the freedom to participate in activities that they prefer. Some participants reported that they had negative experiences before living in other RCFs, which caused them to relocate from one RCF to another.

The results also show that the management of staff members is important for elderly residents’ service utilization and well-being. Existing research proves that low salaries, long working hours, and poor working conditions make caregivers reluctant to work in the RCFs (Bartlett & Phillips, 1995; Matosevic, Knapp, Kendall, Henderson, & Fernandez, 2007). This research confirms that the professional training of staff members, their working attitudes, and job satisfaction may affect the quality of service provided. Staff member’s lack of motivation and high frequency change over in and out of the industry also affect the quality of care. More details about the industry regulations and management of staff members will be explained in the next chapter.
The chefs change frequently. The current chefs have been here only for three months. The worst time was last fall, even the manager had to help with the kitchen occasionally . . . . The chefs are paid very low. That’s why they don’t want to stay long and we cannot have good meals . . . . There are not much professional training for staff members. They don’t know much about how to care for the elderly residents, especially to those who need special care . . . . Two staff members were sent to workshops for training last year, but they left for better pay in another RCF soon after they finished the training. (An elderly resident)

Thirdly, service quality and service utilization are important factors that affect elderly residents’ well-being. While the physical environment is of undeniable importance, it is the actual care provided that has the most significant impact on residents’ quality of life (Bartlett & Phillips, 1995). Access to services and service quality exert an important influence on elderly people’s quality of life including life satisfaction and physical, social, and psychological well-being (Holmen et al., 1994; Hubbard et al., 2003; Traupmann et al., 1992). As already mentioned, having a meal together is an important event for many elderly residents and good food can greatly contribute to their quality of life (Kayser-Jones, 1982). The food service (one of the services mentioned most frequently by elderly residents) is more than just an everyday activity for many residents, and carries with it social meaning that extends beyond the daily routine. Some elderly people commented on the high quality of food they are served. Some reported that they would not eat as well if they were living at home. Meanwhile, some elderly participants were dissatisfied with the food service being provided. They complained about the poor quality of food and the lack of choices. The next chapter will discuss how regulations and inspections can be helpful in improving the quality of service in the RCFs.
7.3.3 Individual factors - elderly residents

In environmental gerontology, there is a concept, “environmental press” which relates Behavioral demand to the environment (Hodge, 2008; Nahemow, 2000). Upon relocation to RCFs, elderly people respond to the environmental press of a RCF by adapting to it. Whether and to what degree the adaptation occurs depends on individual capabilities. This research finds that personal characteristics, health status, and attitudes on aging and the residential care of elderly residents are important determinants of well-being.

First, individual characteristics including the personalities and social skills of the elderly residents are important for their physical, social, and psychological well-being in RCFs. On an aggregate level, elderly residents tend to share similar experiences with others within the same age cohort, which creates a common ground for group conversations and bonding. On an individual level, subjective experiences concerning family relationships, schooling, and work experience also play a significant role in the shaping of one’s life course (Settersten & Mayer, 1997). Elderly residents’ personalities and social skills have direct effects on their social network within the RCF (Power, 1992). The harmony of the social network is crucial for one’s well-being.

Most elderly residents interviewed report that it is easier for them to live with others with similar characteristics, life experiences, and socio-economic status. Once elderly residents move to one RCF, many tend to stay there for years unless the services provided by RCFs cannot meet their demands. This situation implies the importance of harmony among the residents if the RCFs want to keep their clients.
Some elderly residents share two-bed rooms with others. Some of them can get along well with each other, but it does not happen to everyone. Two elderly residents left the RCFs recently because they cannot get along well with their roommates. The manager tried to change rooms for them, but it did not work out. The manager can only inform the family members to take them home, though they don’t have anybody to care for them at home. They don’t have any choice but to leave, because they were always quarreling with their roommates when they lived here. (An elderly resident)

Secondly, a decline in an elderly resident’s health status affects their daily life activities. The decline in one’s health status (e.g., the decline of eye sight, hearing, and walking ability) may limit their mobility, decrease their social interactions with other residents, and constrain them within the RCFs (Bernard et al., 2007; Hodge, 2008). As mentioned before, this research shows that social activities change with the decline of elderly residents’ health status. For example, elderly residents report that they stopped writing because of their degraded eyesight. Their choice of food becomes limited because of dental problems and various food restrictions related to diseases. Decreasing levels of strength and agility also pose significant constraints upon their movement. Besides these changes, they also report occasional fainting spells and decreasing hearing ability, which affect their communication with others.

In only about two or three years, I cannot walk properly anymore, and my eyesight gets poor too. I had surgeries on both of my pearl eyes. I stopped my writing a few years ago . . . , now I have to sit in wheelchairs when I want to go out, but I insist on doing some exercises every day. I guess my body will get worse if I don’t do that. (An elderly resident)

Thirdly, attitudes on aging and residential care are one of the most important aspects that affect elderly residents’ well-being. One’s attitude to awareness of self, sense of control, and focus on others affect the optimistic or pessimistic evaluations of one’s
self-rated health (Bryant, Corbett, & Kutner, 2001). The WHO put forward the concept of “active aging”, which refers to “the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age” (WHO, 2002, p.12). The term “active” refers to continual participation in social, economic, cultural, and spiritual activities (Andrew & Phillips, 2004, p.58). A related concept “successful aging” refers to successful adjustment—mostly psychological adjustment to aging—while maximising one’s desired outcomes and minimising those which are undesired (Andrew & Phillips, 2004, p.58; Rowe & Kahn, 1998). The new models of active and successful aging posit that the quality of life of elderly people does not only depend on their physical and mental health but also on their morale, life satisfaction, and engagement with life (Kristjanson et al., 2003; Menec, 2003). Both active aging and successful aging may have a cumulative effect in extending one’s healthy life expectancy, which can provide mutual benefits to individuals and society.

The results from this research show the positive impacts of active attitudes towards aging and residential care. Some elderly participants report that active attitudes play an important role in their adaptation to being relocated in RCFs. Those who actively adapt to their elderly life often consider residential care as a way to relieve themselves from the heavy demands of housework because of declining energy levels that come with aging. Active participation in a well-scheduled daily routine is helpful for their health maintenance and healing. They can spend more time on maintaining or developing further interests after their relocation, such as singing, calligraphy, handcraft, and gardening. Some of them clean their rooms and do their laundry even though these services are offered. They take housekeeping chores as a form of exercise to maintain their
Active participation in these activities does not only help elderly residents adjust to the transition of the relocation and their life change, but also helps to maintain or improve their physical and psychological well-being.

The willingness to relocate and attitudes on collective life may affect the adjustment to the transition, which is important for the well-being of elderly residents. Active and positive attitudes in adapting to the new life in RCFs after relocation is helpful for meeting the challenges of living in RCFs. Various strategies are taken by elderly residents to manage their lives in RCFs. For example, elderly residents keep searching for better RCFs if they are not satisfied with the current one. Some elderly residents also hire hourly caregivers to offer additional services to them in the RCFs. Some elderly residents occasionally cook simple meals or buy food outside of the RCF if the provided meals do not suit their tastes. Rather than being passively “placed” in a RCF, some elderly residents actually “live” in the RCF, where they make active choices, decisions, and judgments about their living environment (Andrew & Phillips, 2004). Additionally, some elderly residents participate in community affairs where the RCFs is located. These elderly residents continue to contribute to society with their expertise after the relocation.

Taking care of my plants, reading books and newspapers, playing chess, and attending chorus are my daytime activities here. I go dancing in the park almost every evening . . . . I am quite famous for my singing here (laughing), and I encourage other elderly residents to sing with me. People can always hear us singing in our RCF. I have taught them more than 10 songs, and we perform some of them when people come to visit or on festivals. I wrote a song for our RCF and it becomes the indispensible song in our performance every time . . . . The principal of the school next to our RCF always hear our singing and he wanted to hire me as the music class teacher for the students. I wrote a song for the school and taught there for a year. (An elderly resident)
Cultural values of filial piety and Confucianism have traditionally played an influential role in shaping the long-standing negative perceptions of residential care shared by both elderly people and their family members in Chinese society. When the children are young, parents provide care for their children, but as the parents age, they become the recipients of care from their adult children. The public puts pressure on family members who relocate their elderly parents in RCFs, casting it instead as a way of shrugging off their filial obligations. With the socio-cultural changes in recent decades in China, the stigma of residential care is breaking down gradually. Notwithstanding these changes, certain members of the public, including some elderly residents and their family members, still have ambivalent attitudes towards residential care. For elderly people, some of them choose residential care as a preferred choice to enhance the quality of their elderly life; some choose residential care as a strategy to relieve the burden of caregiving on their family members; and others, on the other hand, are reluctant to move and resent being abandoned by their families. Elderly people’s conception of residential care affects their willingness to move, as well as their transition process and well-being after the relocation. For family members, some of them have positive attitudes toward residential care and continue to provide all kinds of supports, especially social and emotional supports, for their elderly parents after the relocation. Some family members are negative about residential care or choose to reduce their supports after their elderly relatives’ relocation. Both elderly residents and their family members’ attitudes towards aging and residential care affect the relocation of elderly residents and their well-being afterwards in both direct and indirect ways.
7.3.4 Individual factors - family members

Existing studies show that the amount of informal support that can be provided by adult children is based on geographical distance, closeness of relationships, and the economic status of adult children (Ng et al., 2002). Increasing work opportunities, especially among women, weaken the caring capability of informal caregivers. Evidence shows, however, that women are still more likely to be caregivers for elderly people than men. Women play an important caregiving role in the daily care and emotional support for elderly people. Furthermore, research in Asian societies finds that obligations to filial piety continue to persist even with the recent dramatic socio-economic changes, albeit in an apparently modified form (Ng et al., 2002). Even for the adult children whose elderly parents move to a RCF, their responsibilities still continue. Family members usually continue to support their elderly relatives in various ways after their relocation, and the continued involvement of family members may influence the quality of care received by elderly residents. To engage informal family caregivers in caregiving to elderly residents is effective in improving their quality of life in RCFs (Gladstone, Dupuis & Wexler, 2006; Milligan, 2006).

In this research, all the family members interviewed report that residential care reduces their burden of caregiving to their elderly relatives. Family members indicate that they realize the importance of continued support, especially emotional support to their elderly relatives after the relocation. This research shows similar findings with Milligan’s (2006) study that family caregivers undertake a wide range of tasks within RCFs. Firstly, family members engage in a range of physical care tasks such as bathing, laundering,
providing bedding, and shopping. Secondly, family members undertake social care tasks, which include financial support, visiting, chatting, and taking the elderly residents out for social activities or to family events. Thirdly, emotional support from family members is valued as the most important form of support for elderly residents. Visiting and engaging in conversations are helpful for elderly residents in adapting. Emotional support also helps elderly residents be positive and active in their elderly life. Fourthly, family members undertake an important monitoring role checking on the quality of care given to the residents. Sometimes, family members also help other residents they get to know, which is especially significant for those who have few visitors (Gladstone et al., 2006; Milligan, 2006). Some family members also have considerable knowledge and experience about the care needs of their elderly family members. Recognition of their expertise by staff members in RCFs can be important in facilitating the quality of care given. Taking advantage of family members’ knowledge of the elderly residents, staff members can offer better physical care to elderly residents, whilst family members offer emotional support and crucial insights into the social and biographical background of the elderly residents. The cooperation of staff members and family members can contribute to the overall quality of care which elderly residents receive.

Every week, I bring her some magazines and newspapers when I come to visit. Sometimes, I take her out for lunch or take her home for a few days during the holidays. She always waits for me and checks through the window when she knows I am on my way to visit her. She likes me to come and talk to her . . . She can manage almost everything. I help her do some laundry and wash her hair . . . I bought her a kettle, which can get hot water just by pressing the button. She cannot use the kettle provided by the RCF, because her hand has a shaking problem. I also got her a cell phone . . . I always bring extra food to share with other elderly residents and staffs when I come to visit. (A family member)
Most family members, however, are unable to visit their elderly relatives and care for them every day because of other social and family obligations in their life. Some family members report that they developed strategies to maximise the support given to their elderly relatives after their relocation. The adult children take turns to visit their elderly parents in RCFs. Some of the adult children contribute more financial support, while others provide more social and emotional support, depending on the different situations of their life.

Both my mother-in-law and my dad live in this RCF. My dad is a quiet person, but my mother-in-law is quite outgoing, so their characteristics are complementary. The good thing for us is that they can keep an eye on each other in the RCF. My mother-in-law has four children and my dad also has four. So we eight children can take turns to visit the two elderly parents here. It makes things much easier and reduces the care burden on us. (A family member)

7.4 Chapter Summary

The results show that most of the elderly residents interviewed are satisfied with their lives in RCFs. Many of them report that their physical, social, and spiritual well-being improved after their relocation to RCFs. A few of them, however, feel isolated and depressed after their relocation. The physical and social environment of a RCF as well as individual characteristics and attitudes are of vital importance to elderly residents’ well-being. Elderly residents’ attachment to RCFs has physical, social, and psychological meanings.

Each RCF, as a place with its unique physical and social environment, exerts a significant influence on the elderly residents’ physical, social, and psychological well-
being. The therapeutic landscape of RCFs is not only composed of the natural and built environments, but also by the socio-cultural environments of these places attached to individual subjective meanings. Elderly residents tend to be affected by the local living environment as well as the nature of the facilities and services in RCFs. The interior environment had a greater impact on their residential satisfaction than the exterior environment. The role of environmental factors and the relation to elderly residents’ psychological well-being depends on the extent to which a person’s expectations of residential care are met. The subjective environment has a greater influence than the objective environment. The more favourable the environment, the more positive impacts it has on the psychological well-being of elderly residents (Phillips et al., 2005).

Besides these factors, the characteristics of elderly residents, their attitudes on aging and residential care, and family support also play important roles in their adaptation and well-being after the relocation from home to RCF. The results confirm the findings from other research that as people age, they tend to use psychological strategies rather than action-based strategies to deal with the challenges they meet. The maintenance of a sense of control and positive self-esteem of elderly residents are important to their successful adaptation (Andrew & Phillips, 2004). Building up elderly residents’ self-esteem and feelings of self-worth and engaging family members to participate in caregiving is helpful in improving the quality of life of elderly residents.

The positive and active attitudes towards aging and residential care are crucial for the well-being of elderly residents. The active aging model has proven to be effective for promoting the well-being of elderly residents in RCFs. The results suggest that the
implication of the active aging model needs the mutual efforts of the government, RCFs, and individuals. This study aims to understand the socio-cultural meanings of aging and residential care to Chinese elderly residents and their family members. These meanings attached with the environments of RCFs affect the well-being of elderly residents and form the unique residential care for elderly people in China. This chapter has answered the question of “how does the relocation to RCFs affect elderly people’s everyday activities and health?” from various perspectives. The next chapter will discuss the challenges of residential care faced by the government, community, and RCFs. It also aims to provide suggestions for meeting the current and future challenges of residential care in Beijing.
Chapter 8 Challenges of Residential Care in Beijing

8.1 Introduction

Equity, equality, efficiency, and effectiveness are important aspects in the research, planning, and policy making of social welfare systems including health care. Equality refers to the services being provided uniformly to the population they are designed to serve. Equity is concerned about to what extent services are being provided to those who need them. Geographically, equality suggests that there should be an even distribution of services per head of population, but what matter more is equality in relation to need which is understood as equity (Gatrell, 2002). Efficiency refers to how to provide services that maximize health benefits while minimizing the cost. Effectiveness means the treatments offered have real benefits.

Equitable access to care resources by care recipients, equal access to government support by RCFs with various forms of ownership, the efficient allocation of care resources, and effective utilization of care services are all goals which the government and RCFs try to achieve. All these issues, however, are embedded in the social structure of Chinese society. In the recent three decades, Chinese socio-economic reform has emphasized growth of the private sector with considerable reduction in collective social provision. Under such circumstances, individual families are likely to take on increasing responsibility for elder care in the future (Bartlett & Phillips, 1997). The extent to which the current residential care industry may function as a complementary resource for elder care beside traditional home care is not sufficiently researched and understood by both
academic researchers and policy makers. This chapter aims to understand the current and future challenges of the residential care industry under recent social welfare reform, especially challenges faced by the private sector. It also aims to provide suggestions to meet these challenges. The specific research questions this chapter aims to answer are Question Five: “what current and future challenges of residential care do the government and RCFs face?” and Question Six: “what changes are needed for policy to meet the current and future challenges in residential care?”

In this research, relevant government documents for understanding social welfare reform and government support of residential care were collected (see Appendix 1) and analyzed. Besides these policy documents, the interviews with RCFs managers, elderly residents, and family members also help to identify the challenges faced by RCFs and the government from various perspectives. Some successful models in practice developed by individual RCFs provide good examples for other RCFs for future development. The next part of this chapter focuses on the challenges in the residential care industry faced by the government and RCFs. The third part provides some suggestions to meet these challenges.

8.2 Challenges in the Management of the Residential Care Industry

The Chinese government started to recognize the importance of improving elder care in the early 1980s. In 1983, the State Council of China founded the Chinese National Committee on Aging in order to address issues related to population aging and elder care. The government has invested substantially in developing residential care since 1984. The history of the current residential care industry, however, is short in China. With the dramatic demographic, economic, and socio-cultural changes in recent decades, the
residential care industry faces many challenges in its development. These challenges were verified in the interviews with RCF managers, elderly residents, and family members in this research. From the analysis of the interviews, three categories of challenges are identified: i) government policies and support mechanisms; ii) RCF planning and design; and iii) management of RCF, respectively. The rest of this section examines these challenges in detail.

8.2.1 Government policies and support mechanisms

Government policies and support mechanisms are important for the development of the residential care industry as it is a social welfare industry. Both the central government and Beijing local government highlighted the necessity to improve the residential care industry in their national and regional development plans. In 2001 and 2006, the State Council promulgated The 10th Five-Year Plan on Elder Care of China (2001-2005) (State Council of China, 2001) and The 11th Five-Year Plan on Elder Care of China (2006-2010), (China National Committee on Aging, 2006). In 2006, the State Council Information Office of China (2006) published a White Paper for the Development of Elder Care of China. The Beijing local government also promulgated a relevant plan of elder care as part of its whole socio-economic plan. The central and local governments also created some preferential policies to support the development of the residential care industry. These preferential policies include policies on the leasehold of land use, utilities preferences, allowance for occupied beds, tax exemptions, and investment from NGOs and the private sector. For example, in 2000, the Central Government and State Council (2000) put
forward *The Decision on Improving Elder Care* and required that a certain proportion of lottery revenue should be invested in improving elder care. The Ministry of Finance and State Administration of Taxation of China (2000) enacted a *Notice of the State Administration of Taxation on Relevant Tax Refund (Exemption) Issues Concerning Residential Care Facilities* to exempt income, housing, and land tax. In 2008, the Beijing Municipal Bureau of Civil Affairs et al. (2008) released *Notice on Accelerating the Development of Residential Care Facilities*. This *Notice* notes that any RCF can receive an allowance of 8,000 to 16,000 Yuan for each increased new bed since 2009.

In practice, the development of residential care faces various kinds of challenges even with the support from the government. Among all the challenges of running RCFs, RCF managers are most concerned about government policies and types of support. All types of RCFs face some common challenges such as the lack of industry regulations, collaboration among various administrative departments, and a unified social welfare system. Government preferential policies may, however, have different effects on RCFs based on their types of ownership, funding sources, and management models.

While the central and local governments have already created some regulations for the residential care industry, many practical industry regulations have not been formed, which has limited the rapid development and performance of this industry. For example, the Ministry of Civil Affairs (1997, 2001) promulgated the *Temporary Management Measures on RCFs in Rural Areas* and *Basic Criterion for RCFs* in 1997 and 2001. From 2000 to 2005, the Beijing Municipal Bureau of Civil Affairs and Beijing Bureau of Quality and Technical Supervision (2000, 2002, 2004, 2005) implemented several management
regulations and evaluation standards for RCFs services, such as *The Management Regulations on RCFs in Beijing* in 2000, *The Standard of RCFs Service Quality* in 2002, *The Standard of Service Quality Control of Clinics in RCFs of Beijing* in 2004, and *The Evaluation Standards for Elderly Health in RCFs of Beijing* in 2005. The results from the interviews with RCFs managers, however, show that most of the regulations have not been put into practice. Even the managers who have been working in this industry for many years report that it is difficult for them to find any practical regulations to follow. The lack of practical regulations results in the variation in the quality of facilities and services among different RCFs.

Industry regulations are necessary. Now there is nothing to follow. It is difficult for the development of RCFs. Some traditional community facilities have been founded for 10 years, 20 years, or even longer, but the facilities and services have not been improved very much (a community RCF manager).

There should be a practical regulation for us to follow. The Civil Affair Bureau organized workshops for RCF managers several times, but we don’t feel we gained much out of the workshops. For example, how should we manage our staff? How different should the services for elderly residents with self-care ability be compared to those without? We need a uniform and practical regulation to train our staff members (a community RCF manager).

Secondly, the level of communication and collaboration between different administrative departments as well as between government administrators and RCFs are deficient. At the administration level, different departments are responsible for various issues related to RCFs. In the Chinese system, the central and local Civil Affairs Administrations are in charge of residential care. The Civil Affairs Administrations, however, cannot meet some of the challenges RCFs face which are under the responsibility
of other administrative departments. For example, some private RCFs face challenges related to land use when they want to expand but the Bureau of Land and Resources is in charge of land use not the Ministry of Civil Affairs. The lack of collaboration between the two departments is inefficient for the management and their ability to resolve these challenges. Meanwhile, the communication between the administration and RCFs is deficient too. RCF managers, especially managers from private RCFs report that they have difficulties being heard at the administrative level. The lack of communication decreases the chances of meeting the existing challenges and getting support from the government. Workshops organized by the administration are one of the ways to facilitate communication between the administration and RCFs. The effectiveness of such workshops is, however, questioned by RCF managers.

At the beginning, we were excited to participate in such workshops. It was not free, sometimes we paid 2,000-3,000 Yuan to go. We thought it could be a good chance for us to have a conversation with the administration. . . . I always passionately talked about my experiences when I got the chance. But we found out that the policy makers or administrative officials would only show up and give talks at the opening and closing sessions. When we got the chance to talk and discuss, they were gone and only the RCF managers stayed there. No one listened to us about the challenges and suggestions . . . . What’s the point of the workshops? There is no communication between the administrators and RCF managers (a RCF manager).

Thirdly, the current social welfare system is still under reform both locally and nationally in Beijing and China, and the system varies between rural and urban areas. Most elderly people with urban household registration are covered by pensions and health care insurance, whereas only a small proportion of elderly people with rural household registration are covered by either pension or health care insurance. Health care insurance
varies even among elderly people with urban household registration. Access to health services can take place either in the RCF assuming in-house health care services are available and covered by the person’s health insurance or at appointed hospitals tied to the person’s health insurance.

The availability to provide in-house health care to elderly residents is another one of the challenges faced by RCFs managers, especially managers of private RCFs. Government operated RCFs use strategies to cooperate with hospitals in order to meet the needs of health care among their elderly residents. Most community RCFs either set up clinics to provide in-house health care or cooperate with nearby community clinics. Compared with the government operated RCFs and community RCFs, private RCFs have less available and accessible health care resources. Under the current health care system, the in-house health care resources in private RCFs may not be accessible to those elderly residents with health care insurance tied to the appointed hospitals. Some clinics in RCFs and sponsored by hospitals were abandoned for reasons such as hospital unwillingness to continue financial support for the RCF clinics or the rooms occupied by the clinics are changed to residences for accommodating more elderly residents.

Fourthly, the results show significant differences between government support and staff levels across RCFs by different ownership type. The amount of financial support varies among RCFs depending on factors such as the size and ownership of the RCFs. Government operated RCFs and community RCFs are more likely to get direct and indirect benefits from the government and communities than private RCFs. The public RCF managers all report that they received an annual allocation of funds from either the local government and/or community administrations, although the amount of funding
varies among RCFs. Local government and/or communities are responsible for the profits or losses of all government operated RCFs and some of the community RCFs. Some community RCFs managers report that they face financial difficulties because the small size of the RCFs places a significant constraint on profit-making. They, therefore, depend on the local government and communities for financial support in order to keep the RCFs running. Government support, especially financial support, favours public RCFs over private RCFs. Private RCF managers report they rarely received any direct financial support from the government. Meanwhile, private RCFs assume sole responsibility for profits or losses. Regarding staff capacity, care staff levels are significantly higher in government operated RCFs as compared to community and private RCFs. The findings are consistent with other research in English-speaking countries (Berta et al., 2005; Smith, 2004). The differences between private RCFs and public RCFs and the uncertainty of the future of private RCFs are concerns expressed by both elderly residents and their family members about their residential life.

Additionally, managers of government operated RCFs and some community RCFs are government employers, which provides them with greater access to the administration including the ability to harness the support needed to meet their challenges in contrast to the private RCFs managers. During the interviews with RCF managers, they reported the way in which they approach the communities and local government for support and how they receive these supports, especially in terms of a financial allowance. The two quotes below contrast the differences:

We make a plan for the maintenance and new purchase of the RCF at the beginning of each year, and submit the plan to community and local Civil Affairs Bureau. We
can receive financial support amounting to about 100,000 Yuan every year. Our managers are government employers, so it is easier for us to approach the local government and community compared to private RCF managers . . . we pay a preferential price for our utility expenses and we are exempted from income tax (a community RCF manager).

The government created preferential policies on the leasehold of land use. I signed my lease for 50 years about 10 years ago. The new Contract Law regulates that any contract can only be effective for 20 years for the longest. Now, I don’t know what would happen in 10 years. Will my contract still be effective . . . . We rarely receive any financial support from the government. Even the allowance for the occupied beds, we got the allowance of 2006 at the beginning of this year (2008) (a private RCF manager).

Private RCFs have adopted a range of strategies to deal with the challenges faced by intense market competition and their disadvantaged position in terms of access to government support. For example, in order to increase the occupancy rate, some private RCFs accept elderly residents with some or no self-care abilities, under the condition that these elderly residents hire special caregivers to live with them in the RCFs. In this way, RCFs are able to bear less responsibility if and when accidents do happen among these elderly residents. A second example is how private RCFs raise funds from its elderly residents. In order to supplement the limited financial resources available to private RCFs, they encourage investments and donations from elderly residents and family members. The living expenses of elderly residents can be deducted if they contribute to the funds collection. Additionally, private RCFs try to attract residents with their flexible management and well-organized social activities.
8.2.2 RCF planning and design

8.2.2.1. Geographical location

As discussed in Chapter 5, the mismatch between the distribution of the elderly population and RCF resources limits equitable and efficient access and utilization of residential care resources. Some elderly people want to move into RCFs close to their community, but they cannot find a suitable RCF. Residential care resources in central districts are unable to meet the demands of elderly people living there. Many RCFs in central districts are often fully occupied and have long waiting lists for places in them. The shortage of land in central districts also limits the expansion of existing RCFs. Compared to central districts, suburban and exurban districts have relatively abundant care resources. The average occupancy rate in these areas, for example, was less than 60 percent in 2007. Some investors from the private sector are interested in residential care industry and plan to develop more RCFs in Beijing, but because of the limited land resources in central districts, many of the new RCFs have been built in or are planned for suburban areas, which increases the competition among the RCFs in suburban areas. Many elderly residents are not willing to move to RCFs located in suburban areas, especially exurban areas, considering the geographical distance away from their former social networks. Some elderly residents choose to live in suburban and exurban RCFs only in the summer and move back to their homes for the rest of the year.
8.2.2.2. Built environment and facilities

The insufficient facilities and limited kinds of services restrict the future development of residential care. Many elderly residents are willing to move to the RCFs that have the capacity and are equipped with resources to meet their multiple care needs. Many of them prefer relocating to a RCF which can meet all kinds of care needs and stay in one RCF as long as possible. They are less willing to be relocated to different RCFs as their health status changes and care needs increase. Meanwhile, RCFs managers also want to improve their existing facilities and services in order to meet eligibility criteria to accept elderly residents with some or no self-care ability. Many RCFs, however, cannot meet the criteria and face difficulties for improvements. Some RCFs are rebuilt from old buildings and the space is limited for expansion, especially those located in central districts. At one study site, the common room of the RCF is located outside of the yard where residents live, which reduces the utilization of this common room by the residents. At another study site, there is only one public washroom for all of the residents in the RCF and the washroom is located at the corner of the yard. Elderly residents report difficulties accessing and using the washroom during the night and in the winter time. Additionally, some small-size RCFs changed some common space such as dining halls and common rooms into residences in order to accept more elderly residents. The lack of common space reduces the chance for social interaction and communication among elderly residents.

There is not much open space for us to use. The left end of this hall is the washroom, and the right end of this hall is the clinic. You can smell the odour and it is not very pleasant. The smell of the disinfecting liquid and washroom combines together . . . . I am afraid to go across the street outside of the yard, so I just walk
around in the hall three or four times a day. I sit down on the bench in the hall when I get tired (an elderly resident).

8.2.3 Management of RCFs

8.2.3.1. Management of the staff members

The results from this research show similar findings with existing research in English-speaking countries. Poor pay and working conditions lead to high levels of staff turnover (Eborall & Garmesan, 2001). Many care staff members are young, female, and low-paid. They frequently transit between different RCFs, or in and out of the industry (Holden, 2002; Phillips & Vincent, 1986, 1988). Meanwhile, a lot of staff members are from rural areas or were previously unemployed in urban areas. Professional training available to the staff members is limited. Some RCFs send their staff members for professional training in order to improve their care skills. Many trained staff members, however, often leave for better positions after the training. With minimum staff levels, many of the existing staff find themselves overworked, which significantly affects their job satisfaction levels.

Milligan (2006) noted that low pay makes it difficult to attract and retain skilled staff, whilst new staff requires more professional training. All these factors may have impacts on the elderly residents’ health outcomes. Discontinuity of care can be confusing for both elderly residents and their family members and may inhibit the ability to build good working relationships. New staff takes time to get familiar with the specific care needs of elderly residents. Whether these care needs are met may result in different health
outcomes for the elderly residents. Family members express concern over the unsatisfactory level of existing care practices as a result of inadequate staff levels. Similar issues can be found in Beijing RCFs.

8.2.3.2 Management of residents

The inability of RCFs to provide independence and choice for residents is one of the criticisms of residential care (Andrews & Phillips, 2002). In this research, RCF managers report challenges they face regarding how to manage elderly residents, preserve their independence, and protect their rights. Taking the notification for going out as an example, some RCFs have flexible regulations. Elderly residents can go out freely once they leave a message with staff members. Some RCFs, however, had several experiences with elderly residents getting lost. They, therefore, implemented strict regulations for residents leaving the RCF as a negative reaction to accidents that had happened in the past.

RCF managers also report that they face challenges concerning how to improve the quality of life for elderly residents including their morale, life satisfaction, and engagement with life. As mentioned in Chapter 7, some RCFs develop diverse social activities for elderly residents to adapt to and enjoy the collective life in RCFs. RCF managers generally report they often lack the experience and knowledge in terms of how to improve the quality of life and life satisfaction of elderly residents. Besides the management of residents, RCF managers face the challenge of engaging with family members regarding ways of improving the quality of life of elderly residents. Many family members continue
to play important roles in providing caregiving, especially emotional care for elderly residents after their relocation. RCF managers, however, report that some family members download all the care responsibilities onto the shoulders of RCF staff members. Some of the family members only come to the RCF once a month to pay for the living expenses of the elderly residents. The staff members often find it difficult to meet the emotional care needs of elderly residents even though they are responsible for their physical care.

8.3 Suggestions for Improvements and Policy Implications

The residential care industry as a social welfare industry should consider issues such as equity and efficiency in terms of resource distribution, needs-related utilization, quality and outcome of care, and the relations among them. The planning of the industry should pay greater attention to whom gets what resources, where do they get the resources, and how better to match the resources with existing needs, especially for the care for those with limited financial resources and those without families. Such knowledge can help policy making and residential care practice more knowledge-based decision-making (Bartlett & Phillips, 1997; Davies, 1994). Based on the interview data and the collection of policy documents, some successful models and suggestions are provided to meet some of the challenges that the residential care industry faces in Beijing.

8.3.1 Administration

Government interventions play an important role in providing equitable and efficient access to residential care for elderly people (Andrews & Phillips, 2002). The
debate on what roles the government should play and what responsibilities the government should take for developing the residential care industry has been going on both in policy making and academic research. In many countries, governments are facing a growing burden of expenses for elder care because of the increasing aging population and utilization of residential care. The expansion of private sector provision becomes one alternative choice to meet the increasing demands of residential care (Andrews & Phillips, 2002). Governments, however, need to understand what services elderly people need to consume, when they want them and how to obtain them, which are also the principles for the following suggestions.

First, more effort needs to be put on improving the implementation of existing policies and the cooperation among different administrative departments as well as between the administration and RCFs. Improvements in the cooperation between administration will help to meet the challenges that RCFs face, such as the example related to land lease of RCFs mentioned in the earlier section. A part from this, health care related affairs need the cooperation of the local Civil Affairs Bureau and Health Bureau. Improvements in the communication between administrative departments and RCFs, especially with private RCFs, will help the administration understand the challenges RCFs face, which also informs the support given to the RCFs to meet these challenges. There are, however, substantial difficulties in putting these suggestions into action.

To improve the lack of communication and collaboration, RCF managers advocate developing a residential care industry association. This suggestion has been well supported by most RCFs managers, especially those from small private RCFs. With the efforts by some RCFs managers, an unofficial association was developed and has already achieved
some successes in unionizing the residential care industry and meeting some of the challenges they face. For instance, the association negotiated and cooperated with an insurance company and successfully developed a RCF accidental insurance policy. The insurance takes responsibility for the risks of accidents for both elderly residents and RCFs. Another example of success is that the association formed a network to provide RCF information for the public, which has improved the information about residential care resources available for elderly people and their family members in Beijing.

The example of the unofficial association is a successful model to follow. The formation of an official association would be helpful in representing the needs and concerns of the residential care industry and facilitate conversation between the administration and RCFs. Additionally, such an association can also play a role in facilitating the implementation of existing preferential policies such as utility preferential pricing and different allowances for RCFs.

Secondly, developing different ways to provide financial support for the residential care industry is necessary. The government advocates developing residential care “by a combination of public and private sources” and “at various levels and through all channels” (State Council of China & Ministry of Civil Affairs, 2000, para.7). The ideal model is to develop a network of RCFs in each district and gradually cover the city. The model requires collaboration between all types of RCFs, including government operated RCFs, community RCFs, private RCFs, and publicly-owned and privately-run RCFs. “At various levels” implies that each city, district, street, and village should provide residential care resources for elderly people. It is recognized that the reliance on government subsidies will be insufficient to develop and run the network. Therefore, “through all
“channels” encourages not only the government but also communities, organizations, and the private sector should make an effort in organizing elderly welfare services (Bartlett & Phillips, 1997). The effective allocation and utilization of the social welfare lottery and an allowance for RCFs would be an important support to the residential care industry for its continual development. The development and management of RCFs cannot depend only on the government’s support, but needs the active involvement of RCFs in the face of market competition.

Thirdly, existing experiences from the government operated RCFs and private RCFs imply the necessity to develop new models of ownership as an efficient way to run RCFs. Many government operated RCFs depend on various financial supports from the government without efficient management of the funding, which places an increasing burden of expenses on the shoulders of the government. Meanwhile, private RCFs have expertise and skills in the management of RCFs, but they are more likely to face financial difficulties in terms of surviving in the face of market competition. A few years ago, the Beijing Municipal Bureau of Civil Affairs developed a new model of ownership to run RCFs, termed as publicly-owned and privately-run RCFs. After a few years’ experiment, this model has proven successful in practice so far. The government usually cooperates with an enterprise in this model. The government provides land and housing for the publicly-owned and privately-run RCF, whilst the enterprise is responsible for the management of the RCF, including the profits or losses. This is a model of public-private partnerships (PPPs) in the residential care industry in China.
In western countries, PPPs were first introduced in 1992 in the U.K. by the Conservative government and subsequently expanded across the world (Institute for Public Policy Research [IPPR], 2001; Osborne, 2000). There are different definitions on PPPs, and the one embraced by the Canadian Council is as follows:

A cooperative venture between the public and private sectors, built on the expertise of each partner that best meets clearly defined public needs through the appropriate allocation of resources, risks and rewards (Canadian Council for Public Private Partnerships, 2010).

An ongoing debate on the performance of PPPs either supports or opposes this model in both theoretical and empirical studies. The advantages of PPPs are identified in the ways such as they are able to introduce private sector’s innovation and management expertise and skills to improve speed of delivery, value-for-money, and efficiencies in traditional public services and infrastructure (Economist Intelligence Unit, 1999; Farrell Grant Sparks, 1998; Hearne, 2009; Osborne, 2000). Whereas those opposed to PPPs focus on: 1) their real costs are higher than traditional government procurement; 2) the private sector fails to manage the services and ends the project even before the contract maturity; 3) their design and service quality fails to meet the standards of publicly delivered services; 4) their inadequate transparency and unclear responsibility of services are not accountable to the public good; and 5) they reduce the flexibility of the public sector to respond to public demands (Falch & Henten, 2008; Greener, 2008; Hearne, 2009; Murphy, 2008).

In the context of the residential care industry in China, the results from this study are positive towards publicly-owned and privately-run facilities. The cost of management cuts down the rent that is covered by the government. The publicly-owned and privately-run model takes advantage of government support and the management skills of the
private sector. A research project conducted in Shanghai studied the outcome after the municipal government changed some community RCFs into publicly-owned and privately-run facilities and continued to provide financial support. The results found that the outcomes are generally positive. In some cases, even though the cost of the government increased after the reform, the care facilities and service quality improved. The study also indicated that the regulations and evaluation of this new model were, however, limited because of its short history (Zhang, 2004). To ensure the success of the new model, the role of government is important to ensure the high-quality, efficient, and responsive services meet the needs of residential care services.

Fourthly, improvements in access to information about residential care for elderly people and their family members are necessary. Based on the results in Chapter 5, access to information about residential care is poor in Beijing, and there has yet to be an administrative system that disseminates such information. This lack of information makes it difficult for elderly people and their family members to gain and access knowledge about residential care. There are some good examples in developed countries; in Canada, for example, the Ontario Ministry of Health and Long-Term Care established an agency called the Community Care Access Centre (CCAC) in 1996. The role of the CCACs is to increase public access to government-funded home and community services and long-term care homes. CCACs function to assist elderly people with assessing their personal care needs and eligibility for various provincial schemes and services. They also provide information about available care providers and help with the application process\textsuperscript{15} (Ontario

\textsuperscript{15} There are, however, some criticisms of the CCACs regarding the increasing diversity and uncertainty on both service provider and user sides as a result of the managed competition system during the restructuring
Ministry of Health and Long-Term Care, Canada, 2009). In Beijing, the RCFs association has done some work to facilitate the improvement of access to information. The RCFs which joined the association get to know the situation of other RCFs. When potential residents are looking for a RCF, some RCF managers are able to introduce them to suitable RCFs based on their knowledge. The information is helpful, although the process is somewhat inefficient. The association still needs to improve access to information through various ways such as offering consultation, and improving publicity through websites, brochures, and newspaper special issues.

8.3.2 Policies, regulation and laws

First, improvements in the quality of services and professional training for staff members and a practical set of industry regulations are crucial for the future development of residential care. The experiences from other countries show that developing an assessment system offers a good way to ensure the quality of services provided by the RCFs. Regulations and an assessment system play an important role in protecting the quality of services and the rights of elderly residents, especially among profit-driven RCFs and for elderly residents with little or no self-care ability. Existing research suggests that the assessment system can focus on aspects such as residents and staff characteristics, physical features of the RCF, the social environment, accessibility within the RCF and to outside services, overall facilities, and safety (Moos & Lemke, 1996). Existing research of community-based services in Ontario, especially in rural communities (Cloutier-Fisher & Joseph, 2000). But CCACs certainly are an example of how access to information can be improved even if they have their own set of operational problems.
has also highlighted the limitations of systems in English-speaking countries which provide lessons from which less developed countries can learn. For example, it has been reported that the long-term care qualification system may separate an elderly couple into different RCFs based on their care needs, which is unacceptable by elderly couples and their family members. The allocation system works in such a way that elderly people are sorted less according to geographic proximity but more in terms of regional administrative boundaries. Sometimes, residents may prefer to be relocated to a closer RCF in a nearby region (Cloutier-Fisher & Joseph, 2000; Hancock & Wright, 1999).

Secondly, existing laws related to elderly people and residential care need to be continually improved to protect the legal rights of both elderly people and RCFs. Currently, the Constitution of the People’s Republic of China (The National People’s Congress of China, 2004) and Criminal Law (The National People’s Congress of China, 1979) both regulate the care responsibility that adult children have towards their elderly parents. The Marriage Law (The National People’s Congress of China, 1980) protects the equal rights between elderly couples, and the Inheritance Law (The National People’s Congress of China, 1985) regulates the issues related to heritage within a family. There has been a rise in the number of legal cases reported between elderly residents and RCFs as residential care becomes an increasingly popular option among Chinese elderly people. For example, on the one hand, family members have reported cases of physical and/or mental abuse among elderly residents, especially those with cognitive impairments and functional problems or who are often isolated by their families and friends. On the other hand, RCFs managers report that the RCFs are often required to pay a large amount of compensation to family members when accidents happen in the RCFs, even though the RCF is not fully
responsible for the accidents. Under these circumstances, elderly residents, family members, and RCFs all argue for the necessity of improving existing laws that protect the rights of each side.

Thirdly, it is necessary to improve the social welfare system including pension system and health care system for elderly people, especially among those with rural household registration. The situation in China is different from developed countries. Taking the U.K. during the 1980s as an example, the private residential sector benefited substantially from state financial support. Since 1993, a much smaller number of clients are now funded by limited local authority budgets. The decreasing demand of residential care utilization by elderly people led to a more competitive situation amongst the private residential sector. Many private RCFs experienced much more difficulty in filling bed spaces than before. The government with decreased funding for residential care shifted increasing responsibility onto the shoulders of local communities and individual families (Andrews & Phillips, 2002). In China, elderly people are traditionally cared for by family members at individual homes. The development of residential care has provided an alternative choice for families. Most of the elderly residents, however, are self-funded. Only elderly people without family and those with low income qualify for government funded residential care. Compared to developed countries in the West, the Chinese government went through a different process of social welfare reform. After 1980s, the social welfare system was transformed from a collective welfare to a multi-level system since the government was not able to handle the increasing financial demands for pension and health care needs (see details in Chapter 4). Social welfare reform has resulted in an increasing gap in financial security and health status between elderly people with urban
and rural household registration during the past two decades (Liu, Hsiao, & Eggleston, 1999). The development of the residential care industry provides a choice for family caregivers to reduce the care burden, whereas social welfare reform downloads more financial burden on individual families. The social welfare system is still under reform, and what Chinese elderly people expect are improvements in financial security from both pension and health care insurance.

8.3.3 Planning

The planning of the quantity of residential care resources and location of RCFs depends on distribution patterns of the elderly population and their demand. The question for planners is where the RCFs should be located and how many residential care resources are needed. The results from this research suggest that access in terms of geographical factors, information, as well as other economic and socio-cultural factors are all important considerations for improved planning. Additionally, different levels of care needs should also be taken into consideration because elderly people with cognitive impairments or functional difficulties often require more complex and costly types of care than those who are relatively healthy.

First, good planning should balance between equitable access and utilization and economic efficiency (Anderson, 1995). With regard to residential care in Beijing, equity, equality, and efficiency are important principles for future policy making and planning. To meet the challenges of the uneven distribution of the elderly population and residential care resources in different districts, the Beijing municipal government plans to create a city-district (county)-street (village) multi-level residential care system. The multi-level
system aims to satisfy difficult levels of demand with charge standards, location, size, and services. In order to maintain economic efficiency with limited land resources in central districts, one option for developing RCFs in central districts is to improve and enlarge existing RCFs and transform some under-used public facilities into areas for residential care. For instance, some community kindergartens and primary schools now attract fewer students than before because of recent demographic changes in those communities. Already, the local government and communities have converted some of these facilities into RCFs in order to meet the increasing demand for residential care and they might consider converting more in the future. Considering the availability of land resources and pleasant physical environment in suburban areas, more new RCFs are also planned for these areas. In reality, many new RCFs have been built in suburban areas and the average occupancy rate has been lower than 60 percent in recent years. Therefore, an overabundance of RCFs can also cause wastage of resources and intensify market competition. In exurban areas, most of the RCFs are traditional community operated facilities for elderly people without children. The residential care resources in these areas would theoretically satisfy the needs of the elderly population, but the facility conditions and quality of care services needs to be improved. Regarding the size of RCFs, large size RCFs are more practical for building in suburban areas than in central districts. This research shows that both elderly residents and RCF managers consider large RCFs a challenge for both the management system and communication between managers and elderly residents. Most elderly residents suggest that 100-bed RCFs are ideal, and they should be located preferably in suburban or central districts.
Secondly, it is important to diversify RCFs to meet different levels of demand when designing the RCFs. The standard charge, services, and size of RCFs are required to meet the different demands of clients according to their financial affordability and self-care ability. Both the government and private sector invested to build some upscale RCFs with high standard charges in the suburban areas of Beijing in recent years. Many elderly residents report that they went to visit these RCFs and are satisfied with the facilities, but unfortunately are not able to afford them. Based on the average income of elderly people in Beijing\textsuperscript{16}, most elderly people feel that 1,000 to 2,000 Yuan per month is an acceptable rate. The results also suggest that RCFs should be designed with healing and treatment functions and be separated into different sections for elderly residents with different levels of self-care ability. Once elderly residents relocate from home to a RCF, many of them do not want to move from one RCF to another when their health status changes. Many elderly residents prefer a one-site facility with different sections for residents with different levels of cognitive impairment and functional difficulties.

Beside the two points mentioned above, physical facilities in some RCFs should be improved. In particular, elderly residents and their family members have expressed greatest concern over the need to improve existing in-house health care facilities and bathrooms, as well as the provision of private telephones. The traditional conception of RCFs as a shelter should be changed to a place where elderly people can engage in active aging. A RCF is suppose to be a safe place that meets the physical, social, and emotional

\textsuperscript{16} The average income of elderly people was 1,338 Yuan per month in Beijing in 2006, with 1,643 Yuan per month (719 Yuan per month in 2000) for elderly people in urban areas and only 316 Yuan per month (244 Yuan per month in 2000) for elderly people in rural areas (Li, 2007).
needs of elderly people instead of being a shelter that provides only food and housing services for elderly people who lack family caregivers.

8.3.4 Management of elderly residents

The level of restriction in terms of regulation, elderly residents’ autonomy, and privacy are important aspects for the management of elderly residents. Different elderly residents may have various lifestyles, care needs, and personal routines. The aim of residential care is to provide caregiving and improve the well-being of each elderly resident. Therefore, an effective way to manage elderly residents is reasonably to adjust the rules according to individual needs instead of a uniform set of regulations. Existing research in English-speaking countries shows that the structure of physical space and social opportunities in RCFs has significant impacts on keeping the connections between pre- and post-institutionalization lives of elderly residents (Elliott, 1995). In practice, newly developed RCFs provide more diverse services to meet the individual needs of elderly residents as compared to the traditional RCFs. For planners, policy makers and RCF managers, the challenge is to recognize and respond appropriately to the ever-changing characteristics and needs of the residents. New types of RCFs should consider developing, supporting, and managing a process of active aging both individually and collectively among the elderly residents in the RCFs (Bernard et al., 2007; Minkler & Fedem, 2002).
8.3.5 Social activities

The models of active aging and successful aging indicate that health means engaging in meaningful activities, such as having something worthwhile to do, balancing between abilities and challenges, accessing external resources, and embracing active and positive personal attitudes (Bryant, Corbett & Kutner, 2001). Elderly people’s physical conditions, sense of security, and ability to do things and be with people are important for their participation in social activities. It is important for RCFs to develop diverse activities for elderly residents and to engage them in participating in the collective life of RCFs. Participation in social activities is helpful for them to adapt to the relocation, develop their self-esteem and feelings of self-worth, and improve their well-being in general. Some successful activities developed in certain RCFs should be promoted to other RCFs as good models from which to learn. For example, monthly group birthday parties are highly valued by elderly residents. They feel that being able to celebrate their birthdays together gives them a greater sense of belonging. A beautiful garden and birdhouse are attractions for family members to visit, especially young grandchildren. A vegetable garden not only provides residents with the opportunity to do some physical exercises, but also provides them with fresh vegetables for meals and a sense of ownership and self-worth. Organizations’ and visitors’ claim to the trees in the garden becomes a good souvenir for their visits and contributions and also helps to raise money for the maintenance of the garden. Mutual visits between RCFs and universities, schools, and organizations help elderly residents maintain their social connections with the larger society. Designing RCFs as education and volunteer bases for teenagers helps elderly residents feel a sense of self-worth and provides a valued opportunity to educate younger generations. Besides these
above examples, monthly newspaper publishing and the provision of places for practicing religious beliefs in the RCFs are also highly valued by the elderly residents.

8.3.6 Public conception and volunteering system

Negative traditional perceptions and social stigma tied to residential care should be broken down. The negative influence of traditional culture on residential care can be reduced if the public understands the purpose and function of residential care with the continuous improvement of the residential care industry. In order to improve the situation, the RCFs and media can play a role in educating the public about residential care. The RCF association and retirement departments of each work place can organize visits to RCFs for retired people and their family members who are interested in choosing residential care. Adult children should respect their elderly family members’ choices. For those elderly people who choose residential care, it is important for their family members to continue to be responsible for visits and other care responsibilities.

Secondly, non-governmental organizations (NGOs) and the private sector should be continually encouraged to invest in and raise funds for improving the residential care industry. Volunteer work should be better organized and systematized. The development of residential care cannot be dependent solely on the government because it is not a feasible option for any government to meet the financial challenges of maintaining a fully-funded residential care industry. The funding and management skills from the private sector can be helpful for the efficient operation of the residential care industry, and the
industry can also provide working opportunities and promote consumption by elderly people.

The volunteer system plays an important role in providing informal care for elderly people both in RCFs and communities in English-speaking countries. The current situation in China is that many people are willing to do volunteer work during their spare time, but there is a lack of organization or a system to organize the individual volunteers. As such, it has been difficult for RCFs to benefit fully from public volunteer work.

Volunteers often come to visit. I agree that the public should advocate participation in volunteering work, but it should be better organized. Well organized and sustained commitment volunteering work will be much more helpful for us than the random visits by different groups of volunteers . . . . We should develop a system to record one’s volunteering work by their working hours. When the person gets old and needs care giving, we can pay them back according to the hours he has contributed (a RCF manager).

8.4 Chapter summary

Socio-economic reform since 1979 has transformed the Chinese economy from a centrally planned economy into a partly market-based economy. The transformation of the economic system affects the residential care industry in many ways. Combined with the current dramatic demographic changes in Chinese society, the residential care industry faces many challenges in its future development. The results of this chapter have identified the challenges of residential care which the government and RCFs face, and have also provided suggestions from different perspectives of how to meet these challenges. The challenges come from government policies and support mechanisms at the administrative level, such as the working relationship between different administrative departments as well as between administration and RCFs, industrial regulations, social welfare systems,
and planning. At the RCF level, the challenges identified come from aspects such as physical facilities and social management. The different challenges between the public and private RCFs based on their ownership are also highlighted in this research. Considering the principles of equity, efficiency, and effectiveness in health care delivery and utilization, suggestions are provided for the government, organizations, and RCFs on aspects such as administration, policy making, planning, volunteering, and management of RCFs. The chapter has also summarized effective models and examples which are proven in practice and from which other RCFs can learn.
Chapter 9 Discussion and Conclusion

9.1 Re-examining the Research Questions

Population aging has direct and indirect implications for social welfare and economic policies as levels of need and dependency tend to increase in elderly people’s lives. Even if future cohorts of the oldest old are healthier than those of today, there will still be an increasing demand for services, pensions, and personal care assistance. The spatial distribution of the elderly population especially the oldest old will be very important for planning elder care and services (Andrews & Phillips, 2005). In China, both formal care provided by residential care and informal care provided by their families and friends play an important role in meeting the care needs of elderly people. The compatibility of care resources with care needs, issues of accessibility, and the role of the environment in influencing health outcomes are questions that have raised the attention of health geographers. The impact of demographic changes in the Chinese kinship system and socio-economic inequities between China’s urban and rural population raises challenges for the provision of elder care, especially among elderly people residing in rural areas (Jiang, 1995). Residential care, as a new developing option of elder care for the increasing elderly population in China, has insufficiently been studied. This study focuses on residential care in Beijing. The findings from this research contribute to understanding the reasons behind why elderly people and their family members choose residential care over traditional home care, the ease or challenge of access to residential care, the well-being of elderly residents in RCFs, the relationship between health and place in RCFs, and the current and future challenges the residential care industry faces.
In order to aid a better understanding of residential care in Beijing, China, six specific research questions were asked at the beginning of this thesis. The following part summarizes the results found in this research in response to each of the research questions.

Q1. What is the spatial distribution of elderly population and residential care resources in Beijing? Do service needs geographically match residential care resources?

China is a country with remarkable regional and local variations. Likewise, there are significant variations in the social welfare system and types of elder care across the country, especially between urban and rural areas. The Beijing municipality consists of 16 districts and two counties. This study examines the elderly population aged 60 and over and the oldest old in Beijing respectively. Both the population aged 60 and over and the oldest old concentrate in the central districts of Beijing. In some exurban areas, the proportion of elderly population is relatively higher than the suburban areas because of labour migration from exurban areas to suburban and central districts. Since those who are most likely to migrate are young workers in the active labour force, a significant proportion of the population in exurban areas typically consists of elderly families. Meanwhile, the distributions of population aged 60 and over and the oldest old are not exactly the same. The distribution pattern of population aged 60 and over implies the future distribution of the oldest old in next two decades, which provides the government with a future picture for planning.

In this study, the indicator RCF beds per 1000 people aged 60 and over is used to map the spatial distribution of residential care resources. The results show that residential care resources are relatively abundant in suburban and exurban areas as compared to the
central districts. The occupancy rate of RCFs is generally higher in central districts than in suburban and exurban areas. Some of the popular RCFs in the central districts are 100 percent occupied and many have long waiting lists to get in. The average standard charge among RCFs in the central districts is higher than in suburban and exurban areas. Maps of the spatial distribution of elderly population and residential care resources reveal uneven geographical distributions among elderly population and care resources with many of the resources failing to match existing care needs. These distribution patterns pose significant challenges for the future of elder care as the elderly population will continuously increase in the next few decades.

Q2. How is the decision of residential care being made instead of traditional home care?

The rapid social change as a result of socio-economic reform reduces the availability of family care resources for elderly people, which facilitates the utilization of residential care. Regarding reasons for choosing residential care, research by Longino et al. (2002) and Wright (2003) showed that elderly people’s relocation is often a combination of health status (both physical and mental), inadequate forms of support at home, fear of living alone, housing-related concerns, and various attractions of living in RCFs such as security and the capacity to be independent. This research finds that the reasons why elderly people move are complicated, which may be affected by one or more factors. These factors include the lack of caregivers, loneliness, health-related issues, housing-related concerns, family relationship issues, and choice of lifestyles. These reasons can be classified as push factors (the challenges of providing informal home care) and pull factors
(the advantages of residential care). Lack of family caregiving resources and companions are often the main reason for elderly people and their families to choose residential care. Family relationships are a unique factor because of the influence of traditional family patterns and the culture of filial piety in Chinese society. Both research in English speaking countries and Asian societies including this research find that elderly residents report that RCFs provide opportunities for making new friends and sharing interests. Collective living helps to combat loneliness, improve personal morale, and encourage the development of healthy lifestyles for elderly residents (Kupke, 2000; Madigan et al., 1996; Siegenthaler & Vaughan, 1998).

Q3. What are the factors that affect access to residential care?

Existing research on access to health care and residential care in English speaking countries indicates that access is not only affected by geographical factors, but also relates to socio-cultural factors and individual health and socio-economic status (Aminzadeh et al., 2004; Anderson, 1995; Joseph & Phillips, 1984; Rosenberg, 1983; Penchansky & Thomas, 1981). In China, most RCFs are established to house elderly people who lack sufficient family care resources regardless of the individuals’ functional status (Gu et al., 2007). Gu et al. (2007) also found that the age was negatively associated with institutionalization, which potentially points to the significance of cultural norms in China and specifically that institutionalization may often be determined by socio-cultural factors rather than physical needs.

This study shares similar results with other studies in Asian societies (Kao & Stuifbergen, 1999; Zhan, Liu, & Guan, 2006; Zhang & Goza, 2006). The characteristics
and preferences of elderly people and the financial conditions of a family are important factors for choosing a suitable RCF for elderly people. This study divides access into five components: geographical access, information access, economic access, socio-cultural access, and the socio-managerial environment. Elderly people and their families take into account all five components during the decision-making process. The major criteria for selecting a RCF are identified as the distance from the primary caregiver's home, affiliation with a hospital, cost, cleanliness as well as the physical and social environment of the RCF. Geographical access refers to factors such as location and distance at the macro-scale and the physical environment and amenities of RCFs at the micro-scale. Access to information about residential care mainly depends on informal information sources from friends or acquaintances. Investigations, visits, and temporary stays, however, are reported to be helpful for gathering more detailed information of a RCF. According to individual financial affordability, elderly residents need to balance between affordability and services provided by RCFs. The levels of elderly people’s participation in the decision making process is closely related to their financial status. The results of who the major decision makers are from this study are different from a similar Chinese study conducted by Kao and Stuifbergen (1999). The latter found that the major decision makers were male caregivers, especially the sons, whereas this study finds that the major decision makers are more likely to be those who pay for the financial expenses which can either be elderly people or their family members. Socio-cultural access refers to elderly people’s attitudes on aging, Chinese traditional values on elder care, and service utilization. Besides the above factors, the socio-managerial environment including the reputation of the RCF, quality of services, management, social activities, and social connections also affect
elderly people’s access to residential care. Compared to western countries, the decision-making process is unique in Chinese society because of the social welfare system and the traditional cultural values placed on elder care. Adult children still face pressures from the public related to obligations to care for elderly parents at home, although residential care has become an increasingly popular option among elderly people.

Q4. How does the relocation to RCFs affect elderly people’s everyday activities and health compared to when they lived at home?

Existing research has emphasized the multiple dimensions in which quality of life is affected apart from health status. They include physical, emotional, cognitive, and social functioning, life satisfaction, and economic status (Arnold, 1991; Wilhelmson, Anderson, Waern, & Allebeck, 2005). The findings of this study coincides with Zhan, Liu and Guan’s (2006) study which found that elderly residents' attitudes toward RCFs were overall positive. Many elderly residents reported emotional and physical improvements after the relocation. A few elderly residents, however, showed low levels of interest in participating in any social activities and became pessimistic about their future after their relocation. This study confirms that there are various factors that influence both the quantity and quality of social interactions between residents as identified in other studies. Some factors include personal attributes such as hearing, speech, sight, ambulate, and cognitive abilities (Bitzan & Kruzich, 1990; Retsinas & Garrity, 1985; Mor et al., 1995; Kovach & Robinson, 1996); structural attributes such as staffing levels and the physical environment (Moore, 1999); and cultural attributes such as the philosophy of care and perceptions of older age.
(Hubbard et al., 2003; Noelker & Poulshock 1984; Reed & McMillan 1995; Timko & Moos, 1990). The results from this research categorize the reasons for the different outcomes of elderly residents’ well-being into three aspects: physical environment of the RCF, social environment of the RCF, and individual factors of elderly residents and their family members.

The results also prove that elderly residents’ attachment to RCFs has physical, social, and psychological meanings. The natural and built landscapes and building design of RCFs have important effects on elderly residents’ well-being. The common areas are reported as places where elderly residents socialize with each other and enjoy positive experiences. The therapeutic landscapes of RCFs are not only composed of the natural and built environments of RCFs, but also the socio-cultural environments of the place, which are attached with subjective meanings to individuals. Social relations, functional ability of elderly residents, and social activities influence the quality of life of elderly people as much as their health status (Arnold, 1991; Wilhelmson et al., 2005). Diverse social activities organized both within and outside of the RCFs help elderly residents adjust to the transition of relocation and their life change. The activities also help them maintain or improve their physical and psychological well-being. Even though the physical environment is important for elderly residents’ well-being, the management system and service quality and utilization has the most direct and crucial influences on residents’ quality of life (Bartlett & Phillips, 1995).

Additionally, the characteristics of elderly residents such as personality and social skill play an important role in their adaptation to the collective life in RCFs. Many
residents also report that the decline of their health status affects their daily life activities. Elderly residents’ conceptions of residential care often affect their willingness to move, as well as their transition process and overall well-being. Active aging provides a good model for their adaptation, but the practice of the model also needs the concerted efforts of the government and RCFs apart from individual efforts. Most family members continue to provide different types of care, especially social and emotional care. Family members also develop different strategies to balance their daily life and other care tasks. In order to improve the quality of life of elderly residents, measures to build up elderly residents’ self-esteem and feelings of self-worth and to engage family members to participate in caregiving are helpful. Regarding the future of elderly residents’ residential life, the results correspond with the conclusion made by Bernard et al. (2007) in their study of English purpose-built retirement village. Many residents express concerns about their future health and care needs and whether the current RCF they stay at will provide a “home for life”. The results from this study also show that elderly residents are uncertain about the future of private RCFs, especially for those RCFs where they paid a high deposit to get in.

Q5. What current and future challenges of residential care do government and RCFs face?

The socio-economic reform from a central planning economy to a market economy in the recent three decades has influenced Chinese society dramatically. Social welfare reform has followed economic reform and has not finished yet. The current residential care
industry in Beijing has only a short history of development. As a result, industry regulations and related laws are incomplete for the management of the industry. Additionally, demographic changes and an increasing aging population pose significant challenges for elder care. The residential care industry as a newly developed industry faces all kinds of challenges during its development. The results organize the challenges into three themes: government policies and supports; RCFs planning and design; and the management of RCFs.

All interviewed RCF managers across different types of ownership report that they face challenges in management because of the lack of industry regulations, collaboration among administrations, and a unified social welfare system. The results show significant differences among levels of government support and staff recruitment across RCFs with different ownership. Government operated RCFs and community RCFs are more likely to get direct or indirect benefits from the government and communities than private RCFs. Since RCFs have expanded their orientation from the traditional role of providing shelter for elderly people who are childless or disabled to one that caters to the health and leisure needs of elderly residents, there are more concerns regarding the planning and designing of newly built RCFs than the traditional RCFs. Planners and managers face challenges in terms of choosing the geographical location and designing the built landscapes of RCFs. Regarding the management of staff members, poor payment, and working conditions in RCFs often compel staff workers to transit frequently between different RCFs, or in and out of the industry. Deficiency in professional training also challenges the management of RCFs by managers and is a concern of elderly residents and their family members. Trained staff members often move on to other RCFs after they have finished training. This finding
has also been identified in other research on nursing staff in long-term care (Brannon, Zinn, Mor & Davis, 2002; Cruttenden, 2006).

Q6. What changes are needed for policy to meet the current and future challenges of residential care?

Equity, equality, and efficiency in access to residential care resources are the planning and policy making aims of the residential care industry. Suggestions are made for more knowledge-based policy making and residential care practice based on the challenges identified in this research and successful models approved in both China and other countries. Suggestions are provided for aspects such as administration, policy making, planning, and management of RCFs. The central and local governments in China have created some preferential policies to facilitate the development of residential care. Efforts should be placed on how to facilitate the implementation of current preferential policies apart from either creating new or improving existing policies. The development of residential care cannot only depend on the government; it also needs efforts from society, communities, organizations, and the private sector, even though residential care is a part of social welfare. The publicly-owned and privately-run RCF model has proved to be a successful model in managing RCFs efficiently because this model takes advantages of government support and the efficient management skills of enterprises. Regarding regulations and laws, it has been suggested that a practical assessment system and adequate/proper industry regulations be put in place in order to guarantee and improve the quality of services, and protect the rights of both elderly people and RCFs. The
suggestions have also addressed the under-reformed social welfare system which plays a crucial role in providing the financial security for elderly people, especially for those with rural household registration.

Planning provides a useful picture of the future distribution of residential care resources. A good plan should balance between equitable access and utilization and economic efficiency. The study confirms the rationality of creating a city-district (county)-street (village) multi-level residential care system in Beijing and designing various standards of RCFs to meet different levels of demand. In order better to manage elderly residents, an effective way is reasonably to adjust the rules according to individual situation, since the health status, personalities, and hobbies vary among elderly residents. The research also summarized some successful social activities organized by RCFs to help elderly residents adapt to their relocation and improve their well-being. Breaking down the stigma tied to residential care requires the long-term efforts of the government, media, and RCFs to educate the public. Volunteer work is also a good way to educate the public about residential care, but it needs to be better organized and systematized.

9.2 Discussion

The dual options of residential and community care for elder care have raised numerous debates in both planning and academic research. Issues of equity, equality, and efficiency in access and utilization of residential care resources have also raised attention of researchers, planners, and policy makers. At the end of this thesis, these issues will be discussed for deeper thinking by researchers, planners, and policy makers about the
challenges of providing sufficient, accessible, and efficient elder care resources to meet the rising demand of a growing elderly population in China.

9.2.1. Residential care vs. community care

Residential care generated a lot of criticism regarding its function and the well-being of elderly residents in English-speaking countries before the 1990s (Gibson & Rowland, 1984; Johnson & Grant, 1985; Salamon & Rosenthal, 1990). These studies showed that some elderly people exhibited depression and feelings of personal insignificance when placed in nursing homes. They had low levels of interest in activities, and increased anxiety about death. For some elderly residents, relocation to RCFs means being deprived of intimate family relationships and close friendships and they often had difficulty finding substitute relationships for emotional support. Their mobility became restricted, and they generally did not have access to outside society. As new residential care models were developed in the 1990s, newer studies have found that retirement-community living helps to combat loneliness, improve morale, and encourage the development of healthy life-styles (Bernard et al., 2007, Laws, 1995; Lucksinger, 1994). With respect to the planning elements of new types of RCFs, such as purpose-built retirement communities in the U.K., U.S., and Canada, the importance of social and leisure activity is emphasised, alongside the need for participation and involvement in activities as a means of maintaining individual health, identity, and well-being (Bernard, Bartlam, Biggs, & Sim, 2004; Bernard et al., 2007; Croucher et al., 2003). New types of RCFs include:
a retirement element – the residents are no longer in full-time employment and this affects their use of time and space; a community element – they accommodate an age-specified population that lives in the same area; a degree of collectivity – with which residents identify and which may include shared activities, interests and facilities, and a sense of autonomy with security (Phillips, Bernard, Biggs, & Kingston, 2001, p.190).

In the Chinese context, the demand for residential care is increasing and it is likely to become the major alternative option for elder care due to socio-economic transformation and the increasing lack of family care resources in China at both the macro-level and micro-level. At the macro-level, economic reforms, urbanization, and welfare reforms are forcing more individuals and businesses to be self-sufficient and self-reliant. At the micro-level, families are declining in size partially due to the one-child policy, coupled with the decreasing availability of family care resources. Elderly people are becoming more financially independent and are more likely than before to make their own decisions about elder care in the future. More and more elderly people think that residential care is a good choice for them to enjoy their elderly life, which also reduces the burdens of care on the shoulders of their families. This study together with other Chinese studies find that most elderly residents in RCFs show positive attitudes toward residential care, which presents a contrast for the residents in traditional RCFs of other countries. To understand the difference, one may have to understand the general living conditions in China. In urban China, most elderly people live in apartments or residential quarters. Carrying groceries upstairs becomes a major challenge for their everyday activities (Zhan, Liu, & Guan, 2006). The social connections between neighbours are relatively weak in new residential quarters because of different backgrounds of residents. Many elderly people feel lonely and inconvenienced in their daily activities living in such residential quarters where there
is a lack of open space and common areas for leisure activities. Newly developed RCFs help to make up for the disadvantages of these residential quarters by offering elderly residents diverse social activities to develop a healthy lifestyle. The majority of elderly residents in RCFs have positive attitudes toward residential care and report improvements in their physical and mental health after moving to RCFs. They also express their preference for living in RCFs compared to living at home. Residential care is perceived as a positive and safe option for their older life (Zhan, Liu, & Guan, 2006).

Regarding community care, in the recent two decades among English-speaking countries, policy makers and researchers have advocated the reallocation of resources towards programs aimed at home and community care. This orientation aims to provide alternatives to the more expensive option of residential care, in response to the rising demands of providing care to an increasingly elderly population (Gibson & Rowland, 1984; Milligan, 2006). In China, the Chinese government began to notice the challenges of population aging and took actions on improving elder care in the early 1980s. Improvements to the residential care system also began in the 1980s. Based on the demographic and socio-cultural situation, the Chinese government advocates community care as the main form of elder care for economic efficiency, while residential care is considered as a supplemental option. The policy states that “elder care should be based on home care and community care with the support of residential care” (The Central government & State Council of China, 2000, para.8). Community and home-based services will continue to be the choice for most elderly people who may prefer to live in the community and maintain China’s cultural norms and/or who lack access to residential
care resources. Community and home-based services are attractive to Chinese elderly people for its fulfillment of expectation of filial piety if these services can also meet the essential medical needs of elderly people (Gu et al., 2007).

The Beijing local government created a model called “four nearby solutions” for community care, which is designed to offer elderly people with study resources, social activities opportunities, caregiving resources, and opportunities for participation in community affairs. This model is effective and efficient in theory, but many elderly people do not have promising evaluations and expectations of this model. In the current situation, community services are not well developed to provide caregiving services for elderly people living alone at home. Especially among fast growing new neighbourhoods, they have yet to develop much “community spirit” to provide collective services for the elderly residents in the community (Bartlett & Phillips, 1997). Aging in place will be perfectly tenable for most elderly people when the support services are planned and can be delivered on a neighbourhood-by-neighbourhood basis in the future (Hodge, 2008). Community care may be ideologically sound, but it can be financially very expensive to achieve satisfactory standards and distribution (Andrews & Phillips, 2002).

Besides the academic debates and policy orientation on residential care and community care, the characteristics of the future elderly population and their preference for elder care options also play a significant role in the development of elder care. The study conducted by Gu et al. (2007) reveals that the institutionalized oldest old in China are more likely to be younger, male, urban dwellers, and to have lower family caregiving resources and exhibit poorer health as compared to the oldest old living in the community. The younger elderly generation and urban elderly dwellers are more likely to accept
residential care than are the older generation and those living in rural areas who remain bound by traditional cultural influences. Regarding gender difference, financial security and cultural beliefs of elderly people play important roles. The survey data show that elderly women are less financially stable than elderly men (Beijing Municipal Bureau of Statistics, 2007). Furthermore, elderly women are generally more conservative and traditional than elderly men as a result of traditional culture norms (Gu et al., 2007). Those who exhibit poorer health often need more care resources than relatively healthy elderly people. When asked about future choice of elder care, most of the family members interviewed showed their desirability towards choosing residential care. They report their concerns for the burden of the one child generation and the development of community care. They think that residential care will gradually be more accepted by the public and it will be a trend for the future choice of elder care.

To sum up, both residential care and community care have their advantages and disadvantages. The history of the current community and residential care systems in China are both short and still under development. Based on the current demographic and social-economic level of China, community care will be more efficient and effective, and it will be the mainstream for elder care in the future. Nevertheless, given even the most optimistic predictions of the success of community care, existing research has estimated that residential care will continue to expand slowly (Day, Klein, & Redmayne, 1997). What we learn from the residential care industry is also helpful for improving community care services.
9.2.2. Equity, equality, and efficiency

Equity, equality, efficiency, and effectiveness are important factors in health policy making. In theory, each elderly person should have equal access to elder care resources, but this does not often happen in reality. As a general rule, a conflict between efficiency and equity exists in planning and resource distribution, as well as in resource provision and utilization. The conflict exists between the desire among providers to manage resources efficiently and the expectation of users to have those resources provided conveniently and equitably. For example, planners may make decisions either to provide one large facility with a comprehensive range of services or provide several smaller facilities which are closer to the population that needs them. The first solution offers economies of scale for the provider, while the other minimizes travel costs for the user. It is not quite so simple, since users might need to access advanced services by traveling further to a larger facility. There are important debates about the geography of provision, since the spatial distribution of services is uneven and the travel cost might be outweighed by the quality of service provided (Gatrell, 2002).

Residential care is relatively expensive and is only currently accessible to a minority of the population in China. This study of residential care in Beijing shows that the spatial distribution of resources does not match needs within the community. Therefore, as proved in other studies in English speaking countries, the current resources will make it difficult to meet the increasing demands fully or equitably in the near future (Andrews & Phillips, 2002). Empirical studies show that elderly people’s access to these services is shaped by many factors, including their health and functional levels and their socio-
economic status (Aminzadeh et al., 2004). Elderly people with different health status and functional levels have different care needs.

Ways to improve equitable access to residential care among elderly people with different care needs is related significantly to the rational allocation of care resources. The central districts of Beijing have the highest proportion of elderly population with relatively few residential care resources, but it is more challenging to develop new RCFs in central districts than in suburban areas considering the availability of land resources and the better physical environment. More new RCFs can be developed according to the demands of residential care resources in suburban areas to improve economic efficiency. The city-district (county)-street (village) multi-level residential care system planned by the government should take issues of equity and efficiency into serious consideration in order to maximize the benefits of resources to meet different care needs.

Regarding information access, elderly people and their families have unequal access to information because they derive their information mainly from friends and acquaintances, as a result of the lack of an official informational access system. A suggestion is given to create an official department in the Chinese local governments for evaluating the needs of elderly people and providing information of RCFs based on the example of Community Care Access Centres (CCACs) in Ontario, Canada.

Regarding economic access, the current social welfare system is tied to the Household Registration System in China and the coverage of social welfare is much higher in urban areas than rural areas. In Beijing, most elderly residents in RCFs are self-funded, and only elderly people who are childless and those without the ability to work are eligible
for government funded residential care. The majority of elderly people with rural household registration are still financially dependent on their families for income and health care expenses. The results from this research show that the financial affordability of elderly people has significant impacts on their participation in the decision-making process of elder care. Unequal access to pension and health care insurance directly and indirectly affects elderly people’s access to residential care according to their household registration.

Regarding socio-cultural access, existing research in English speaking countries has confirmed that the factors such as education, social status, and former occupation influence access to residential care resources (Aykan, 2003; Couch & Kao, 1998; Cuijpers et al., 1999; Quinn et al., 1999; Spore et al., 1995). There is a current lack of research in China regarding how these factors affect socio-cultural access to residential care by Chinese elderly people. The uniqueness of the Chinese context is that the cultural influence of traditional filial piety on public conceptions of residential care still remains strong. Families may have different attitudes towards residential care based on their understanding of residential care and other individual socio-cultural characteristics. With respect to differences between urban and rural areas, residential care is generally less likely to be accepted in rural areas than in urban areas.

9.2.3. Future development of residential care industry

A key component of this research is to study the relationship between health and place in RCFs from the perspective of health geography. The results have emphasised the
importance of the social environment and individual factors on the well-being and quality of life of elderly residents, even though the physical environment also has a significant influence on health outcomes. The understanding of physical and socio-cultural meanings of therapeutic landscapes in RCFs to individuals is helpful to improve the future planning and service quality of residential care. The active aging model provides a guideline for improving the quality of life of elderly residents in RCFs. The new orientation for the development of the quality of residential care should focus on building elderly residents’ self-esteem and feelings of self-worth besides the provision of traditional physical care.

As confirmed by Day et al. (1997), the demand for residential care will continue to expand as a result of an increasing aging population and lack of home care resources in China. The residential care industry, however, faces numerous challenges with respect to government policies and supports, RCFs planning and design, and the management of RCFs. Public RCFs are at a better position than private RCFs in the market competition, notwithstanding the economic reform from a central planned economy to market economy has opened up the opportunities for private sector to invest in the residential care industry. Zhan, Liu, and Bai (2005) find that differences exist across various types of ownership in facility conditions, access to health care resources, staffing level, and staff members’ salary range. Meeting these challenges needs long-term efforts from governments, society, and RCFs as well as substantial improvements in aspects such as administration, policy making, planning, and the management of RCFs.

One significant and unique aspect to understand residential care in China is to consider the influence of the traditional culture of filial piety. As a result of the dramatic socio-economic changes in recent decades in China, filial piety is now affiliated with new
meanings. When adult children are not available to care for their elderly parents at home due to geographical distance or other obligations, they may express their filial piety through financial and emotional support to supplement their inability to provide direct physical care for their parents. With the development of residential care, for instance, to provide one’s elderly parents with high quality residential care in an upscale RCF is considered a form of filial piety (Zhan et al., 2005). Drawing from the results from the interviews with elderly residents and family members regarding their perceptions about future residential care, both groups are looking forward to seeing improvements in the residential care industry and being able to find their “home for life” as they age. They also emphasise the importance of maintaining and improving their social and physiological well-being in addition to improvements in their material well-being in recent years in China. The new meanings of filial piety and expectations on residential care in Chinese society shed light on the future development of residential care in China.

9.2.4. Limitations

One limitation of this research is that all the elderly participants are from central districts with urban household registration and they all have self-care abilities. Knowledge about the elderly people from suburban and exurban districts, especially those with rural household registrations only comes from secondary data such as statistical data, collected documents and reports, and existing literature. This research only recruited elderly residents without cognitive impairments or severe functional problems in the six study sites. Therefore, elderly residents with some or no self-care ability are missing in this study.
The majority of the residents in these six RCFs are those with urban household registration. A possible reason for the limited range of participants is that the outgoing elderly residents are more likely to be from urban areas and be willing to talk about their experiences, whereas elderly residents from rural areas are more likely to have concerns about residential care.

Another limitation is that this research did not take into account gender differences or use a gender analysis. Other studies have discussed gender difference existing in the need for support and utilization of elder care (Hodge, 2008). Hodge (2008) finds that the need for support by female and male elderly people differs little at the younger age level. The most significant difference happens to elderly people aged 85 and over because of the greater longevity of elderly women. As many as 70 percent of elderly women aged 85 and over tend to live alone, and they are more likely to be financially dependent on their family members than elderly men. Therefore, it might be interesting to study the gender differences among the oldest old in Chinese society, especially in relation to how Chinese traditional culture affects gender differences. There is also the potential to go back and reanalyze the transcripts using a gender analysis to understand how women’s roles are constructed in Chinese society and what this means for elderly women in RCFs and their female relatives and friends who support them.

The third limitation is that this research does not study how the ownership, size, and operating costs of RCFs affect the quality of care. As mentioned before, the Chinese government opened up opportunities for all funding sources to invest in residential care industry in the recent two decades. The residential care industry is growing at a rapid pace,
and various types and sizes of RCFs have been founded in Beijing. It is necessary to understand the relationship between the quality of care, ownership, size, and operating costs of the RCFs. The research on the experiences of residential care industry in the recent two decades will be helpful for efficient management of the city-district (county)-street (village) multi-level residential care system and provide suggestions for future planning and policy making.

9.2.5. Key contributions and future direction

This research has systematically studied the residential care industry in Beijing, China. Within the academic field, this study is among the first few studies on residential care in China from the perspective of health geography. With the challenges of population aging and increasing demands and utilization of residential care among the elderly population in China, studies in this area are urgently needed to contribute knowledge for both researchers and policy makers. Secondly, the methodology of this study is relatively new in the research on residential care in China. It follows the recent calls to use social theories and qualitative methods in studies of the new geography of health (Kearns & Andrews, 2005; Rosenberg, 1998), which is absolutely inadequate in the health geography research in China. This study aims to understand the distribution of residential care resources, access and utilization of residential care services, and management of RCFs from multiple perspectives (the perspectives from elderly residents in RCFs, family members, and RCF managers) by using some key concepts in geography of health and geography of aging, and quantitative (mapping) and qualitative methods (in-depth, semi-
structured interviews). Thirdly, this study aims to understand residential care in the unique Chinese socio-economic and cultural context based on existing research both inside and outside of geography in English speaking countries and some Asian countries. Compared to the studies of residential care in English-speaking countries, one of the unique aspects of this study is its contribution of understanding the cultural meaning of filial piety in elder care in the current context of China. By studying the access and utilization of residential care, this study highlights the reconfiguration of filial piety during the dramatic socio-economic changes in Chinese society in the recent three decades.

More specifically, at the theoretical level, the results of this study help to understand how the interaction of geographical, economic, and socio-cultural factors determines the access and utilization of residential care, secondly what the physical and social meanings of therapeutic landscapes are to elderly residents individually and collectively in RCFs and the impacts on their well-being, and thirdly how to construct active aging model and healthy living environments for RCF elderly residents. At the empirical level, this study of the geography of population aging and residential care in Beijing contributes to a general understanding of the geographical distribution of care needs and care resources, which provides references for the future planning of residential care resources in Beijing. Findings regarding reasons for choosing residential care confirm the future directions for developing elder care in China, which aims to develop community care with the support of residential care. The results concerning the access to residential care by elderly people and their family members will be helpful for future improvements in equitable and efficient access to residential care. The well-being of elderly residents in RCFs and how environments affect residents’ health outcomes provides experiences and
suggestions for improving the quality of residential care services. This study has also identified the challenges facing residential care and provided corresponding suggestions to meet these challenges. All the theoretical and empirical contributions of this study provide insights for policy makers, planners, and RCF managers with knowledge of the allocation of residential care resources and quality of residential care services. This study also provides a useful starting point for future research on residential care and elder care in China.

For future research directions, the following suggestions are made:

First, regarding financial security, the pension and health care systems are the two most important components for elderly people. The current pension and health care systems are still under reform, and the Chinese government is working hard to create a unique system that caters to its unique economic, political, and cultural situation. From the perspective of geography, future research interests can focus on the spatial distribution of the elderly population among different regions, and how regional economic, social, and cultural factors affect the pension and health care systems at the local level. Suggestions are needed to provide policy makers with new ideas for securing the financial stability of the growing elderly population based on regional differences in China.

Secondly, the meaning of filial piety and conceptions of elder care are changing with the socio-cultural changes as a result of the economic reform since the end of 1970s in China. It will be interesting to study how these economic and socio-cultural changes affect access and utilization of residential care among Chinese elderly people, especially
those who live in rural areas. There is a lack of understanding about the challenges of elder care in rural areas, as well as the socio-cultural barriers of using residential care.

Thirdly, since the geographical location of care resources play an important role in access to residential care, more detailed data should be collected to analyze geographical access to residential care resources. In addition with more detailed behavioral data, GIS and statistical modeling could be used to provide a better understanding of the allocation of resources and demands, and provide the public with information of available residential care resources.

Fourthly, there is need for research to be conducted on elderly people with different age groups, gender differences, different self-care abilities and care needs, experiences of different types of RCFs, and RCFs with different care philosophies and practices. It is important to understand how these factors affect the well-being of elderly people and provide suggestions for improving elderly residents’ quality of life in RCFs.

Last but not least, more research should study newly developed community care in China. In the face of continual demographic changes and a fast growing elderly population in China, the challenges for the elderly population, their families, and policy-makers will grow in tandem. In light of this situation, more research should be conducted on community care to provide suggestions for the development of community care which is identified as the most popular choice and main option for elder care in China. All these future research directions will be helpful to improve accessibility to residential care and the quality of residential care, as well as to provide suggestions for the Chinese local and central governments to meet the future challenges of elder care.
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233


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Appendices

Appendix 1 List of government policies and documents

<table>
<thead>
<tr>
<th>Area</th>
<th>Level</th>
<th>Year</th>
<th>Policies and Documents</th>
<th>Administration</th>
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<td>Retirement system</td>
<td>National</td>
<td>1958</td>
<td><em>Temporary Regulations on Retirement</em></td>
<td>State Council of China</td>
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<tr>
<td></td>
<td></td>
<td>1978</td>
<td><em>Temporary Regulations on Worker’s Retirement and Quit</em></td>
<td>State Council of China</td>
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<tr>
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<td></td>
<td>1982</td>
<td><em>Decision on Creating Retirement System for Cadres</em></td>
<td>State Council of China</td>
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<tr>
<td>Health care system</td>
<td>National</td>
<td>1991</td>
<td>The government started to rebuild the cooperative medical system in rural areas.</td>
<td>State Council of China</td>
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<tr>
<td></td>
<td></td>
<td>1998</td>
<td><em>Establishment of the Basic Medical Insurance System for Urban Employees</em></td>
<td>State Council of China</td>
</tr>
<tr>
<td>Year</td>
<td>National/Local</td>
<td>Event/Program/Principle</td>
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<tr>
<td>1983</td>
<td>National</td>
<td>Foundation of China National Committee on Aging</td>
<td>State Council of China</td>
<td></td>
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<tr>
<td>1984</td>
<td>National</td>
<td>Social welfare conference in Zhangzhou put forward two changes for the development of residential care</td>
<td>Ministry of Civil Affairs of China</td>
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<td>1994</td>
<td>National</td>
<td><em>The Seven-Year Program for the Development of Elder Care in China</em></td>
<td>National Development and Reform Commission of China, China National Committee on Aging</td>
<td></td>
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<td>2000</td>
<td>National</td>
<td>Decision on Improving Elder Care</td>
<td>The Central Government &amp; State Council of China</td>
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<tr>
<td>2000</td>
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<td><em>Suggestions on Accelerating Social Welfare Socialization</em></td>
<td>State Council &amp; Ministry of Civil Affairs of China</td>
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</tr>
<tr>
<td>2001</td>
<td>National</td>
<td><em>The 10th Five-Year Plan on Elder Care of China (2001-2005)</em></td>
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<td></td>
</tr>
<tr>
<td>2006</td>
<td>National</td>
<td><em>The 11th Five-Year Plan on Elder Care of China (2006-2010)</em></td>
<td>China National Committee on Aging</td>
<td></td>
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<td><em>White Paper for the Development of Elder Care of China</em></td>
<td>State Council Information Office of China</td>
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<td><em>The 10th Five-Year Plan Compendium of National Economy and Social Development of Beijing</em></td>
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<td>2001</td>
<td>Local</td>
<td><em>The 10th Five-Year Plan on Elder Care of Beijing</em></td>
<td>The People’s Government of Beijing Municipality</td>
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<tr>
<td>Elder Care</td>
<td>Local</td>
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<td>Title</td>
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<td><em>Suggestions on Supporting Social Invest in Building RCFs</em></td>
<td>Beijing Municipal Bureau of Civil Affairs</td>
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<td>2007</td>
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<td><em>Report on Elderly Population Information and Development of Elder Care in Beijing 2006</em></td>
<td>Committee on Aging of Beijing</td>
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<td>2008</td>
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<td>Laws</td>
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<td>1980</td>
<td><em>Marriage Law</em></td>
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<td>1985</td>
<td><em>Inheritance Law</em></td>
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<td>RCF design</td>
<td>National</td>
<td>2002</td>
<td><em>National Standard of Urban Residential Quarters Planning of China</em></td>
<td>Ministry of Housing and Urban-Rural Development of China</td>
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<td>Quality of services and professional training</td>
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<td><em>Temporary Management Measures on RCFs in Rural Areas</em></td>
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Appendix 2 Research protocol and questionnaire for RCF managers

Step 1: Choosing two government operated residential care facilities (RCFs), two community operated RCFs and two private RCFs for case study, some of which are located in central districts and some of which are located in suburban districts.

Step 2: Contacting managers of these RCFs by emails or telephone calls and briefly introducing my research project (6 managers).

Step 3: Sending the managers letters of information and consent forms.

Step 4: Arranging time for interviews in the RCFs.

Step 5: Interviewing managers in their offices. Each interview is planned to last one to one and half hours and we will use Mandarin during the conversation. Before each interview starts, I will briefly explain the purpose of the study and assure the interviewees that their comments will be kept anonymous and confidential.

Step 6: The interviews will be semi-structured interviews based on the following questionnaire. The interviews are planned to be audio-recorded, but in accordance with the interviewee’s wishes, notes alone may be taken instead.

Step 7: The content of the audio recordings will be fully transcribed, and content analysis will be based on the framework proposed.
Basic Information

1. Ownership: Governmental operated_______, Community_______, Private_______.

2. Location: Center_______, Suburb_______, Exurb_______.
   Located alone_______, Within a hospital_______.

3. No. of beds______________.

4. Occupancy rate: Less than 50%____, 50-69%____, 70% and over____.

5. Residents’ characteristics:
   Age group: 50-64______, 65-79______, 80 and over______.
   Gender percentage: Male_____; Female______.

6. Type of residence:

<table>
<thead>
<tr>
<th></th>
<th>NO. of units</th>
<th>Expense</th>
<th>TV</th>
<th>Phone</th>
<th>Conditioner</th>
<th>Washroom</th>
<th>Alarm</th>
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7. Facility:

<table>
<thead>
<tr>
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<th></th>
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<tr>
<td>Common room</td>
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<td>Wheel chair provided</td>
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<tr>
<td>Gym</td>
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<td>Health Clinic</td>
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<td></td>
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<tr>
<td>Dining room</td>
<td></td>
<td></td>
<td>Agreement with a hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Library</td>
<td></td>
<td></td>
<td>Other</td>
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</tbody>
</table>
8. Staff:

   No. of nurses______, No. of doctors______.

   No. of non-medical staff______, Total number ____,

9. Eligibility of the residents:

   With full self-care ability________, With some self-care ability________,

   With no self-care ability________.

   Are there any other required criteria?

Q4. Support from the Government

10. Do you receive direct support from the government (e.g. annual grant for each bed)?

11. Do you receive indirect support from the government (e.g. preferential prices for utilities)?

12. Do you receive any other kind of support (e.g. from community, organizations)?
Q5. Challenges and Future

13. What are the current and future challenges for RCFs?

14. What do you plan to meet the challenges?

15. Other comments
Appendix 3 Research protocol and questionnaire for elderly residents in RCFs

Step 1: Choosing two government operated residential care facilities (RCFs), two community operated RCFs and two private RCFs for case study, some of which are located in central districts and some of which are located in suburban districts.

Step 2: Contacting managers of these RCFs by emails or telephone calls and briefly introducing my research project. Asking them to help me recruit elderly residents to participate in the project (5 elderly residents per RCF, 30 in total).

Step 3: Contacting the managers again and getting their feedback. Selecting elderly residents to be interviewed from those without cognitive impairments and severe functional problems, as those are typically too physically ill to participate or have severe communication problems.

Step 4: Contacting the participants by telephone calls or visiting. Sending them the letters of information and consent forms.

Step 5: Arranging time for interviews in the RCFs.

Step 6: Interviewing them in the RCFs. Each interview is planned to last one to one and a half hours and we will use Mandarin during the conversation. Before each interview starts, I will briefly explain the purpose of the study and assure the interviewees that their comments will be kept anonymous and confidential.
Step 7: The interviews will be semi-structured based on the following questionnaire. The
interviews are planned to be audio-recorded, but in accordance with the
interviewee’s wishes, notes alone may be taken instead.

Step 8: The content of the audio recordings will be fully transcribed, and content analysis
will be based on the framework proposed.

### Basic Information

1. Gender: Female ○, Male○
2. Age: 50-65 ○, 66-75 ○, 76-85 ○, over 85 ○, N/A ○
4. Household registration: Urban○, Rural○
5. Monthly income:
   - Less than 500 Yuan ○, 500-999 ○, 1000-1999 ○, 2000 and Over ○
6. Previous occupation__________
7. Level of education__________

### Q1. Decision Making

8. Health status before institutionalization compared to your friends:
   - Excellent ○, Very good ○, Good ○, Fair ○, Poor ○.
   - Health status now:
     - Excellent ○, Very good ○, Good ○, Fair ○, Poor ○.
9. No. of children: _____________.

10. Living arrangement before institutionalization:

   Living with your spouse ○, Living with the family of one of your children ○,
   
   By oneself ○, Other ○.

11. How did you make the decision to move to a RCF?

12. What role did your family play in the decision making?

Q2. Access to Residential Care

13. How did you find this facility?

14. Why did you choose this facility? What factors were most important?

15. Did you visit the RCF before you moved in?
16. Did you have to wait before getting into the RCF? How long did you wait? Did it seem a long time to you?

**Q3. Sense of Place**

17. How long have you been living in this RCF?

18. What are your daily activities in the RCF?

19. What are the differences between living in RCF and at home?

20. What do you like about living in a RCF and what you don’t like?
<table>
<thead>
<tr>
<th>Q4-Q5. Impact of the Social Reform and Suggestions for RCFs</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. Are you enrolled in pension system?</td>
</tr>
<tr>
<td></td>
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<tr>
<td>22. Do you have other financial support besides a pension? (e.g., from families, relatives, friends)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>23. Are you enrolled in health care insurance?</td>
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<td></td>
</tr>
<tr>
<td>24. Other Comments</td>
</tr>
</tbody>
</table>
Appendix 4 Research protocol and questionnaire for family members of elderly people in RCFs

Step 1: After interviewing elderly residents in RCFs, I will ask them to help me with recruiting one of their family members who plays an important role in the decision making process of their residential care to be interviewed.

Step 2: Contacting the elderly residents again and getting feedback from them.

Step 3: Contacting the family members who are willing to be interviewed by email or telephone calls (around 20 participants). Sending them the letters of information and consent forms.

Step 4: Arranging time and place for interviews.

Step 5: Carrying on interviews. Each interview is planned to last one to one and a half hours and we will use Mandarin during the conversation. Before each interview starts, I will briefly explain the purpose of the study and assure the interviewees that their comments will be kept anonymous and confidential.

Step 6: The interviews will be semi-structured based on the following questionnaire. The interviews are planned to be audio-recorded, but in accordance with the interviewee’s wishes, notes alone may be taken instead.

Step 7: The content of the audio recordings will be fully transcribed, and content analysis will be based on the framework proposed.
Basic Information

1. Gender: Female ○, Male ○
2. Age: _______.
4. No. of children: _______.
5. No. of siblings: _______.
6. Monthly income:
   Less than 500 Yuan ○, 500-999 ○, 1000-1999 ○, 2000 and Over ○
7. Occupation__________, your spouse’s occupation__________.
8. Level of education__________

Q1. Decision Making Process

9. Living arrangements of seniors before institutionalization:
   Living with her/his spouse ○, Living with the family of one of her/his children ○,
   By oneself ○, Other ○.
10. How did the senior make the decision to choose residential care instead of home care?
    Did anyone else also play a role?

11. What role did your family play in the decision making?
### Q2. Access to Residential Care

12. Why did you choose this facility? How did you find this facility? What factors were most important?

13. Did you visit the RCF before your parent moved in? Did you visit along or with your parent or with other family members?

14. Did you have to wait before getting your parent into the RCF? How long did you wait? Did it seem a long time to you?

### Q3. Sense of Place

15. What do you like about the RCF and the care your parent receiving? And what you don’t like?

16. How often do you come to visit her/him? Do you provide some financial support? Do you provide some other types of support?
17. Do you expect your children to provide elderly care for you when you grow old?

**Q4-Q5. Other Comments**
Appendix 5 Information letter to RCF manager

Dear RCF manager,

My name is Yang Cheng and I am a doctoral student in the Department of Geography, at Queen’s University in Kingston, Ontario, Canada. I am writing to ask you to consider the possibility of your RCF becoming one of the research sites for my doctoral dissertation research entitled “Long-Term Care for Elderly People in Residential Care Facilities in Beijing, China”. This research is being funded through a Graduate Dean’s Doctoral Field Travel Grants from Queen’s University.

As we know, the traditional form of long-term care for the elderly in China continues to be informal home care by families. The Chinese government has carried out a social reform of formal care for elderly people since the end of 1990s. More and more Chinese elders choose to live in RCFs, but there is a lack of both theoretical and empirical studies of residential care for elderly people in China since the short time period of the reform. Therefore, the goals of this research are:

1. To understand why more and more elderly people in Beijing choose residential care.
2. To understand the important factors of choosing residential care facilities.
3. To understand the status of elderly people living in RCFs.
4. To explore the relationship between health and environment for elderly people in RCFs.
5. To explore the current and future challenges of residential care in China.

To answer these questions, my research involves the participation of six RCFs in Beijing. In each RCF, I would like to interview five elderly residents, you or one of your managers, and some of the family members of elderly residents who I have interviewed. I also plan to interview five policy makers who are knowledgeable about the social welfare system. The interview with you or one of your managers should take between 60 and 90 minutes. To this end, I have attached the questionnaire and a consent form.

I would also like your help in recruiting five elderly residents in your RCF. Elderly residents to be interviewed should be selected from those over 60 years old, without cognitive impairments and severe functional problems. It will take each participant 30 to 45 minutes to finish the interview. The interview of the elderly residents will follow the questionnaire I have attached also for your information.
Should you or one of your managers agree to be interviewed:

1. Participation in this research is completely voluntary, and you are free to withdraw from the research at anytime.
2. Participants will receive a copy of the signed consent form.
3. During the interview, sensitive issues may be discussed. You can refuse to answer any question if you are uncomfortable.
4. The interview is to be audio-recorded, but if you prefer only notes will be taken.
5. You have the right to stop or pause the tape at anytime. The interview that has been recorded can be erased if you wish.
6. If some abuse is brought up, the researcher is obligated legally to inform authorities.

Only my supervisor Professor Mark W. Rosenberg and I will access the interview transcripts. All information will be destroyed when they are no longer being used for the proposed research.

If you have any questions, concerns or complaints about the research procedures contact me (Yang Cheng, Department of Geography, Queen’s University, Kingston, Ontario, Canada, K7L 3E6, e-mail: 5yc5@queensu.ca, telephone: 1-613-533-6000 ext. 77215) or Professor Wuyi Wang (Institute of Geographical Sciences and Natural Resources Research, Chinese Academy of Sciences, 11A Datun Road, Chaoyang district, Beijing, China, 100101, e-mail: wangwy@igsnrr.ac.cn, telephone: 86-10-64889286). Professor Mark W. Rosenberg (Department of Geography, Queen’s University, Ontario, Canada, K7L 3E5, e-mail: mark.rosenberg@queensu.ca, telephone: 1-613-533-6046), or the General Research Ethics Board (GREB) Chair at Queen’s University, email is: chair.GREB@queensu.ca. The GREB Chair after July 1 will revert back to Joan Stevenson from Steve Leighton [Chair July 1/07 to June 30/08].

Thank you for considering this request and I look forward to hearing from you.

Sincerely yours,

Yang Cheng
Appendix 6 Information letter to elderly residents

Dear Madam/Sir,

My name is Yang Cheng and I am a doctoral student in the Department of Geography, at Queen’s University in Kingston, Ontario, Canada. I am writing to ask you to consider the possibility of your RCF becoming one of the research sites for my doctoral dissertation research entitled “Long-Term Care for Elderly People in Residential Care Facilities in Beijing, China”. This research is being funded through a Graduate Dean’s Doctoral Field Travel Grants from Queen’s University.

As we know, the traditional form of long-term care for the elderly in China continues to be informal home care by families. The Chinese government has carried out a social reform of formal care for elderly people since the end of 1990s. More and more Chinese elders choose to live in RCFs, but there is a lack of both theoretical and empirical studies of residential care for elderly people in China since the short time period of the reform. Therefore, the goals of this research are:

1. To understand why more and more elderly people in Beijing choose residential care.
2. To understand the important factors of choosing residential care facilities.
3. To understand the status of elderly people living in RCFs.
4. To explore the relationship between health and environment for elderly people in RCFs.
5. To explore the current and future challenges of residential care in China.

To answer these questions, my research involves the participation of six RCFs in Beijing. In each RCF, I would like to interview five elderly residents including you, one of your managers, and some of the family members of elderly residents who I have interviewed. I also plan to interview five policy makers who are knowledgeable about the social welfare system. The interview with you should take between 30 and 45 minutes. If the interview is more than 40 minutes, you may take a break or break it as two interviews as you wish. To this end, I have attached the questionnaire and a consent form.

I would also like your help to recruit one of your family members to be interviewed. Your family member being interviewed should be the one who played an important role in the decision making process that led you to choose the RCF where you are now living.
Should you or one of your managers agree to be interviewed:

1. Participation in this research is completely voluntary, and you are free to withdraw from the research at anytime.
2. Participants will receive a copy of the signed consent form.
3. During the interview, sensitive issues may be discussed. You can refuse to answer any question if you are uncomfortable.
4. The interview is to be audio-recorded, but if you prefer only notes will be taken.
5. You have the right to stop or pause the tape at anytime. The interview that has been recorded can be erased if you wish.
6. If some abuse is brought up, the researcher is obligated legally to inform authorities.

Only my supervisor Professor Mark W. Rosenberg and I will access the interview transcripts. All information will be destroyed when they are no longer being used for the proposed research.

If you have any questions, concerns or complaints about the research procedures contact me (Yang Cheng, Department of Geography, Queen’s University, Kingston, Ontario, Canada, K7L 3E6, e-mail: 5yc5@queensu.ca, telephone: 1-613-533-6000 ext. 77215) or Professor Wuyi Wang (Institute of Geographical Sciences and Natural Resources Research, Chinese Academy of Sciences, 11A Datun Road, Chaoyang district, Beijing, China, 100101, e-mail: wangwy@igsnrr.ac.cn, telephone: 86-10-64889286). Professor Mark W. Rosenberg (Department of Geography, Queen’s University, Ontario, Canada, K7L 3E5, e-mail: mark.rosenberg@queensu.ca, telephone: 1-613-533-6046), or the General Research Ethics Board (GREB) Chair at Queen’s University, email is: chair.GREB@queensu.ca. The GREB Chair after July 1 will revert back to Joan Stevenson from Steve Leighton [Chair July 1/07 to June 30/08].

Thank you for considering this request and I look forward to hearing from you.

Sincerely yours,

Yang Cheng
Appendix 7 Information letter to family members

Dear Madam/Sir,

My name is Yang Cheng and I am a doctoral student in the Department of Geography, at Queen’s University in Kingston, Ontario, Canada. I am writing to ask you to consider the possibility of your RCF becoming one of the research sites for my doctoral dissertation research entitled “Long-Term Care for Elderly People in Residential Care Facilities in Beijing, China”. This research is being funded through a Graduate Dean’s Doctoral Field Travel Grants from Queen’s University.

As we know, the traditional form of long-term care for the elderly in China continues to be informal home care by families. The Chinese government has carried out a social reform of formal care for elderly people since the end of 1990s. More and more Chinese elders choose to live in RCFs, but there is a lack of both theoretical and empirical studies of residential care for elderly people in China since the short time period of the reform. Therefore, the goals of this research are:

1. To understand why more and more elderly people in Beijing choose residential care.
2. To understand the important factors of choosing residential care facilities.
3. To understand the status of elderly people living in RCFs.
4. To explore the relationship between health and environment for elderly people in RCFs.
5. To explore the current and future challenges of residential care in China.

To answer these questions, my research involves the participation of six RCFs in Beijing. In each RCF, I would like to interview five elderly residents, one of the managers, you and some other the family members of elderly residents who I have interviewed. I also plan to interview five policy makers who are knowledgeable about the social welfare system. The interview with you should take around 30 minutes. To this end, I have attached the questionnaire and a consent form.

You were identified by (insert name of RCF resident previously interviewed) as someone I might interview about how (insert name of RCF resident previously interviewed) chose the RCF where she/he is now living.

Should you or one of your managers agree to be interviewed:

1. Participation in this research is completely voluntary, and you are free to withdraw from the research at anytime.

262
2. Participants will receive a copy of the signed consent form.
3. During the interview, sensitive issues may be discussed. You can refuse to answer any question if you are uncomfortable.
4. The interview is to be audio-recorded, but if you prefer only notes will be taken.
5. You have the right to stop or pause the tape at anytime. The interview that has been recorded can be erased if you wish.
6. If some abuse is brought up, the researcher is obligated legally to inform authorities.

Only my supervisor Professor Mark W. Rosenberg and I will access the interview transcripts. All information will be destroyed when they are no longer being used for the proposed research.

If you have any questions, concerns or complaints about the research procedures contact me (Yang Cheng, Department of Geography, Queen’s University, Kingston, Ontario, Canada, K7L 3E6, e-mail: 5yc5@queensu.ca, telephone: 1-613-533-6000 ext. 77215) or Professor Wuyi Wang (Institute of Geographical Sciences and Natural Resources Research, Chinese Academy of Sciences, 11A Datun Road, Chaoyang district, Beijing, China, 100101, e-mail: wangwy@igsnrr.ac.cn, telephone: 86-10-64889286). Professor Mark W. Rosenberg (Department of Geography, Queen’s University, Ontario, Canada, K7L 3E5, e-mail: mark.rosenberg@queensu.ca, telephone: 1-613-533-6046), or the General Research Ethics Board (GREB) Chair at Queen’s University, email is: chair.GREB@queensu.ca. The GREB Chair after July 1 will revert back to Joan Stevenson from Steve Leighton [Chair July 1/07 to June 30/08].

Thank you for considering this request and I look forward to hearing from you.

Sincerely yours,

Yang Cheng
Appendix 8 Consent form (RCF managers)

Researcher: Yang Cheng

Department of Geography, Queen’s University, Kingston, Ontario, K7L 3E6

Phone (office) 1-613-533-6000 ext. 77215

E-mail 5yc5@queensu.ca

Thesis Title: Long-Term Care for Elderly People in Residential Care Facilities in Beijing, China

I, the undersigned, agree to be interviewed by Yang Cheng for the purpose of her Ph.D. research. I understand that I will be participating in research that will explore the experience of elderly residents in my RCF and the challenges of running a RCF. I have read the letter of information and the interview questionnaire guide.

I understand that my participation in this research is completely voluntary, that I am free to withdraw at anytime, and that withdrawing my participation will not affect my job or the RCF. All questions have been answered to my satisfaction. I understand that the information will be kept secure and confidential and that my name will not be identified. While the results of the study may be used in future publications and conference presentations, I understand that all records of this interview will be destroyed when they are no longer being used for the proposed research.

☐ I agree to digital recording of the interview.

Name (please print): __________________________________________________________

Signature: __________________________________________________________________

Date: _____________________________________________________________________
Appendix 9 Consent form (elderly residents)

Researcher: Yang Cheng

Department of Geography, Queen’s University, Kingston, Ontario, K7L 3E6

Phone (office) 1-613-533-6000 ext. 77215

E-mail 5yc5@queensu.ca

Thesis Title: Long-Term Care for Elderly People in Residential Care Facilities in Beijing, China

I, the undersigned, agree to be interviewed in the research by Yang Cheng for the purpose of her Ph.D. research. I understand that I will be participating in research that will explore the experience of my decision of moving into RCF and my living here. I have read the letter of information and the interview questionnaire guide.

I understand that my participation in this research is completely voluntary, that I am free to withdraw at anytime, and that withdrawing my participation will not affect any service I receive. All questions have been answered to my satisfaction. I understand that the information will be kept secure and confidential and that my name, my family’s name will not be identified. While the results of the study may be used in future publications and conference presentations, I understand that all records of this interview will be destroyed when they are no longer being used for the proposed research.

☐ I agree to digital recording of the interview.

Name (please print):_______________________________________________________

Signature: _______________________________________________________________

Date: _________________________________________________

265
Appendix 10 Consent form (family members)

Researcher: Yang Cheng

Department of Geography, Queen’s University, Kingston, Ontario, K7L 3E6

Phone (office) 1-613-533-6000 ext. 77215

E-mail 5yc5@queensu.ca

Thesis Title: Long-Term Care for Elderly People in Residential Care Facilities in Beijing, China

I, the undersigned, agree to be interviewed in the research by Yang Cheng for the purpose of her Ph.D. research. I understand that I will be participating in research that will explore the experience of my parent’s decision of moving into RCF and his/her living here. I have read the letter of information and the interview questionnaire guide.

I understand that my participation in this research is completely voluntary, that I am free to withdraw at anytime, and that withdrawing my participation will not affect any service my parent receives. All questions have been answered to my satisfaction. I understand that the information will be kept secure and confidential and that my name, my parent’s name will not be identified. While the results of the study may be used in future publications and conference presentations, I understand that all records of this interview will be destroyed when they are no longer being used for the proposed research.

☐ I agree to digital recording of the interview.

Name (please print):_______________________________________________________

Signature: _______________________________________________________________

Date: _________________________________________________
### Appendix 11. Information of the surveyed RCFs

<table>
<thead>
<tr>
<th>RCF</th>
<th>Location</th>
<th>Ownership</th>
<th>Beds</th>
<th>Occupied Rate</th>
<th>Information of residents</th>
<th>Type of unit</th>
<th>Charge (Yuan/Month)</th>
<th>Staffs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Changping</td>
<td>Private</td>
<td>102</td>
<td>Summer 100%</td>
<td>60 residents</td>
<td>Single bed unit</td>
<td>1420-2340</td>
<td>Doctor (2), Nurse (2), Other staffs (14)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Winter 60%</td>
<td>Average age 75-80</td>
<td>two-bed unit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60-70(6-7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Over 90 (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Female 60-70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Dongcheng</td>
<td>Community</td>
<td>25</td>
<td>100%</td>
<td>25 residents</td>
<td>Single bed unit</td>
<td>1150-1750</td>
<td>Nurse (1), Other staffs (6)</td>
<td>Rebuilt from a kindergarten</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Average age 84</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>70-80(3)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>80-90(17)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Over 90 (5)</td>
<td></td>
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<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td>Male (60%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Dongcheng</td>
<td>Community</td>
<td>32</td>
<td>100%</td>
<td>32 residents</td>
<td>Two-bed unit</td>
<td>1000-1300</td>
<td>Doctor (1), Nurse (1), Other staffs (6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>three-bed unit</td>
<td>1000-1300</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>four-bed unit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Dongcheng</td>
<td>Co-operated</td>
<td>76</td>
<td>100%</td>
<td>76 residents</td>
<td>Single bed unit</td>
<td>1675-2650</td>
<td>Nurse (1), Other staffs (12)</td>
<td>Rebuilt from a primary school</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(23): 2650</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>two-bed unit</td>
<td>1675</td>
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<td></td>
</tr>
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<td></td>
<td>(27): 1675</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>Age</td>
<td>Staff</td>
<td>Room</td>
<td>Cost</td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>E</td>
<td>Changping</td>
<td>80</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Changping</td>
<td>712</td>
<td>35%</td>
<td></td>
<td></td>
<td>172</td>
<td></td>
<td></td>
<td></td>
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</table>
### Appendix 12. Information of interviewed elderly residents

<table>
<thead>
<tr>
<th>RCF No.</th>
<th>Sex</th>
<th>Age</th>
<th>Marriage Status</th>
<th>House registration</th>
<th>Income</th>
<th>Occupation before retired</th>
<th>Education</th>
<th>No. of children</th>
<th>Living arrangement before move</th>
<th>Family attitudes</th>
<th>Factors</th>
<th>Relocation period</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 1</td>
<td>F</td>
<td>60-65</td>
<td>Widowed</td>
<td>Urban</td>
<td>Over 2000</td>
<td>Professor</td>
<td>Undergraduate</td>
<td>1</td>
<td>By oneself</td>
<td>Support</td>
<td>Social Environment</td>
<td>10 months</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>F</td>
<td>77</td>
<td>Widowed</td>
<td>1000-1999</td>
<td>Worker</td>
<td>Junior school</td>
<td>5</td>
<td>By oneself</td>
<td>Support</td>
<td>Physical and social environment</td>
<td>1 year and 9 months</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>M</td>
<td>81</td>
<td>Widowed</td>
<td>Over 2000</td>
<td>Cadre</td>
<td>High school</td>
<td>2</td>
<td>By oneself</td>
<td>Support</td>
<td>Physical and social environment</td>
<td>6 years</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>M</td>
<td>75</td>
<td>Married</td>
<td>3000-4000</td>
<td>Cadre</td>
<td>Junior school</td>
<td>3</td>
<td>With spouse</td>
<td>Support</td>
<td>Physical and social environment</td>
<td>3 years</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>F</td>
<td>69</td>
<td>Married</td>
<td>1000-1999</td>
<td>Worker</td>
<td>Primary school</td>
<td>3</td>
<td>With spouse</td>
<td>Support</td>
<td>Physical and social environment</td>
<td>3 years</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>F</td>
<td>79</td>
<td>Widowed</td>
<td>Over 2000</td>
<td>Professor</td>
<td>Undergraduate</td>
<td>1</td>
<td>By oneself</td>
<td>Support</td>
<td>Physical and social environment</td>
<td>4 years</td>
</tr>
<tr>
<td>B 7</td>
<td>F</td>
<td>82</td>
<td>Widowed</td>
<td>Urban</td>
<td>1000-1999</td>
<td>Worker</td>
<td>Evening school</td>
<td>1</td>
<td>With one of the children</td>
<td>Support</td>
<td>Location</td>
<td>6 months</td>
</tr>
<tr>
<td>No.</td>
<td>Gender</td>
<td>Age</td>
<td>Marital Status</td>
<td>Location</td>
<td>Income Level</td>
<td>Education</td>
<td>Children’s Support</td>
<td>Children’s Decision</td>
<td>Years of Support</td>
<td></td>
<td></td>
<td></td>
</tr>
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Appendix 14 Sample of transcripts

Questions:

10. Living arrangement before institutionalization: Living with your spouse ○, Living with the family of one of your children ○, By oneself ○, Other ○.

11. How did you make the decision to move to a RCF? (see Appendix 3 Questionnaire for elderly residents in RCFs)

Answers:

I lived with my son after my partner passed away. After a while, I moved out of his home to live by myself. Doing grocery shopping and cooking meals are really challenges for me. I have three sons and a daughter. My oldest son has diabetes, so my daughter-in-law needs to care for him. I used to live with my second son, but his wife passed away a few years ago, and the nanny who used to care for me went back to her own home. My little son is still at work. He is busy. My daughter’s home is a two-bedroom apartment, and it will be crowded if I move in. Here is the best choice for me. (An elderly resident)

Analysis:

Open coding: see the comments in the text.

Concept: self-care ability, family care capacity.

Conceptual categories: challenges of providing home care.

Themes: choosing residential care, decision making process.
Appendix 15 Ethics certificate

June 13, 2008

Yang Cheng
PhD Candidate
Department of Geography
Queen’s University

GREB Ref #  G GEO-079-98
Title: “Long-Term Care for Elderly People in Residential Care Facilities in Beijing, China”

Dear Yang Cheng:

The General Research Ethics Board (GREB) has given approval to your proposal titled “Long-Term Care for Elderly People in Residential Care Facilities in Beijing, China.” In accordance with the Tri-Council Guidelines (article D.1.6) and Senate Terms of Reference (article 6), your project has been approved for one year. At the end of each year, GREB will ask if your project has been completed and if not, what changes have occurred or will occur in the next year.

You are reminded of your obligation to advise the GREB, with a copy to your unit REB, of any adverse event(s) that occur during this approval period (details available on webpage www.queensu.ca/vpe/greb/addforms.htm#Adverse). An adverse event includes, but is not limited to, a complaint, a change or unexpected event that alters the level of risk for the researcher or participants or situation that requires a substantial change in approach to a participant(s). You are also advised that any adverse events must be reported to the GREB within 48 hours.

You are also reminded that all changes that might affect human participants must be approved by the GREB. Examples of required approvals are: changes in study procedures or implementations of new aspects into the study procedures that affect human subjects. These changes must be sent to Linda Frid at the Office of Research Services or FRID@queensu.ca prior to implementation. Ms. Frid will seek the approval of the GREB reviewer(s) who originally assessed your application.

On behalf of the General Research Ethics Board, I wish you continued success in your research.

Yours truly,

Steve Leighton
Professor and Chair
General Research Ethics Board

Copy.  Chair Unit REB: Beverley Mullings
Faculty Supervisor: Mark W. Rosenberg
Dept Contact: Joan Knox