A comparison of dementia care policy between Scotland and Taiwan

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Abstract
Dementia is a specific illness which particularly affects older age groups. Since the evidence shows that both Taiwan and Scotland are aging societies, Taiwan and Scotland both face the challenges of increasing numbers of people with dementia. In order to decrease the burden on societies and economies, both countries have good intentions to satisfy the complex needs of people with dementia by providing and delivering high quality services for dementia care. However, Scotland is currently more advanced than Taiwan in their policy towards dementia care. Thus, the aim of this cross-national comparative paper is to use comparative analysis to examine the different features of policy and its delivery in dementia care between Scotland and Taiwan, particularly in service provision and delivery for people with dementia. However, due to political, social, economic and cultural differences, policy learning and transfer are not a straightforward exercise. Political party competition, demographic aging, and globalization are the driving forces for Taiwanese policy makers. In order to satisfy the needs of Taiwanese people, policy makers are pressured to adopt the social policy and its delivery from more developed countries in order to achieve international standards.

Through a comparative policy analysis could offer more information for Taiwan to learn a lesson from Scotland. Law and policy provide good recommendations for people with dementia and the stakeholders. This paper focuses on health care, social care, financial security, and housing services to explore how the features of the law and policies influence and contribute to services for people with dementia and family members in Scotland and Taiwan.
**Introduction**

Dementia care is a prominent policy concern in developed countries and aging societies (Moise et al., 2004), because dementia inflicts a large burden on the economy and society of a country. Both Scotland and Taiwan are facing the challenges of increasing numbers of people with dementia, and the diversity of services that need to be provided for people with dementia.

Policies in dementia care were initiated earlier and were more comprehensive in Scotland compared with Taiwan. Since the UK Parliament devolved powers to the Scottish Parliament in 1999, the Scottish Government has focused more intensively on the issue of dementia care and many care policies have been initiated to benefit people with dementia. In order to improve the quality of dementia care, the Scottish national dementia strategy was issued. In Taiwan, though the *Disability Welfare Act* (Department of Social Affairs, 1980a) acknowledges people with dementia and categorises them as disabled people, no public sector was responsible for their wellbeing until 2004. It can be seen that Scotland is more experienced in its policy towards dementia care and that Taiwanese policy makers may learn from its example.

**The typology of welfare regimes**

According to different indicators or dimensions, many scholars have established different welfare system theories to compare differences and similarities. However, regime theory cannot sufficiently explain most of the welfare regimes in the world, because welfare states are in transition (Esping-Andersen, 1996) and it is easy to establish a new welfare regime through adding or replacing some important attributes (Arts and Gelissen, 2002). Furthermore, Taiwanese and Scottish welfare states are both unique and they cannot be explained fully by any of the welfare regimes alone. Thus, it is not easy to compare similarities and differences between Taiwanese and Scottish welfare states by using regime theory. Recognising these drawbacks, it may be helpful for the task at hand. I can still use the concept but not the detail.

**Scottish welfare regime**

It is difficult to fit Britain into any of the three welfare state types identified by Esping-Andersen (1990), because the British system has distinctive attributes which are an uneasy mix of the market and universalism (Cochrane et al., 2001). According to Esping-Andersen (1990), Britain is classified as a liberal
welfare regime, because the key attributes in its welfare state are predominantly market-centred, means-tested assistance, and limited decommodification. However, in 1999, Esping-Andersen considers that the UK is classified as having little labour regulation, a mix of residual and Universalist welfare state, and non-familialist. Thus, Clarke et al. (2001) conclude that the British welfare system is in transition from a mix of liberal and social democratic regimes to a combination of neo-liberal and residual social democratic regimes, using regimes of Esping-Andersen.

Scotland has its own welfare system which is different from the other British countries, exacerbated when the UK Parliament devolved powers to the Scottish Parliament in 1999; and when the Scottish National Party came to office in 2007. Since different political ideologies often introduce different welfare systems, regime theory might be inappropriate to explain Scottish welfare systems. Thus, it is possible that the Scottish welfare systems could be classified as the “undefined” regime (Ragin, 1994), because the Scottish welfare system is a transitional system from a liberal regime to a social democratic regime due to its specific characteristics.

Taiwanese welfare regime
The Taiwanese welfare regime is dynamic in response to the different ideologies of its political parties. As Goodman and Peng (1996) note, the development of Taiwanese social welfare is a learn-as-we-go approach.

Esping-Andersen (1999) categorizes the East Asian area as the fourth world because of its unique version of capitalism, such as high employment, strong labour market regulation, and an egalitarian distribution of income. However, Aspalter (2002b) argues that the Western welfare states theories are not sufficient to explain the East Asian (including Taiwanese) welfare states because the social structure, political parties, social pressure groups, and institutional arrangements are different from Western countries. Goodman and Peng (1996) also argue that although the Taiwanese welfare system revises many Western social welfare ideas, it does not follow any particular Western welfare state types in terms of social, cultural, and political background.

The Taiwanese welfare state is determined by the political choices and preferences of its major political parties. Economy is also a factor in the welfare state. It is suggested that economic development is more important
than party preference in welfare effort (Mabbert and Boderson, 1999). Particularly, Taiwan is a newly industrializing and modernizing country (Goodman and Peng, 1996; Giddens and Griffiths, 2006). This led to the remarkable transformation in the Capitalist economy of Taiwan (White and Goodman, 1998). The economic development has shaped the Taiwanese welfare state. However, according to Aspalter (2002a), there is a direct causal relationship between political competition and welfare state construction in Taiwan through democratic elections, particularly, in 2000 when the Democratic Progressive Party (DPP) won the presidential election over the Chinese Nationalist Party (also known as Kuomintang, KMT) which was in power for prior decades.

Prior to the 1990s, Taiwan had been classified as a conservative welfare regime (Hill and Hwang, 2005) and a residual social insurance system (Goodman and Peng, 1996; Aspalter, 2002b). At that time, the welfare system was introduced by The KMT which was established in 1912 by Dr. Sun Yat-sen (Father of the Nation) whose political ideology was influenced by Bismarckian political theory which emphasised the function of family and state sectors, and through mutual aid to establish a social security system (Goodman and Peng, 1996).

However, democratization has significantly changed the Taiwanese welfare state after the 1990s (Ku, 2002). There has been an ideological competition between the two key Taiwanese political parties, the social democratic welfare (DPP) and multicultural (KMT) regimes. The Democratic Progressive Party (1993) argues that its welfare effort is to establish a welfare country with left-wing political ideology to provide universal and maximum welfare benefits for the whole population. Based on the political ideology and social insurance principle, the Kuomintang (2007) sets out a new welfare regime, a multicultural welfare regime, to offer different benefits and services to different groups in the population: women, older people, children and adolescents, indigenes, disabled people, and foreign spouse families.

On the other hand, democratization also limits the development in the Taiwanese welfare state, because political parties only focus on how to please voters to acquire political power instead of the actual welfare of the voters (Ku, 2002). In order to gain electoral support, the expenditure of social security will continue to increase in Taiwan (Ku, 2002). It can be anticipated that the
increase in the public debt will be simply transferred to future generations (Myles, 2002). Thus, regime theory is not appropriate to describe the current Taiwanese welfare system and it cannot predict how the Taiwanese welfare state would be changed and formulated in the future. Perhaps, the “undefined” regime also suits the Taiwanese welfare state, because the Taiwanese welfare system is a transitional system from a conservative regime to a social democratic regime.

**Dimensions of dementia care policy**

Law and policy provide good recommendations for people with dementia and the stakeholders. There are four key aspects that might play the most important roles in dementia care: health care, social care, financial support, and housing services. The features of the law and policies of the four key aspects influence and contribute to services for people with dementia and family members in Scotland and Taiwan.

**Health Care**

Since dementia is a progressive disease, there will be a great change in the disease process, and memory problems will get worse over time (Alzheimer Scotland, 2006). At the severe end of the disease, people with dementia may be completely dependent. Failure to recognise time, place and person, illogical speech and incontinence are all very common (Jacques et al., 2004b). Therefore, continuing medical attention is required in dementia in order to manage these progressive symptoms (Mace and Rabins, 1999).

Many Acts and reports are related to health care in Scotland. The *National Health Service Act 1946* laid down the foundation of National Health Service (NHS). Later in 1948, the NHS was introduced in Scotland (Crombie et al., 2003). The Scottish Executive was established in 1999 and from then on, the Scottish Executive Health Department has been responsible for all health policies and the supervision of the NHS (Crombie et al., 2003).

Prior to 1995, there were several different health insurance schemes in Taiwan, including Government employee’s insurance, labourer’s insurance, teacher’s insurance of private schools, farmer’s insurance and military personnel insurance (Bureau of National Health Insurance, 2007). However, these schemes only cover about 59% of the population (Bureau of National Health Insurance, 2007). In order to ensure that the entire population could obtain
appropriate health care, the Taiwanese Parliament passed the *National Health Insurance Act* in 1994 and the National Health Insurance program was launched to offer universal health care in 1995 (Bureau of National Health Insurance, 2007). The Bureau of National Health Insurance is the responsible authority for the National Health Insurance program and it is administrated by the Department of Health, Taiwanese Executive (Department of Health, Taiwan). Since 1995, the *National Health Insurance program* began to provide health care for all patients. Taiwanese health care became highly accessible because of the high coverage rate of hospitals. Moreover, Taiwanese patients could go to hospitals directly without referrals from GPs. Free health care is possible, if a person with dementia was categorized as having *Major illness and injury: Senile and pre-senile organic psychotic conditions* (Bureau of National Health Insurance, 2007).

According to the above mentioned policies, it seems to indicate that both Scotland and Taiwan have set up a health care system and provided health care for people with dementia. In practice, Taiwanese health care is more accessible than that of Scotland and early diagnosis and treatment is possible for people with dementia. Therefore, it may not be necessary to transfer all related health care policy from Scotland to Taiwan, because earlier diagnosis is more likely occur in Taiwan. Institutions are responsible for providing long-term care, when people with dementia move into care homes. However, unlike acute dementia care described above, the standards of long-term care in Taiwan are less satisfactory. It is necessary to establish related quality indicators for institutional dementia care.

**Social Care**

An increasing aging population not only has social and economic implications but it also places greater demand on health care and social care (General Register Office for Scotland, 2006). Unfortunately, as yet, dementia cannot be cured by any medicine. Although health care could control physical and mental problems of people with dementia, social care plays an important role in improvement of quality of life (QOL) for people with dementia and their families. The main social care policies for people with dementia, which include social justice and social inclusion, rights protection, partnership, family caregivers, community care, institutional care, care standards, and research and development. It is the most important responsibility for dementia care practitioners to associate with others working in services and provision for
disabled people and older people (Adams and Manthorpe, 2003). Modernization, inclusion, justice for all, community based care, support of carers and partnership between agencies and service users and carers are the key themes in social care for people with dementia (Jackson et al., 2003). Moreover, when social inclusion is valued in institutional care, it is possible to achieve the objective of protecting the rights of people with dementia living in care homes. Furthermore, in order to provide knowledge and skills for new treatment, it is necessary to invest in research and development in dementia care.

**Social justice and social inclusion**

Social justice is true equality, equal rights, and equal distribution (Sevenhuijsen, 1998). Social inclusion is total acceptance without condition (Repper and Perkins, 2003). Due to negative stereotypes and social stigma, people with dementia have to face many social restrictions and barriers. The promotion of social inclusion should be built upon integration, prevention, understanding, inclusiveness, and empowerment (The Scottish Office, 1999). Thus, the Scottish Executive (2000b) claims that good health care should be based on social justice and integrated services to empower people with dementia to preserve independence and dignity in health care.

However, in Taiwan, dementia is regarded as an aged and progressive condition and people with dementia in the acute confused stage are treated as psychiatric patients. There is no consideration of social justice and social inclusion for people with dementia in Taiwan today. Thus, the concepts and policies related to social justice and social inclusion need to be learnt from Scottish experience to reduce social restrictions and barriers for people with dementia and their families. In institutional dementia care, if policy can focus more on social justice and social inclusion and the policy is implemented, it may make the care home staff respect and listen more to the residents and their families, and the QOL for people with dementia living in care homes may be more enhanced.

**Rights protection**

The introduction of the *Adults with Incapacity (Scotland) Act 2000* almost completely changed the law about people with dementia (Alzheimer Scotland, 2006). This Act considers that the sheriff should consult any attorney directly and the attorney should consider the wishes and feelings of adults with
incapacity, and exercise minimum intervention under the Act (Scottish Executive, 2000a). His/her action should benefit adults with incapacity and encourage them to choose their own guardian, continuing attorney, and welfare attorney as well as to develop new skills concerning their property, finance, and welfare (Scottish Executive, 2000a).

In 1980, the Taiwanese Parliament passed the Senior Citizens’ Welfare Act to enable the Taiwanese Executive to protect the rights of economic security for older people and to provide sufficient social welfare for them (Department of Social Affairs, 1980b). In the same year, the Disability Welfare Act was also passed. This Act considers that people with dementia have the same rights as everyone else, such as employment, education, health and rehabilitation care, and social welfare service (Department of Social Affairs, 1980a). They are the first two Acts which address the concerns of older people and people with dementia (Lung and Lin, 2005). Subsequently, more Acts were set up in order to protect the rights of older people and to improve the QOL for older people, including the Regulations on Promoting Senior Citizens’ Welfare Committee in 1998 (Department of Social Affairs, 1998c) and the Contract Format of Care Homes in 2005 (Department of Social Affairs, 2005).

Thus, both the Scottish and Taiwanese Government have developed policies to protect the rights of people with dementia. However, it is also important to put these policies into practice, to educate institutions and staff about the equal rights of people with dementia.

**Partnership**

An integrated care system aims to provide seamless services for people with dementia. In order to provide the highest quality services, promoting wellbeing, and risk management, social work services should be required to integrate the public, private and voluntary sectors (Roe et al., 2006). Although the NHS in Scotland might meet some challenges on the aspect of partnership (Kerr et al., 2005), the aging population forces the Scottish Government to focus on the severe challenges of complex health care and delivery (Kerr et al., 2005). According to the Scottish Executive (2000c), effective innovative care involves the NHS, local authorities and voluntary sectors working together to provide health and social care quickly, individually and flexibly, which meet the needs of older, fragile people at home based on independence and dignity. The Scottish Executive (2003) also recognises that partnership with social work is
to develop person-centred and integrated care for older people in the community, and has to ensure it could deliver faster and better services to meet the needs of older people. The report of Jay et al. (2005) advises that joint services should involve service receivers and carers to design and deliver services for older people based on the two principles of person-centred care and an outcome focus. Moreover, Jay et al. consider that to meet the demands of an aging society and older people, the housing, health, and social services should form a partnership for efficient planning and delivery of service.

However, in Taiwan, the care model is divided into a social care model and health care model. They are administrated by two different departments, the Department of Social Affairs and the Department of Health. There still is a gap between these two care systems in Taiwan. People with dementia tend to have higher dependency and need more care from both health and social services. In order to deliver this balance of care for people with dementia more effectively, the lesson of partnership policy needs to be learnt from Scotland. Although the principle of partnership exists, the practice can be problematic (Dowling et al., 2004; Rummery, 2009).

**Family caregivers**

The *Carers (Recognition and Services) Act 1995* offers the assessment concept for assessing the care ability of carers, and connecting the purposes of care (The UK Parliament, 1995). The responsibility of carers is set out in the *Community Care and Health (Scotland) Act 2002* and it encourages carers to contribute their views to assess care needs before providing services to the cared-for person (Scottish Executive, 2002). The Scottish Executive (2006) claims that in the carer dimension, Scottish social policy has integrated recognition, partnership, and joint working to support family carers.

Scotland has developed the above policies to support family caregivers. However, in the society of Taiwan, as the culture of “filial piety” is commonly emphasized, taking care of the elderly or sick family member is generally regarded as the responsibility of the family (Chang, 2003). Thus, to date there is no Government document which focuses on family caregivers in Taiwan. It is important to have related policies to support family caregivers whether caring for people with dementia is the responsibility of the families or the whole society.
Community care
The Scottish Government continues to support the community care policy, and combine existing resources with new ones to provide social work, health and housing services for people who need them (The Scottish Office, 1998). The Care in the Community (1999) enables the Scottish Executive to develop and implement community care (The Scottish Parliament, 1999). The Report of the Joint Future Group (2000) states that older people at home need access to a diverse and continuing care, including “intensive support and care schemes; more flexible and comprehensive short break services; and a practical, low level shopping/domestic/household maintenance service” (Scottish Executive. Joint Future Group, 2000: 12). The Community Care and Health (Scotland) Act 2002 enables Councils to set up a Direct Payments Scheme to empower older people who are cared for in the community (Scottish Executive, 2002).

In Taiwan, there were about 85,383 people with dementia in 2004 (Lee, 2005). Only about 19,047 persons lived in care homes (Department of Social Affairs, 2007). Most people with dementia lived in the community and were cared by their families. Thus, it is necessary to have sufficient resources for carers in order to look after people with dementia in the community. In order to achieve the goal of care in the community and community care through community resources development and volunteer participation, the Department of Health began to provide home nursing care for people in need in 1987 (Department of Social Affairs, 1998e). Currently in Taiwan, the care resources provided by the Government consist of financial support for health care and institutional care, and living cost for medium and low income people (Zhou et al., 2005). In addition, free respite care, emergency service lines, home care, and home nursing care were also offered for people with dementia (Zhou et al., 2005).

Nevertheless, in practice, there were only fifteen day care centres which provided 1502 places for people with dementia in Taiwan in 2005. The free respite care offered by the local Government only lasts seven days per year and 8-32 hours per month for free home care. In addition, the cost of individual home care is equivalent to £3.6 per hour which is higher than the cost of institutional care. The cost of day care (£200-£300 per month) and respite care (£500 per month) is not cheaper than institutional care (£300-£800 per month). Accordingly, due to the insufficient and expensive community care, the ideals of care in the community and care by the community are not achieved at this moment. Thus, taking care of people with dementia is still the
responsibility of the family in Taiwan today.

**Institutional care**

Since dementia is a progressive and incurable disease, many of people with dementia are likely to spend the latter part of their lives in care homes. As Reilly et al. (2005) say, “Approximately one third of people with dementia are likely to enter residential care” (p. 8). That is, 30% of the 63,000 Scottish people diagnosed with dementia are living in institutions. When people need more support after assessment of individual’s needs and circumstances, residential or nursing homes generally can offer more than what they can receive from their own homes or the community (Department of Health, 1989). Moreover, institutional care also provides the services that community care could offer such as respite care, day care, home care, terminal care, hydrotherapy, and consultant-supervised post-operative/convalescent care (Peace et al., 1997); and the quality of services might even be better than community care (Huber, et al., 2005).

In Taiwan, the number of people with dementia living in care homes was about 19,047 in 2004 (Department of Social Affairs, 2007). Owing to insufficient long-term beds for people with dementia, Taiwanese care homes are encouraged to establish special care units to offer small scale but diverse and professional services for older people with dementia (Department of Social Affairs, 2007). The only qualified staff can be employed to provide professional care for older people (Department of Social Affairs, 1998g). The Taiwanese Government also evaluates care homes to ensure quality of care (Department of Social Affairs, 2000a) and, in order to encourage care homes to offer higher quality of care for older people, awards are given to care homes with good performance (Department of Social Affairs, 2000b).

Institutional care can offer a one-stop service which fits well with the current situation in Taiwan where low birth rates and economic burden have led adult children to work outside the home leaving elderly or disabled people at home and where community care is generally considered to be insufficient and expensive. Therefore, the institutional dementia care policy plays the crucial role in dementia care in Taiwan. Fortunately, both Scotland and Taiwan have developed policies to improve the QOL for older people living in institutions, and therefore quality indicators for institutional dementia care will be essential in Scotland or Taiwan.
Care standards
The aims of care standards are to minimize poor-quality care and to enhance average level of care (Huber et al., 2005). In order to evaluate care quality or performance of care homes accurately, care standards for older people living in care homes have been developed in both Taiwan and Scotland. The Scottish Executive (1999) developed the care standards for residential care, day care, home-based care, respite services, and carers' services to make services better. The Regulation of Care (Scotland) Act 2001 enabled the Scottish Government to establish a system of regulation of care services, and to set up an inspection to ensure that social services could fulfill national care standards (Scottish Executive, 2001c). Accordingly, the National Care Standards was set up to improve the quality of institutional care (Scottish Executive, 2001b). In the Range and Capacity Review Group (Hunter et al., 2006), in order to ensure that individuals could receive care with the quality of national care standards, eight regulation and inspection bodies, across housing, social and health care were established.

Using the principles of “dignity, privacy, choice, safety, realising potential and equality and diversity” (Scottish Executive, 2005:7), the Scottish Executive developed 20 standards in the National Care Standards: Care home for Older People in 2001 which was subsequently revised in 2005. In these Care Standards, issues of residents are considered before moving in (standards 1 to 6), when settling in (standards 7 to 11), day-to-day life (standards 12 to 19), and moving on (standard 20). The standards are grouped under headings which follow the person’s journey through the service (Scottish Executive, 2005:5). That is, Scottish care standards prefer to consider service users rather than the other stakeholders when evaluating quality of care in care homes.

Taiwanese care standards for care home were initially modified from two care standards from the USA and the UK, and divided into five main categories, 120 criteria to evaluate the care homes for older people, comprising management and administration, personal and professional care, physical environment and safety, rights and prevention, and improvement and innovation (Ministry of the Interior, 2000). However, in reality, written document may not truly reflect on the true situation. Thus, I argue that the current Taiwanese care standards are subjective and unsuitable for evaluating care homes.
Although in general the care standards in Taiwan and Scotland are both designed for older people living in care homes, the requirements of people with dementia living in care homes are more complex and the requirements are different in many aspects. I would suggest that a specific care standard is required for people with dementia.

In conclusion, an institution could adopt and modify the existing care standards that are appropriate for its policy and goals to improve the QOL for residents. However, people with dementia living in care homes need specific care standards and separate quality indicators. In addition, the quality indicators should be high in reliability, validity, and acceptability. Due to lack of finance and human resource, it is necessary to develop a set of quality indicators which is simple, efficient, and effective to assist care homes to improve quality of care and QOL for people with dementia.

**Research and development**

With regard to research and development in dementia care, the first dementia services development centre (DSDC) was established in 1989 at the University of Stirling, Scotland (Adams and Manthorpe, 2003). The DSDC (2006) offers information, education, training, publications, consultancy and research about dementia care for staff, students, carers, and Governments.

In Taiwan, the Department of Health established a sector within the Bureau of Nursing and Health Services Development in 2004 to be responsible for caring for people with dementia, and increased investment in research into dementia care, such as eight research projects in 2005 and five in 2006 (Huang, 2006).

A dementia research and development centre with diversity and integration could provide more knowledge and information for stakeholders. There is no centre like this established in Taiwan. The Taiwanese Government may need to consider the investment in dementia research as well as establish a professional dementia research centre for offering information, education, training, consultancy and research for stakeholders.

Overall, in order to improve quality of care and QOL for people with dementia, Scotland has developed a social care policy based on the person-centred care approach because this approach is focused on individual needs and based on joint working to integrate all care resources to provide services effectively for
people with dementia and their carers. However, the areas still requiring further improvement in Taiwan include social justice and social inclusion, partnership, carers, community care, and research and development.

Financial Support
Dementia will influence significantly personal and public finances in the future (Jacques et al., 2004a). In addition, the costs of dementia care are higher than other diseases given its progressive and incurable nature (Alzheimer Scotland, 2006). Thus, the given system should offer different kinds of financial help for older people, including "the retirement pension; means-tested income support with special premiums for the very old and disabled; housing benefit; attendance allowance, and, for those who provide care, the invalid care allowance" (Kraan et al., 1991: 47).

The expenditure on health care in Scotland takes up one third of the annual budget and the funding comes from taxation and national insurance (Crombie et al., 2003). When an older person is living at home or in a care home and requiring care services, there will be financial aid. For instance, the Scottish Government combined resources and manage services for offering older people free home care up to four weeks from leaving hospital from 2002 (Scottish Executive, 2000b). The local authority will make a payment of £90 per week for personal care and £65 per week for nursing care without further assessment" (Bell et al., 2001: 5) direct to the care provider. Since 1 July 2002, the Scottish Executive has offered payment (£145 per week) for free personal care for people aged 65 and over, and a free nursing care payment (£65 per week) for people of any age, if they need it (Scottish Executive Health Department, 2006). In addition, from October 2002, older people and disabled people can obtain free local off-peak bus travel (Scottish Executive, 2001a).

In Taiwan, similar financial aid was also proposed. For example, the Taiwanese Executive has provided economic security for older people, including an elderly living allowance for the medium and low income family, elderly allowance of special care for the medium and low income family, and annuities insurance since 1980 (Department of Social Affairs, 1980b). The Taiwanese Government makes a payment of £45 per month for the medium income older people and £90 per month for the low income older people (Department of Social Affairs, 1998a). The Taiwanese Government has provided free health checks for older people since 1998 (Department of Social
Affairs, 1998b). Medium and low income older people can obtain free health care since 2000 (Department of Social Affairs, 2000c). The Taiwanese Government offers payment up to £100 per month for the family who meet the conditions from 2002 (Department of Social Affairs, 2002a). The local Government makes a payment of £60 per month for older people whose total properties are under £100,000 (Department of Social Affairs, 2002b), and offers free home care (8-32 hours per month) for those who meet the different conditions (Department of Social Affairs, 2004a).

Compared with Scotland, the evidence seems to indicate that the funding from the Taiwanese Government is insufficient to support people with dementia and their family caregivers. For example, the GNI per capita is £18,800 in Scotland in 2005 which is 2.33 times that of Taiwan (£8,085). However, the Scottish Government provides payment (£156 per week) for free personal care for those aged 65 and over, if they are assessed as needing it; and a free nursing care payment (£71 per week) for those assessed as needing care. In Taiwan, the maximum total payment which all polices permitted is £120 per month and this is only for one low income older or disabled person. This means that the payment is 7.5 times higher in Scotland. Thus, according to national budgets, serious consideration is required for the Taiwanese Government to raise the sums currently given to support care expenses for those in need.

**Housing Service**

The housing policy has great influences on the physical environment for people with dementia. Wandering and disturbed behaviour of people with dementia could be improved by adapting the environment to meet their unique needs (The Scottish Office, 1998). Thus, a well-designed environment will benefit people with dementia to gain self-esteem and appreciation, and this will assist them to be as independent as possible (Jackson et al., 2003), especially lower level environment which could be more beneficial (Jay et al., 2005).

In Scotland, the local authorities promote high quality rented housing to meet community care needs by integrating housing providers (The Scottish Office, 1998). The smaller domus-like units, special care units within residential homes, and the Confused and Demented Elderly units were developed because they could deliver more flexible and effective health and social care to fit the needs of people with dementia and their family caregivers (Jackson et al., 2003). In addition, Scotland’s social and sheltered housing stock is
'age-friendly' based on access, design, and security (Holdsworth et al., 2005). The Government improved and adapted housing with emerging IT and health technology to provide a warm and safe home for older people (Holdsworth et al., 2005).

In Taiwan, the aim of The Design Standard for the Basic Facilities and Establishments of Senior Citizens’ Housing (2003) is to set up a quiet, safe, hygienic, and bright environment for older people who can live independently (Department of Social Affairs, 2003b). The Government asked the providers of older people’s housing to offer safe and sufficient space and areas for older people (Department of Social Affairs, 2003a). The Government provides low interest loans to encourage the private sector to build rented houses which have standardized facilities and equipment with obstruction-free, convenient, and personalized environment for senior citizens (Department of Social Affairs, 2004b).

Housing for people with dementia should adapt to their needs and be convenient, comfortable and warm (Adams and Manthorpe, 2003). A specific design for impaired memory, impaired learning, impaired reasoning, impaired sense, and for reduced stress are also essential (The Dementia Services Development Centre, 2006). In addition, designing interiors for people who have dementia should be based on the following principles: to be able to find things and directions simply, to see and recognise objects and features easily, to meet varying ethnic and cultural requirements, and to benefit staff, carers, and visitors (Pollock, 2003).

Housing is a determinant to the health and wellbeing for older people (Holdsworth et al., 2005). The Government should develop housing policy with detailed attention to the designing of the built environment for people with dementia. Scotland has already not only focused on the housing policy for older people but also people with dementia. Taiwan still has room for improvement.

**Summary**

Dementia is a specific illness which particularly affects older age groups. Since the evidence shows that both Taiwan and Scotland are aging societies, Taiwan and Scotland both face the challenges of increasing numbers of people with dementia. In order to decrease the burden on societies and economies, both
countries have good intentions to satisfy the complex needs of people with dementia by providing and delivering high quality services in health care, social care, financial security, and housing services.

In the University of Stirling, Scotland, the DSDC was established in 1989. It is a centre principally for providing information, education, training, publications, consultancy, and research for all stakeholders. In 1997, needs assessment for people with dementia was commenced in the document *Framework for Mental Health Services in Scotland*. From then on, the Scottish Executive has published further Acts and reports focused on how to offer the high quality services in dementia care. Hunter et al. (2006) commented that the specific needs of dementia care could be met in Scotland. Furthermore, the authors reported that high QOL for people with dementia could be created in Scotland by providing “more flexible services, step up and step down, better use of equipment and adaptations, technology and telecare, mainstreaming of joint future, and increasing emphasis on promoting active aging and on prevention” (Hunter et al., 2006: 31) based on the principle of minimum intervention.

On the other hand, the Taiwanese Government has begun to take dementia care more seriously from 2004 onwards. Therefore, a sector within the Bureau of Nursing and Health Services Development has been established to be responsible for dementia care, dementia research, and promotion of the importance of dementia care.

As has been stated before, both Scottish and Taiwanese Government have constructed related policies for people with dementia in relation to health care, rights protection and institutional care. Nevertheless, it is less comprehensive in Taiwan. For example, issues related to social justice and social inclusion, partnership, carers, community care, research and development, financial support, and housing are not fully covered in dementia care policy in Taiwan.

As discussed above, well-designed care homes could offer better 24-hour individual care and activities by qualified nurses and trained staff for people with dementia. Institutional care could also provide the one-stop service to meet all needs of people with dementia. It can provide everything which community care could supply but with a wider range and higher quality of services. Institutional care could be the best option for meeting the requirements of people with dementia and their families in the modern society.
However, people with dementia and their families do not generally want to enter long-term care due to low quality of most Taiwanese care homes. Thus, if care homes are good then there might be less reluctance to go into one. However, Scotland is more experienced than Taiwan in most care policies for people with dementia and their families, but there is no quality indicator for institutional dementia care developed in either Scotland or Taiwan to assess the quality of institutional dementia care. Therefore, in this research I propose that the development of a series of quality indicators to evaluate quality of care and to improve QOL for people with dementia living in care homes is an important task.
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