

**CULTURE, CARE, AND
COMMUNITY
EMPOWERMENT:
International Applications of Theory and
Methods**

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Table of Contents

Contents

Foreword.....	Tadao Takayama	
Preface.....	Tokie Anne and Mary E. McCall	
Acknowledgements		
Contributors		
Part 1	Theoretical Foundations of Empowerment	
Chapter 1	What is Empowerment? Mary E. McCall and Tokie Anne	10
Chapter 2	Cultural Values and Empowerment Mary E. McCall	19
Chapter 3	The CASE Model: A New Framework for Empowerment Tokie Anne and Mary E. McCall	29
Part 2	International Practice and Application of the CASE Model of Empowerment	
Chapter 4	A Community Empowerment Model for Healthy Longevity: The Japanese Experience Tokie Anne	42
Chapter 5	Empowerment in Planning for an Aging-Friendly Community in Sweden Cecilia Henning and Ulla Åhnby	55
Chapter 6	Empowerment of Seniors with Special Needs: Housing for Deaf Seniors in the United States Mary E. McCall	70
Chapter 7	Promoting Social Inclusion of Older People: Challenges for Policy on Ageing in Australia Helen Bartlett, Jeni Warburton and Chi-Wai Lui	79
Chapter 8	Intergenerational Family Relations and Social Support in a Comparative Perspective: The OASIS Project and Care Networks in Israel Ariela Lowenstein	92
Chapter 9	Counterpoint: Empowerment for who? An emergent debate in Sweden Owe Anbäcken and Petra Dannapfel (with Mary E. McCall)	105
Part 3	Overview of International Applications	
Chapter 10	Conclusions and Next Steps: Empowerment Across Cultures Tokie Anne and Mary E. McCall	116

Foreword

Dr. Tadao Takayama

I am pleased to have the privilege of providing special assistance to this talented group of authors who bring together their unique cultural perspectives and experiences in empowerment work. The CASE Model of empowerment framework developed by Dr. Tokie Anme provides students, faculty, and practitioners in any country with a practical application and guidance for empowering elders in various aspects of their lives. The chapters in this book illustrate the usefulness of this framework in different cultural contexts – Australia, Israel, Japan, Sweden, and the United States – and in different areas – social inclusion, family care-giving, health promotion, housing, and housing for seniors with special needs. This book took shape over many years of scholars from several countries around the world coming to share their individual and culture perspectives with researchers, students, and policymakers in Japan. The international and cross-cultural exchanges and collaborations that have been created out of this work will continue to grow in the future, nurturing cultural understanding and mutual learning. I have been happy to be a part of supporting their visits and learning from them the lessons of working to empower elders, regardless of cultural context, so that we may all create communities and nations where all members can reach their full potential.

Preface

Tokie Anne and Mary E. McCall

As industrialism and economic development have swept across the globe, cultural values and the role of the elderly in various societies have become casualties of the drive towards materialism and economic progress. As many industrialized nations face an aging population and the economic strains of changing dependency ratios, societies will have to create social policies and programs to meet the needs of their new demographic. And, these needs will have to be addressed through the cooperative efforts of many facets of any society – governments, both national and local, non-governmental organizations, non-profit and private-sector organizations, and families and individuals themselves. At the OECD forum in 2002, William Novelli, Executive Director of the AARP, noted that nations need to enact social policies related to aging issues that create economic and social sustainable development, design and nurture broad conversations and processes that include a wide range of participants' voices, and support positive social change so that we can create healthier communities across the lifespan (Novelli, 2002). The analysis of any country's policies and programs from even 50 years ago reveal that new theories and methods of social program development, implementation, and analysis are required to face population profiles that have never existed before on the planet. The long-discussed notion of empowerment is a useful concept or goal in this new world, but one which requires a concrete framework for implementation – a framework which can cross national and cultural boundaries to be utilized in many different situations.

This book offers such a framework of community empowerment, initially devised in Japan, but one which can be fruitfully applied in other settings, with appropriate accommodation to any local cultural values. It is only through the understanding and incorporation of cultural values that any general framework for empowerment will be effective. Equally important are the methods used to evaluate the effects of such programs to ensure the real progress is being made. And, then, there may be hope that we can create communities that can meet their own needs, in an interdependent manner that draws on many levels of contribution to make lives worth living across the lifespan, regardless of where on earth we live.

ORGANIZATION OF THE BOOK

In the first section of the book, Theoretical Foundations of Empowerment, Chapter 1 summarizes the history of the concept of empowerment, how it has been utilized across a variety of settings and issues, and how, more recently, it has come to be seen as both a *goal* and a *process* that occurs at multiple levels and requires collaboration amongst multiple groups to truly achieve. In Chapter 2, we offer the rationale for being conscious of cultural values when engaging in an empowerment process, especially given the rapid social and cultural changes that many societies are facing today. Traditional cultural values are obsolete in some cases, morphed into a hybrid of new and old values in other cases, and a crucial element in any hope of successful program development and implementation in all cases. Jackson (2002) points out the importance of examining aging and other human developmental phenomena only in the context in which it is occurring.

Chapter 3 presents the CASE Model of empowerment offered here, developed initially in Japan over many years. In the second section of the book, International Practice and Applications, we offer examples from a variety of countries where the CASE empowerment model has been applied. These countries include Japan (Chapter 4), Sweden (Chapter 5), the United States (Chapter 6), Australia (Chapter 7), and Israel (Chapter 8). Chapters 4 through 6 offer applications at a more local level, analyzing empowerment processes on the specific issues of health promotion, housing, and housing for seniors with special needs within relatively local, small communities. Chapters 7 and 8 approach the empowerment process from a more national perspective, providing unique insights into the challenges faced when attempting to inculcate empowerment practices at a national level. We then present a Counterpoint perspective from Sweden (Chapter 9) which raises questions about when empowerment of one group occurs (the elderly), what implications might that have for others involved in a care provider relationship with those older persons? In the concluding chapter (10), we offer an overarching summary of what we have learned works well in a variety of culture contexts and provide concrete tools to assist in empowerment efforts. Our hope is that this work contributes to the global efforts of many who seek to create environments in which we can all thrive and be truly empowered.

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We want to acknowledge the incredible support that Dr. Takayama has provided for all of us over the years to come to Japan and both contribute to and learn from the intentional policy and program development that scholars and practitioners there have worked so hard for over the years. We would like to thank the Japanese Ministry of Health, Labor and Welfare, the Japan Foundation for Aging and Health, Kagoshima International University, and the University of Tsukuba for all of their financial support of this project and its contributors.

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Part 1 Theoretical Foundations of Empowerment

Chapter 1
What is Empowerment?

Mary E. McCall and Tokie Anne

We must open the doors of opportunity. But we must also equip our people to walk through those doors.

Lyndon B. Johnson

The concept of empowerment is one that has engaged theorists and practitioners across a variety of disciplines and community action areas for decades. The ideal that individuals, local communities, and national governments would all work to maximize the value of personal choice that will ultimately lead to the fullest experience of being human as can be imagined by any one person, is a laudable goal that continues to galvanize many efforts around the world today. Over the years, there have been questions about the validity of such a seemingly ethereal goal and the probability of its achievement within the myriad diverse local circumstances around the globe. For example, Rubinstein, Kilbride & Nagy, (1992) point out that “for the elderly [and many other groups, potentially], particular conditions affecting their choice-making are entailed by structural and contextual issues” (p4). Yet more recent international efforts, while acknowledging the complexity of the goal of empowerment, continue to pursue this ideal and to face the realities of customizing empowerment efforts to local situations. To create a theoretical and historical context for the model of empowerment presented here, we offer a brief summary and analysis of varied theoretical and practical approaches to the notion of empowerment, before offering a framework for empowerment that, we believe, can be applicable in a variety of situations and circumstances around the world.

Overall, across the varied conceptual and practical models of empowerment, there is a common element of the recognition that empowerment must occur at multiple levels, and the acknowledgement that those levels must be integratively addressed for full empowerment to occur. Empowerment has been discussed as both an end in its own right AND as a step to deal with longer-term broader issues such as health status, income disparity, and fundamental human rights (Wallerstein, 2006). Initial notions of empowerment come from Paolo Freire’s work in the field of education and with severely disenfranchised poor people in Brazil, where clearly structural and contextual issues were at the fore in confronting illiteracy. Freire (1970) noted that there must be three essential components of effective empowerment: education, organization, and networking. Thus, the various levels at which empowerment processes must occur are the individual (acquiring education), the local community or social group (organization with others for similar goals), and then at a larger systemic societal level (networking with other organizations to accomplish larger institutional and systemic changes). Cowger (1994) also distinguished between personal empowerment (individual self-determination), social empowerment (the array of societal resources and opportunities available for individuals to utilize), and collective empowerment at the community level where organized networking opportunities are created (e.g., the American Association of Retired Persons

(AARP) in the U.S.). The World Health Organization (Wallerstein, 2006) concurs that empowerment can and must occur at multiple strata – personal, local community, and broader organizational levels as well. This same multi-leveled approach can be found in another theoretical approach to the concept of empowerment. Clark (1989) outlined four types of empowerment: 1) effective deliberation and moral reflection; 2) empowerment as personal process; 3) empowerment as political activism and social process; and 4) empowerment as balance and interdependence (between potentially competing social interests). The similarities between all these models are clear. Empowerment means claiming proactive authority and engagement at the personal individual level, the local social level, and the broader interdependent systemic levels. A closer analysis of each of these levels will reveal some of the continuing challenges to creating true empowerment across these strata.

Personal empowerment. Individual empowerment has been defined as a process whereby individuals work to reduce personal powerlessness and dependency by having increased control over their lives (Heumann, McCall, & Boldy, 2001; Lord & Hutchison 1997; Rappaport, 1987). Liaschenko ((1998) enumerates four facets of personal autonomy that include Clark’s effective deliberation and moral reflection but also include independent and free action and authenticity as important elements. Collopy (1988 cf. Hofland, 1990) defined autonomy as “a cluster of notions including self-determination, freedom, independence, liberty of choice and action. Generally, it refers to human agency free from outside intervention and interference.” And yet, to develop personal autonomy within the particular structural context, there must be relative definitions and manifestations of autonomy. For example, if an older person is physically and mentally healthy, with adequate economic resources, and living independently, their sense and experience of empowerment will look very different on the surface from one who is ill and poor and living in a nursing home. Yet this latter individual can still assert and practice autonomy within their specific set of circumstances. For example, choosing when and whether to eat or to participate in activities in an institution can provide as much a sense of autonomy and empowerment as being able to transport oneself to a desired location or activity. Clark (1989) notes that empowerment may be more easily grasped by thinking about what occurs when people have no power – powerlessness, helplessness, hopelessness, and paternalism may be found. When individuals are experiencing these feelings then empowerment is not occurring.

The potential benefits of individual empowerment are great. As individuals become involved, they gain invaluable personal skills. Individuals learn they have the ability to tap into potential they never knew existed within themselves. They acquire self-confidence and self- esteem. They acquire a variety of important leadership skills such as organizing and leading groups, problem-solving, and decision-making (Heumann, McCall, & Boldy, 2001; Lord, 1994; Lord & Hutchison, 1993). The field of health care has seen the beneficial outcomes of personal empowerment and shifted from a deficits approach (what can this individual not do for themselves and therefore what services must replace those abilities) to a strengths approach (asking what this individual can do for themselves, and how can services support those self-care skills, both in terms of development of those skills and maintenance of those skills) (Fast & Chapin, 1996;

Wallerstein, 2006).

As noted in an earlier discussion of empowerment (Heumann, McCall & Boldy, 2001), there are inherent risks in letting people make their own decisions. Often, those decisions are not what we (as professionals or providers or even family members) might choose for them. But, the underlying human value of individual dignity and rights must outweigh those risks that someone may choose self-neglect over self-care. As many have noted (Neill, 1994; Sykes, 1995; Wallerstein, 2006) empowerment is more often about those in power getting out of the way of those who seek personal empowerment. Sometimes this is done willingly, and sometimes unwillingly. But for those of us who have experienced personal empowerment and the opportunities to act on it, as well as seen it develop in traditionally marginalized communities around the world, we know this is a goal worth struggling for and supporting. However, as Wallerstein (2006) notes, “While participatory processes make up the base of empowerment, participation alone is insufficient if strategies do not also build capacity of community organizations and individuals in decision-making and advocacy.” (p4)

Community empowerment. In addition to the empowerment of individuals, there is a requirement that local resources and opportunities be available to individuals so that there are true choices to be made by them. Community empowerment refers to a process by which a local community gains power and control over its resources and organizations in order to meet the needs of its population, and to create an equitable system where individuals are engaged in building and maintaining local institutions and programs to improve the quality of their lives. This may entail the reorganization of existing agencies and/or programs in a community or the development (with community members actively involved in the creation process) of new groups and services directly tied to explicitly expressed needs. For example, the location of care options (i.e., home vs. institution), as well as the available mix of formal and informal care providers makes it harder for person to truly be able to choose meaningful and desirable options for themselves. Davey, Femia, Zarit, et al., (2005) reported that there were significant differences between the U.S. and Sweden in the mix of formal and informal care options, partially reflecting underlying cultural values about older persons, their needs, and what the respective roles of government, family, and individuals should be in providing care.

Communities in Japan have recently been taking measures to make themselves both more attractive regionally to people (so that they either relocate or don't leave to begin with), and to promote the sense that these communities are places where people see an environment where they can live for a long time with a sense of security and their needs being appropriately met. For example, since 2003, Myoko City has been focused on developing prevention- and community-based care programs to help prepare people for living longer in their communities. Thus, programs such as exercise modules focused on increasing muscle strength help delay the need for long-term care and assist elders in staying in their own residences longer. The Regional Comprehensive Support Center is a new agency that was developed to centralize information, referral, and services for community members and provide a mechanism for citizens to give feedback on services and suggest new ones to meet their needs. Since 2001 community centers called “Chiiki

Genki Chaya” (Happy Café’) have been created and can now be found in more than 80 areas. They have actually become a center for intergenerational exchanges, thus nurturing a growing sense of interdependence among various community members. Japan is also creating regional networks among support providers so that networks can provide a more integrated support system for people in the community, coordinating efforts by diverse service providers (Yamauchi, nd).

There are clear benefits to empowerment of the overall community. The community development process ultimately instills a growing sense of community awareness in individuals, which ultimately carries over into the enhancement of community life (Edginton, Compton & Hanson, 1989). Individuals develop a sense of caring for their community and are therefore more motivated to be involved in their community and to have an impact on it. There is a greater sense of interdependence, cohesion and cooperation among members of the community (Arai, 1995; Condeluci, 1991; Kerr, 1990). All of this further strengthens community pride and empowerment. Empowerment encourages people to do their best and create positive and effective networking among people. It promotes sharing of interests and empathy with other people. Wallerstein (2006) in her review of global empowerment initiatives, found that outcomes of community empowerment included an increased sense of community coherence, and the development of social capital and community assets. In addition, however, she refers to what the World Bank describes as an essential characteristic of community empowerment - what they call “the opportunity structure – the institutional, political, economic and governmental context that allows or inhibits actors to create effective action.” This points to the next level of empowerment that can synergistically work with the first two levels of empowerment.

Systemic empowerment. While many specific groups of individuals have worked for empowerment focused around particular issues (e.g., aging, literacy, education, disabilities, etc.) there has recently been a shift from the focus on certain groups of people to a focus on creating vital communities that can integrate and fulfill the needs and desires of all subgroups within a community. Thus, even though there have been specific world-wide meetings and fora focused on specific groups (i.e., the International Year of Older Persons in 1999), the themes of that meeting were “a society for all ages” and adopting a “life course perspective.” Thus, aging and other interests are now seen in the context of communities that need to support all people across the lifespan, beginning even in prenatal health, to ensure that each person can reach a meaningful and supportive later life. One theoretical framework that underpins this integrated approach about meeting the needs of people of any society across their lifespan was presented by Moody (1976) in terms of a continuum of social values related to elders in different societies and at different historical periods. [This analysis was also presented in other work by one of the editors here (Heumann, McCall & Boldy, 2001).] The four models or stages of how societies might approach the needs of elders, or any other group, were defined by Moody as (1) rejection; (2) social service; (3) participation; and (4) self-actualization.

In the Rejection stage, elders or any other unempowered group is repressed, segregated, or neglected. We can find this in countries where older people are “put away”

into nursing homes (often when not even needing nursing services) or other groups are excluded from mainstream society. In today's changing and aging societies, it is difficult to find a society in which older people can be entirely rejected, although the underlying attitudes and stereotypes may perpetuate the desire to do so. In the second stage of Social Service, needs of the elderly or particular groups are acknowledged by governmental agencies, but the recognition is based on the assumption of neediness of that group. The agency (local or national) interacts with group members, both individually and collectively through policies from a position of authority and power, and "knowing best." Decisions are made for the individuals and groups by the agencies. This can be seen in the United States in policies that have moved from strict national limitations on Medicaid spending to the opportunities for states (such as Oregon and Florida) to apply for using national funds in a block grant manner in order to design and provide services in ways that are more appropriate to their local populations. The service delivery is still based on guidelines provided by the government agencies, rather than a more fluid and individualized model that would allow the individuals to spend their allocated funds as they choose.

In the third stage of Participation, the locus of choice and control begins to move to the individual and can be seen in the variety of "consumer rights" movements across the globe. The United Kingdom was a leader in this in the early 1990s with the National Health Service and Community Care Act, and even some health maintenance organizations in the U.S. are now beginning to shift focus from reactive health care to preventive health care in a manner that assists people in developing individualized plans for healthy living. However, participation by individuals may range from sharing information to being involved in decision-making about their care, or actually arranging their care themselves. It is crucial that the rhetoric of empowerment not obscure shades of what seems like empowerment, but is not.

In stage four, Self-Actualization, a society becomes one where individuals and communities, along with the broadest levels of government and social institutions, engage collaboratively to remove barriers for persons and local communities so that all can both contribute to the development and sustenance of a livable community and benefit from the resources available. Thus, over a lifetime, the interdependence of persons at different life stages, and with different needs, is built into the social system – locally and nationally.

One example of an approach that would manifest Self-actualization is offered by Nusberg (2000) in a discussion document entitled Strategies for a Society for All Ages. This provides 42 recommendations that are designed to be suggestive rather than prescriptive, and though all may not be relevant to the heterogeneous societies – local and national - around the world, many will be applicable to varied countries. The common theme is interdependence across life stages and generations and between the empowerment levels noted earlier, – personal, community and systemic. Strategies are organized around issues as varied as health, education, economic security, work and other productive activity opportunities. They encourage personal, social, and communal empowerment actions (in line with Cowger, as above) such as eliminating discriminatory

practices so that individuals have increased opportunities to make choices for themselves, and creating family-supportive policies that take into account the varied family roles that people hold over their lifetimes.

Other examples of the growing number of Self-actualization approaches are increasingly apparent around the world. As summarized by Wallerstein (2006),

“In 1978, the World Health Organization's Alma Ata Declaration first articulated the goals of community participation and equity, with subsequent extension to empowerment in the Ottawa Charter and Jakarta health promotion declarations. The bringing together of health with social and economic development has been a relatively recent phenomena, with the 2000 United Nations Millennium Development Goals, which included women's empowerment and health interventions, the World Bank's Strategic Framework and poverty reduction strategy, which identified empowerment of poor people as one of two priority strategies to improve development effectiveness, and the Commission on Macroeconomics and Health, which has advocated health sector investments for economic growth in developing nations.” (p. 17)

In addition, recently a report was produced for Health Canada that analyzed the societal challenges facing Japan, Finland and Australia (Policies for Aging Populations: An International Perspective (Lilley, 2002)). In Australia there have been national initiatives to create communities where people can age-in-place. In Canberra, there was a framework for future planning provided, entitled “A Society for All Ages: The ACT Government Policy Framework for Ageing, 2007-2009” (Publishing Services, 2007). This framework addresses multiple layers of social life, including health promotion and care, support services, social inclusion and activity, housing transportation, education and work, as well as other areas. A similarly comprehensive community development plan is being created and implemented in a region in northern California, in the United States, entitled “Contra Costa for Every Generation” (<http://www.foreverygeneration.org>). Clearly, many global organizations, nations, and local communities have come to the realization that integrating multiple levels and approaches to address serious systemic problems is the only realistic, though admittedly complex, method by which to create major social change.

Evaluation of empowerment processes. All of these efforts demonstrate the movement of many countries from a focus on particular issue or interest group to the understanding that all of us live in interdependent systems that must be treated as such and that any successful program to support and sustain individuals must ultimately support and sustain efforts at the local, national, and international levels with systems that reinforce each other. And because empowerment processes do occur at multiple levels, and the needs of any individual or society will change over time, evaluation of empowerment efforts must be an integral part of any movement towards change. Once empowering change has occurred, one cannot assume that the work is done and systems

will maintain themselves. Thus, evaluation methods must be in place from the beginning of any empowerment process and must be engaged in consistently over time (Wallerstein, 2006). Admittedly, evaluation of empowering is highly challenging, especially when multiple levels of engagement and change are occurring. However, we believe that starting with specific targets for change can, in fact, aid the monitoring and evaluation process, even if the contributing factors to that change are multiple and complex. Including a wide and representative range of persons involved in all stages of social change, especially during the evaluation stage, will strengthen the ability to assess whether and what kind of positive transformations have occurred. While no clear true experimental designs can really be employed in this endeavor, any progress we make towards documenting interventions (even complex ones) and the progress towards desired outcomes will move societies toward understanding the effects of programs and policies in a deeper manner.

Multiple methods of evaluation have been developed by the World Health Organization, the Pan American Health Organization, the World Bank, and systems developed by Rifkin (2003, cf Wallerstein, 2006) and Bartle (2008). All agree that evaluation must include participation by those who, most importantly, are impacted by empowerment programs, and hopefully, those are the same participants who developed such programs from the start. A mix of methods (quantitative, qualitative, etc.) is required, while not necessarily requiring an experimental randomized design – which is unrealistic in most community settings. Evaluations should be of both processes and outcomes. Dimensions of “Capacity-building, Human rights, Organized sustainability, Institutional accountability, Contribution, and Enabling environment are part of the CHOICE model developed by Rifkin (2003, cf Wallerstein, 2006). Bartle (2008) also offers a set of training manuals for community empowerment, including those for evaluation, based on years of experience working on development projects around the world, and his methods also address similar issues such as communications, information, intervention, leadership, organization, etc.

What all of these evaluation methods have in common is the need to include those who were directly involved in the design and implementation of empowerment processes, and to be specific about what elements of change are to be measured and evaluated in order to conclude that progress is being made. In the empowerment process and evaluation model offered in this book we, too, include those critical elements. But before we introduce our framework for empowerment, we want to discuss the specific role of cultural values in understanding why and how a specified model of empowerment can work in any given set of cultural circumstances, once the fundamental analytic lens of cultural understanding is utilized.

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Chapter 2 Cultural Values and Empowerment

Mary E. McCall

Every day in various countries and communities around the world, competing values vie for priority in the allocation of resources and the development of policies and programs in terms of health care, education, clean water, or those that might affect not just the elderly but many others in any given society at any given time. Key cultural values of self-reliance vs. dependency, individualism vs. collectivism (or individual vs. family-orientation), equity vs. adequacy, and private vs. public responsibility get played out in daily decisions. Yet, in the long run, the question remains as to how we can all create sustainable models of community, regardless of specific cultural settings, that provides appropriate support so that all community members feel empowered and can experience an adequate and life-affirming level of sustenance and development, thus achieving the kind of self-actualized society we discussed in Chapter 1. By examining different countries around the world that are facing similar challenges, even with very different cultural values and contexts, we can perhaps learn from each other creative and more appropriate ways to deal with the complexities of social, demographic and economic changes that we all encounter in this new century.

One critical element in empowerment work is, as was mentioned in Chapter 1, sensitivity to local conditions and circumstances and part of this is the set of cultural values that any particular group or nation holds. This chapter discusses how cultural values can change over time and the potential impact on social policies that those changes can have. Each subsequent chapter will begin with an introduction to the dominant cultural values of the society being discussed, and any changes over time in those values that would affect social policy and empowerment efforts. We believe that understanding and analyzing how to support the empowerment of individuals and communities across the globe requires sensitivity to contextual issues and the creation of a framework that can be flexibly applied in a variety of circumstances. To illustrate the examination of the role of values in different societies, we use an oft-cited comparison between the United States and Japan – two societies that historically have been seen as polar opposites in many respects and yet, as we'll see, may be becoming more like each other than ever before in history.

As the world becomes smaller in the sense that there is increasing contact between cultures and societies, it will be intriguing to see the effects of intercultural contact on social values, and then how those affect social policies for citizens of different countries. For example, as Japan's current generation of young adults (who have had much more contact with Western countries than any previous generation) grows older, will they maintain the more traditional values of family and community, or will they begin to look more like some Western societies in terms of individual autonomy and choice? As the United States faces increasing distance between rich and poor individuals within its society, how or **will** they, be able to strike a balance in their social values in order to stop the divide from growing even larger? Holding onto traditional values in the face of major demographic changes has already resulted in some very challenging and

unintended consequences in some countries. For example, in trying to deal with unsustainable population growth through the implementation of a one-child policy, China is now facing an unprecedented gender imbalance in terms of the number of young adult men compared to women. The gender preference, a traditional cultural value that was, in part, based on economic necessity in the past, has resulted in a new major social challenge for China. Similarly, we can see that reproductive policies in India being designed in order to ensure sustainable economic, social, and health futures for their population are very difficult to separate from the long-standing cultural values that ascribe higher value to male children than female children and the social roles of both husbands and mothers-in-law as the gatekeepers to empowering individual women around childbearing decisions. Local and national efforts for the empowerment of women demonstrate that as women become more educated and skilled enough to contribute financially to their household, they gain more power over their reproductive behavior and choices, and family planning efforts can be effectively utilized. And yet, these empowerment processes necessarily had to take into account the specific cultural context of the important roles of husbands and mothers-in-law in order for successful empowerment of women to occur and begin to provoke real social change.

A Comparative Framework

To gain insight into the relationship between nations as we become a more interdependent world, it is helpful to have an analytic framework with which to understand comparative social change. One provocative and appropriate framework for the analysis here is Convergence Theory (Levy, 1966, cf Marsh 2007; Form and Bae, 1988). Convergence Theory posits that, with increasing modernization, all industrial societies will become similar in structural arrangements, *and value orientations*, because industrial development requires a particular set of functions and relationships to develop in order to succeed. These arrangements and orientations are called “functional imperatives.” This is a fairly Eurocentric approach to understanding economic change and its accompanying social development (assuming that other countries will become more like developed central European societies over time). In contrast, one could utilize the Anti-Convergence Theory, postulating that the deeply ingrained cultural background and historical traditions of a country, such as in the case of Japan, would prevent convergence with another country’s experience of industrialization. In a different approach, Dore (1973, cf Sugimoto, 1997) offers the Reverse Convergence Theory, stating that other industrial nations are, in fact, converging on Japan’s system in terms of business practices, educational approaches, etc. and other nations will meet the Japanese on their ground eventually. A fourth alternative theory is the Multiple Convergences Theory, which states that two or more types of development are observable, depending on when industrialization began and the type of cultural background that predominated. Within this model there is first, the “late developer hypothesis” – that is, in contrast to the Anglo-American model of development of early industrializers, later developers like Japan had to evolve different social configurations to cope with different domestic and international constraints. We can also see this in Germany and Italy, as well as Japan, where they had to design systems that could maintain some components of traditional culture while also creating political and economic systems to deal with emerging

industrialization. In many countries today, radical population changes are challenging societies to rapidly change social policies to address such changes in a more intentional manner, so they don't end up with a demographic profile (e.g., senior-heavy such as Japan, or child-heavy such as India) that is economically and socially unsupportable or unsustainable.

To apply this comparative framework of Convergence Theory, we compare one specific pair of countries - Japan and the United States. We choose these two countries because they have often been compared in terms of how they view and treat the elderly in their respective societies. As Japan and the United States move through the 21st century, they face very similar challenges as their rapidly aging populations grow. At the same time, both countries are also dealing with increasing economic demands as health care costs increase, and growing populations call for higher public expenditures. In addition, both countries have been affected by the growing "global village." The interchanges between the United States and Japan have been linked in a special way because of World War II, and educational, economic and business developments since then, as well as the general increasing effects of "westernization" on many Asian countries.

Clearly, the United States is the larger and the more culturally heterogeneous of the two countries. Japan is both much smaller and, at least on the surface, looks much more culturally homogeneous, although it, too, is responding to greater numbers of immigrant and native populations in its midst. However, it is clear that there is a much stronger sense of national pride or perhaps even national identity in Japan than most Americans might proclaim for themselves about their identity as Americans. Interestingly, this sense of national identity and/or pride in the United States may actually be increasing since the terrorist attacks of September 11, 2001, and it will be intriguing to see what effects this may have, if any, on domestic social policies generally, and those for the elderly, specifically. And, finally, a major underlying difference in orientation toward society and others around them is the continuum from individualism to collectivism. On one end of the continuum, we have the United States, obviously one of, if not the most individualistic nations on the earth. In contrast, we might think of a country that would be on the other end of the continuum – a country like Sweden, where communal and social democratic values shape the daily economic and family lives of citizens there. Somewhere in between these two extremes is Japan. We would argue that Japan has, historically, been much closer to the Swedish end of the values spectrum, but has, in the past 50 years, moved slowly and inevitably towards the individualistic side of the range. For us as gerontologists, this socio-historical transformation, happening before our very eyes, is one of the unique experiences that we may have the opportunity to observe. The intriguing question, of course, is – what will Japan look like in another 50 years? Will it become more similar to the United States in terms of cultural values of individualism? Or will it remain somewhere in the middle and able to maintain important traditional collectivist values and policies? Or will it create some new way of social functioning that we cannot yet imagine? Conversely, will the United States become more like Japan, or any other country with different cultural values? Only time will tell.

The concept of *structural lag* can help us here to grasp the reality of the time lag

between the social and demographic changes that have occurred, and our response to them with appropriate social and economic policies. This is being felt acutely in the United States, as they struggle to determine how best to address Social Security, Medicare and Medicaid policies, even as these challenges have been seen coming for the last several decades. Interestingly enough, Japan has done a better job of responding more quickly to the demographic changes, and perhaps this is due to its smaller size, and more centralized government, which likely leads to more political flexibility than in the United States. More specifically, however, we want to examine various aspects of health care social policy affecting the elderly, and analyze how the underlying cultural values of Japan and the United States have influenced these policies, whether they have become more similar or remained fundamentally different in terms of orientation, and what we might learn from each other in order to more effectively empower individuals and communities in meeting the needs of all citizens.

We choose to examine various aspects of the health system in each country, since this is the linchpin for much of the quality of one's life in their later years. More specifically, four areas of health services and policy will be discussed. The first of the four areas to discuss is the actual *structure or delivery system* of a nation's health care services— a critical factor in any society in terms of how it approaches meeting the health needs of its citizenry. For the elderly, a major concern is long-term care (LTC) coverage, and we know that there is a major difference between Japan, which has a social insurance LTC system, and the United States, which currently has no public LTC system in place. Secondly, we want to look at the *focus of health care* – whether a society is focused on preventive care vs. reactive or acute care. Third, we believe that the *locus of decision making* – who gets to make decisions about and for older persons, and what that locus reveals about the value placed on the individual in determining or choosing their health care is an important component of understanding cultural values around health care. Finally, we discuss the *location of care* – is it family-based, community-based or provided for the individual only – and how that reflects underlying social values.

Structure of health care. If we begin with the structure of health care and health policy, we can see clear differences between the two countries. In Japan, basic health care is structured somewhat similarly in that largely the government and businesses pay for it. For the more expensive long-term care, it is funded through a national health insurance plan. Realizing that their aging population would increase the need for such care, but also acknowledging the political infeasibility of increasing both taxes and employer contributions to cover such needs, Japan devised a system where it is not paid for through taxes, but through an insurance plan that all citizens pay into and benefit from. In the United States, there is essentially a health care system that is privatized – paid for through employment, or, if someone is poor or disabled or over 65, public programs such as Medicaid or Medicare will pay some very basic health care costs. There is essentially no program that covers long-term care costs. Fundamentally, Americans pay for their own health care expenses.

Each of these structures reflects some fundamental social values of each country. In the United States model, health care is a privilege or a commodity available to those

with adequate resources. In more socialist countries, however, health care is seen as an important part of developing the “social capital” needed to ensure a healthy populace, so it is a governmental, social, and fiscal priority. In Japan, similar community and social values are seen reflected in their structure, as well, where everyone contributes and everyone benefits. However, with the economic constraints resulting in political hesitation to take on more universal public responsibilities for health care, for example, they developed the long-term care insurance plan. In contrast to Japan, but in concert with the cultural value system of individual independence and self-sufficiency, the United States leaves health care to the individual, with only the minimum support for the neediest of our society. The consequence of this for older people is that, for many, much of their income goes to health care expenses (particularly medication costs), and the state of their health can suffer without adequate care, which, eventually, leads to greater costs for more expensive care.

Recently, there has been a new policy enacted to cover prescription medications for older people and this has helped some with medical costs, though everyone agrees the system is bulky and difficult to navigate. There continue to be discussions of the possibility of a national health program and yet this continues to be a course of intense and contentious debate across the country, with no real progress made. One of the fundamental components of such a national health plan would be more preventive care, with the goal of saving money in the longer run, from not having to treat persons who are more ill than they might otherwise be under a different system. This is related to what the focus of care actually is in each country – more preventive or more reactive after illness or disease has set in.

Focus of health care. In some countries, especially perhaps nations with extremely limited economic resources, a decision is often made to focus on preventive care. This serves a number of purposes. In general, and in the long run, it will lower health care costs, as conditions or diseases that might become more expensive over time untreated are treated early or controlled. In addition, it supports the development of what was mentioned earlier – social capital. If a society is to function well, the human capital it has must also function well. Thus, preventive health care is a basic step towards developing that functional human capital. So, even in an era of shrinking economic resources, health care maintains its place as an important social priority.

In Japan, the focus is on preventive public health. Public health centers, serving all ages and all incomes, provide health education, screening, consultation and support from prenatal education and care, to senior exercise classes and recreational day care centers. And while the wait may be long for some basic services (as is common in many countries with national health care systems) they are, in fact, available to all.

We can contrast this type of system with the more reactive health care model of the United States. There, a person is more likely, if insured, to be able to have state-of-the-art medical treatment for a serious condition that may well have been preventable if the overriding message of health care was to prevent disease, rather than treat it well once it has developed. But if uninsured or poor, one gets treatment through emergency medical

services, generally, rather than through ongoing preventive care. But, as has often been said about welfare programs, Medicaid, etc., - “programs for the poor often become poor programs.” This can be seen happening now in many places across the country, where Medicaid services and reimbursements are being cut and more poor people are receiving poorer or no care at all. Such a system clearly reflects that uniquely American notion of self-sufficiency and an expectation that the private individual, rather than the public community or society at large, will take responsibility for his or her own health care. Thus, it may seem on the surface that individuals have some “power” when it comes to health care, but only if they already have the economic power to purchase those services.

However, there has been some movement, from some health maintenance organizations, to encourage and support preventive health practices. This can be seen in television and print advertisements targeted towards parents who might not choose to have their children vaccinated against typical childhood diseases, etc. However, the motivation for this seems to come from an economic impetus (saving money) rather than a social capital impetus (saving people for the future of society). The United States remains the only industrialized country without universal prenatal care for its citizens, continuing to rely on the individual to make choices about what health care to utilize, even when those choices are limited by the system and may have dire consequences for people (e.g., infant mortality and/or disability).

Locus of decision-making about health care. This value of individualism and self-sufficiency relates to the third area under examination here – that of the locus of decision-making about health care. Does the individual decide what health care they need/want/receive – or does a “system,” typically a governmental system? Japan is somewhere in the middle – an industrialized country with a deep and abiding sense of commitment to family and society that often overrides individual interests or desires. Currently in Japan, recipients of elder care receive vouchers with which they can purchase services themselves. Japan has often been held up as the “ideal” society in the ways in which they “value” and treat their elders, and yet, as with so many ideals, the reality is different in many ways. As we will see shortly, that is changing rapidly these days as younger Japanese become more individual-oriented and this shift may have profound effects on health and other types of care for the elderly there. For example, traditionally, family members would provide all the care for an older person, or at least be closely involved with care decisions. Currently, Japan is in the midst of training a huge cadre of professional case managers, who will fill the void left by relatively less involved family members. Education and licensing of these case managers is a priority there. This is a major shift in who will make decisions about health care for older persons in Japan.

Interestingly enough, however, while the United States espouses values of freedom of opportunities and autonomy of choice, it has one of the most limited and limiting models of care compared to European countries like England, Germany, Austria, and the Netherlands. Health care choices are constrained by private and public insurance plans and what they will or will not pay for. As noted above, it is the only industrialized country that does not provide free and universal pre-natal care, let alone long-term care coverage for major health catastrophes. Clearly, the United States continues to grapple

with the conflict between the values of individual freedom and autonomy and the values of social and communal responsibility and care.

Location of elder (health) care. Another area in which we can see values reflected in care practice is the place in which elder care occurs. For this section, we want to differentiate specific medical care (which generally takes place in medical institutions in both countries) and the more general type of care (assistance with daily tasks, etc.) that elders also need. So, for example, in the United States, the majority of older people live alone, and while some care is provided by family members, much is also being supplied by professionals. Most surveys reveal a strong desire on the part of older Americans to live on their own, even if close to children. However, in Japan, the majority of older persons live with their families in three- or four-generation households and care occurs there. While this is changing in Japan, due to a variety of reasons, it is still the general custom. In order to really understand the impact of these changes, let's look for a moment at what has happened to family structure in the last 100 years in these two countries.

In both countries, over the 20th century, life expectancy increased dramatically. In the United States they went from a life expectancy of 46 in 1900 to a life expectancy in the late 70s in 2000. In Japan, a similar change occurred, although life expectancy is even higher there – one can expect to live into their early 80s. In both countries, over the last century, there has also been an overall decline in fertility. So, for example, in Japan, while there are an overall greater number of households, there are fewer people in each. The number of nuclear households in Japan has been decreasing since 1975. The number of 3-generation households has also declined, while the number of households headed by single people has risen. We see a similar trend, even more dramatically, in the United States (U.N., 1994). What effects have these changes had on intergenerational relationships and attitudes, and how might these affect the health care of elders?

Generational relationships. Rosenthal and Martin-Matthews (2000) have used the term “structural potential” to “denote how family structure creates the potential for experiencing various types of family role demands.” Bengtson and Harootyan's (1994) term “the beanpole family” describes a multi-generational family with only few members at each generation. In whatever form the family has taken in these societies, and whatever the analysis and conclusions are about those forms and changes, there have been a number of consequences for intergenerational and care-giving relationships within families. This is especially important to be aware of as the traditional source of care-giving changes. These consequences have affected both the need for social policies to address family circumstances, and the attitudes which people carry into their choices about supporting such policies or not. We can see, for example, that while the average household size in Japan was around 5, until 1955, it declined to about 3 by the 1990s and the current average number of children is about 1.8. This has resulted in today's nuclear families in Japan “enjoying” a new sense of autonomy and independence from one's in-laws, but also for many, mostly women, it has meant a more solitary and lonely life. This may have resulted in less connection between generations and thus a more distant attitude among younger Japanese towards policies directed at the old. Many would argue that the same situation holds in the United States, for example, with adult children in one state

and elderly parents in another. In both countries, this has spawned a whole new industry of geriatric case managers, long-distance care-giving services, local services who manage for long-distance adult children, etc. These services are taking over the traditional family role of care-giving.

In Japan, a 2001 national survey showed that almost twice as many people under the age of 80 (even those in their 60s and 70s) as those over 80 felt that it was not desirable for 3 generations to share a home. However, overall, this is a small percentage of people, with 60% of adults still feeling that it was desirable to share a home (Takagi & Silverstein, 2006). Thus, there seems to be some shift occurring in attitudes about family responsibilities and relationships. Recent analyses of the Japanese General Social Survey (JGSS), collected in 2001, demonstrated that most Japanese, especially those over the age of 60, felt that the individual and/or family, rather than the government, should be responsible for the financial livelihood of the elderly. However, when it came to responsibility for the medical and nursing care of the elderly, more Japanese, including more elderly themselves, felt that the government should take more of a role (Takagi & Silverstein, 2006). In the United States, however, both financial and medical responsibilities are seen as belonging to the individual, except for those persons who are in extreme circumstances and cannot provide a very minimal subsistence for themselves. In such cases, the government will step in, but not provide more than a bare floor level of support. And the role of the government in provision of care continues to be a source of difficult discussion in the United States, illustrating again the deep and abiding cultural value of self-sufficiency and individual responsibility for one's well-being.

So, given this analysis, what we can see about the convergence of cultural values between these two countries with very different histories and yet facing a similar future in terms of aging populations and increasing economic pressures? In some ways, Japan may be starting to look more similar to the United States in the following ways: As younger family members adopt more traditionally Western values of independence and individualism, older Japanese citizens may need to deal with their health care issues on their own and there have been structural changes that seem to be supporting that direction of movement. With the increasing professionalization of elder care providers in Japan, the locus of health care decision-making may be moving away from the individual, to the organization, similar to the system in the United States where insurance policies delimit what choices people have (unless one buys their own health care services privately). And, as older people become more likely to live alone, they also may be more likely to seek health care on their own.

The United States, in some ways, may be seen as becoming more similar to Japan in two ways: there continues to be discussion about a national health care policy and small progress on specific implementation methods can be seen. Yet, the national debate on this topic remains stalled in many ways. Many health insurance companies and health maintenance organizations/providers are, however, moving to a more prevention-oriented approach to health care, even if for financial motivation at this point. However, the locus of decision-making remains with the organization (insurance companies) rather than the individual (unless one pays privately), and the location of care continues to be focused on

the individual, rather than the family or community.

Thus, it seems that there may be slight evidence for the Convergence Theory in this small example, which coincides with the much larger, multi-nation studies of convergence that have been conducted over the years (see Marsh, 2007 for a summary). What this analysis does demonstrate clearly, is that understanding the role of culture and cultural values is critical to understanding the potential changes that might occur from an empowerment process. Thus, any efforts in empowerment must first be situated within the cultural and historical context of the given society of focus.

Conclusion

As Ann Robertson pointed out several years ago: “our very individuality exists only as a result of our embeddedness in a network of relationships both private and public. None of us is totally independent of our context – social, political and economic; rather, we are located and live within complex webs of mutual dependence or interdependence.” (Robertson, 1997, cf Gee & Gutman, 2000). Thus, empowerment processes cannot be designed or implemented independent of the embeddedness within local and cultural contexts, which are under girded by cultural values. As societies change over time, so do their values, and they reshape them and resultant social policies and programs in that light. The sooner we recognize and incorporate these change processes in our empowerment efforts, the sooner we can create communities and social policies that support that reality. In the next chapter, we offer a particular framework for empowering older persons and other community members, with a specific set of goals in mind, but a framework which we believe can be fruitfully applied in any cultural context, *if people pay close attention to and incorporate existing cultural values in the empowerment process.*

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Chapter 3

The CASE Model: An International Framework For Empowerment

Tokie Anne and Mary E. McCall

This chapter presents the CASE Model of the process of empowerment through **four stages** (Creation, Adaptation, Sustenance, and Expansion) that occur at **three different levels** (personal, community, and systemic), as outlined in Chapter 1. There are also specific functional skills that operate at each stage. These four stages and three levels of empowerment must be also be appropriately placed within the cultural contexts of various countries, as outlined in Chapter 2, addressing what we call **critical components** for success. We propose that if this model and the requisite skills for empowerment can be effective in a rapidly evolving social context such as Japan, where the model originated, and which will be explored in detail in the following chapter, then they may well be appropriate for application in many societies around the world. And, as we will see in other chapters from other countries, this framework can help us to see the similarities across seemingly different societies that face the same issue of caring for its citizens across the lifespan. Thus, we may all, hopefully, move in the direction becoming *self-actualized* societies.

In many countries around the world, it is most likely that initially, an “*empowerment culture*” for both individuals and the community must be developed in order to recognize the need to promote mutual help. This may be more or less of a challenge, depending on the history and social/political systems of a specific society. As noted in Chapter 2, existing cultural values may be an impediment to overcome at the outset of an empowerment process. For example, in Chapter 4, we see that the concept of empowerment is a relatively new idea in Japan, a traditionally family-based culture. However, in Chapters 5-8, we see that in other countries, such as Australia, Israel, Sweden and the United States, there has been a long history of commitment to empowering individuals and communities. Even in these countries with histories of positive social attitudes toward empowerment, there are competing interests, such as economic pressures, that provide challenges to those who strive to empower elders. When shifts in cultural values are achieved, this can provide a strong means of influencing people. To change or address any existing social problem, the cultural traditions and attitudes that were perpetuating the unfulfilling situations need to be intentionally faced first. As a result, more community members will at least begin involvement in the empowerment process with a more open attitude to see how things develop. The first steps in the proposed CASE model of empowerment are designed to help address cultural values that may create an initial barrier to action and progress.

FUNDAMENTAL FACTORS FOR EMPOWERMENT

In this new model of empowerment – CASE – there are **four stages**: *Creation, Adaptation, Sustenance, and Expansion* (see Figure 1). In the first stage, *Creation*, the desire for change and improvement of a given situation or social problem spurs the idea for how to start an empowerment process. During the second stage of *Adaptation*, the empowerment efforts must be adjusted to circumstances of the particular situation. In the

stage of *Sustenance*, empowerment work can get to a steady state, so that processes are efficient and consistent. In the fourth stage of *Expansion*, new outcomes may be desired and articulated, so that the process can develop and expand to include new people and new goals.

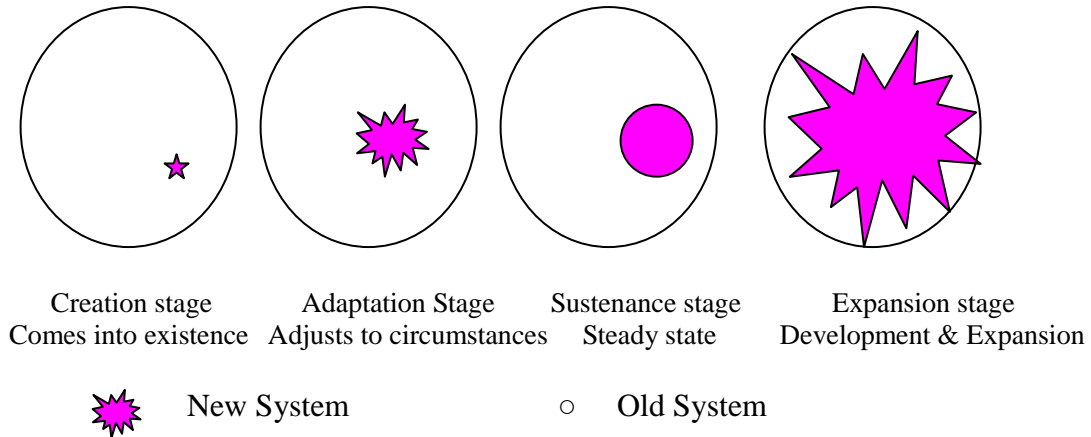


Figure 1. The CASE Model of Empowerment

All of these stages take place within a fundamental context of human empathy and cultural values, so that each person is valued and included equally in the work. A visual image of the functional skills of the empowerment model can be seen in Figure 2 below. This representation of the process can be helpful for some people in the community who might have a hard time envisioning what the various components of this process look like. In Figure 2, we show that the functional skills for empowerment are: Targets and Strategies, Processes and Organization, Evaluation, Information, and Effectiveness.

Targets and Strategies help us to plan what our desired outcomes will be and how we can begin to reach those outcomes. The *Targeted Outcomes* that are discussed later help focus our attention on the most important goals. Then we can start to devise our specific strategies for achieving those goals. The strategies may involve new programs, specific types of activities, etc. In future chapters, we will learn about the various strategies that have been used in different countries around the world in trying to reach the *Targeted Outcomes* of a particular empowerment process situation. Over each stage of the CASE Model, the Targets and Strategies may be modified, in order to maximize reaching them over time.

A second key set of functional skills for empowerment is developing new Processes and creating an efficient Organization so that work can get done and people have a clear sense of what is happening, and why, and what is being accomplished. Across the stages of the CASE Model, Processes will be developed that will need to be adapted to local circumstances, and then solidified to be efficient while also being flexible to respond to changing needs. Ultimately, we want to have an organizational model that can work interdependently with other organizations and processes at different

levels (e.g., local with national) so that efforts work smoothly together.

Evaluation is a key skill for empowerment at all stages of the CASE Model. If we can identify outcomes early on, and the measures we want to use to assess our effectiveness than we must have ideas about how to evaluate our progress as we move through different stages.

Also important is the kind of information that we collect and share with all members of the empowerment process. Information is a foundational element that underlies the Targets and Strategies, Processes and Organization, and Evaluation skills. If we do not have good information systems, then the other skills will not work well. Information is key for people to understand what is occurring, what outcomes are being achieved, and what they might be able to do to participate in a meaningful way in the empowerment work. Information systems that are clear, consistent, and accessible must be developed throughout all stages of the CASE Model.



Figure 2. Diagram of Functional Skills for Empowerment

Another underlying factor for functional skills in empowerment is Effectiveness. Clearly, one ultimate outcome of empowerment is the effectiveness of new programs and processes that we put into place to achieve our goals. In the first stages of the CASE Model, especially if we are designing new programs, we must be open to seeing how we can improve effectiveness over time. This will be especially a challenge if one is working in an environment where initially, a culture of empowerment does not already exist and

so sometimes creating new collaborations and working with new teams of people does not seem so efficient. But this will change over time, as people move through the later stages of the CASE Model.

And, finally, the most fundamental skill for empowerment is a sense of Empathy for other people that we can relate to as other human beings. Understanding and being sensitive to the cultural context in which we are working, and having feelings for what other people are facing, will help us finally achieve our goal of a self-actualized society, where all people feel supported and able to develop their ultimate potential.

Table 1 below summarizes the different functional skills across the four stages of the CASE Model. This can help visualize what is appropriate for people to be aware of at each stage, and what can be the focus of their efforts for each skill in each stage.

Table 1 Functional Skills for Empowerment by Stage

Stage	Creation	Adaptation	Sustenance	Expansion
Targets & Strategies	Articulate desired targets for outcomes and devise new strategies for how to achieve them	Share the vision as a team and create logical and flexible strategies	Implement the strategies with high quality and consistency	Develop a new vision and strategies for new targeted outcomes
Processes & Organization	Create new processes and organization to achieve outcomes	Adjust the processes as a team and design logical and flexible organizations	Implement new processes and organizations with consistency and flexibility	Expand new processes and organizations to utilize comprehensive
Evaluation	Design initial measures for meaningful evaluation of targets	Adjust the measures as team based on early feedback	Conduct regular evaluations with established measures	Utilize evaluation results to expand empowerment targets and strategies
Information	Discover what new information is needed to share targets and strategies with people	Adjust the information and communication for individuals, the team, and the community to	Share important information with consistency and flexibility	Comprehensive use of the information for communication and evaluation
Effectiveness	Create clear indicators of effectiveness	Adjust the indicators of effectiveness based on initial feedback	Pursue the effective use of resources	Expand ongoing effective use of resources for targets

There are also a set of what we call *Critical Components* in any empowerment process. These include the *Identified Community* for a particular empowerment project, which agrees upon a set of *Targeted Outcomes*. These outcomes are always within a set of *Contextual Factors*, which will help identify both challenges and opportunities for moving through the CASE stages. In addition, *Initial Resources* must be identified so that both the *Contextual Factors* and *Initial Resources* can be effectively incorporated into and addressed throughout the empowerment process.

Identified Community. Initially, or sometimes at the same time as the general

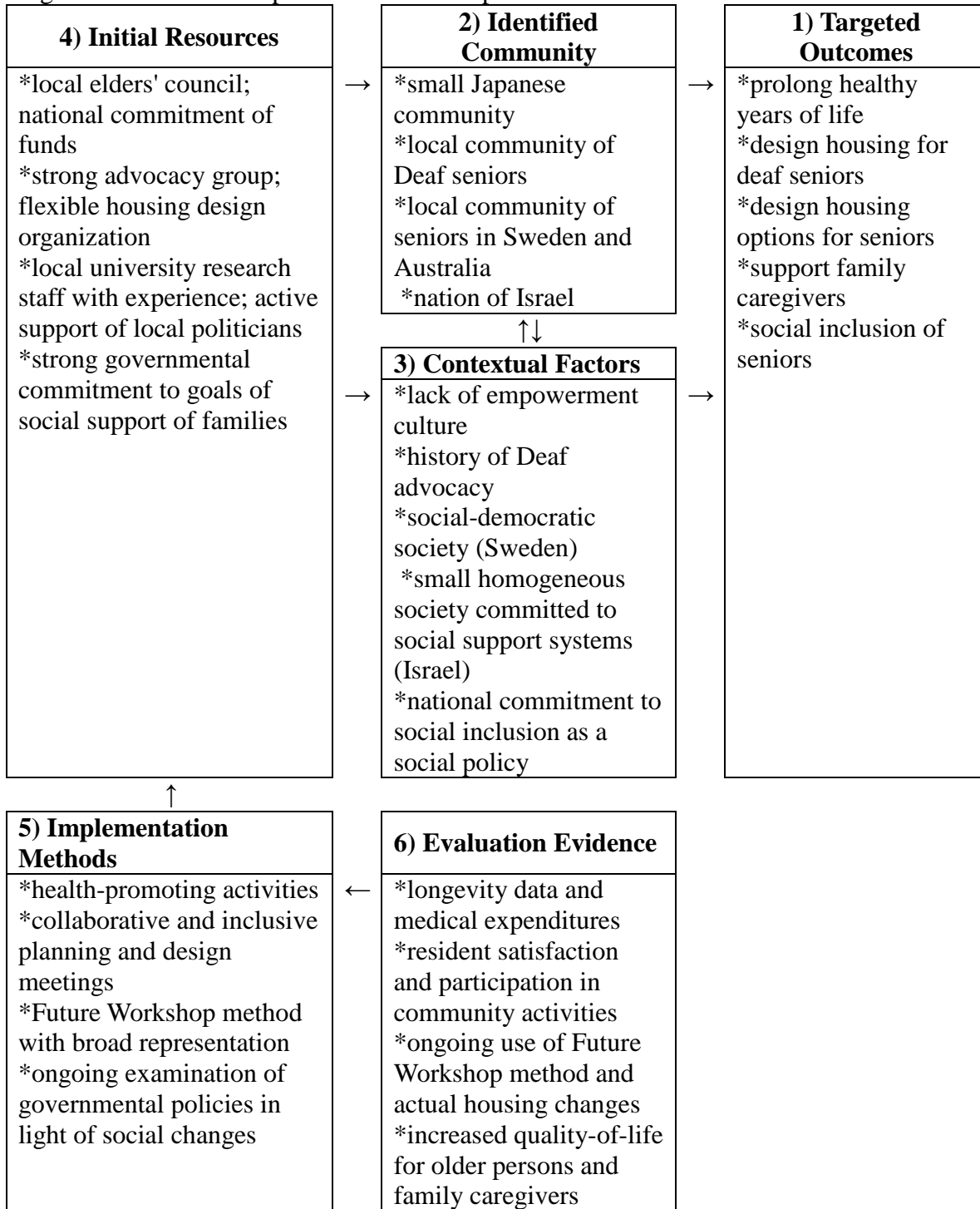
problem/outcome specification, the community that will be involved in the empowerment process must be identified. This may range from a very local neighborhood (such as in Australia, Sweden or Japan) or specified group (such as Deaf seniors in the United States) to a nation itself (such as Israel, and in some ways, Australia, as well). Who in the community should be specifically involved may take some time to delineate, as often there are either competing interests in a given community, or some members may feel that they are not relevant to a particular problem (e.g., why should young adults be involved in programs for older adults, or vice-versa?). Thus, there is often give-and-take between the *Identification of the community* and the specification of the *Targeted Outcomes*.

Targeted Outcomes. It is vital for empowerment efforts to work that specific and measurable outcomes be identified from the start – whether they are health and well-being outcomes (Japan and Australia), housing (Sweden and the U.S.), or family caregiving support (Israel). It is vitally important that the people who will be most directly affected are involved in the delineation of those outcomes. There is a long history of “outsiders” coming into various communities and specifying what they perceive as a desired outcome, only to find out that that particular outcome is currently irrelevant to the members of that community. This is where sensitivity to and understanding of cultural values (both local and societal) plays a major role. For example, the recognition that the needs of lifelong citizens vs. immigrants will differ (i.e., in Israel) is a critical area of sensitivity. Participation by *all* community members, from a perspective that acknowledges what is not just logistically, but culturally important to them, is critical to identifying outcomes that they will be invested in pursuing and making real.

The realities of the *Contextual Factors* of the *Identified Community* must be acknowledged and articulated. For example, what are the demographics of the community – in terms of age, gender, and income distribution? What is the physical location of the community and how does that impact empowerment efforts (e.g., is it remote? Close to other population areas? Accessible to local resources like government and non-governmental agencies and support services?). What has been the local history in terms of the targeted outcomes – have people tried to address the issue before? What contributed to success and failure?

Initial Resources. Once a community and targeted outcomes are identified and the background factors understood, then related factors must also be uncovered and intentionally examined. These *initial resources* include who holds informal power in the specified community, and what resources are already available, both in and outside of the community. Identifying these related factors must occur early in the empowerment process so that the leverage of local and other resources – individually, socially, and institutionally – can be mobilized throughout the process. Figure 3 below provides a visual image of these various factors.

Figure 3. Critical Components for the Empowerment Process



The CASE model – Stages and activities.

FIRST STAGE. The first stage in the CASE model is the *Creation* stage, where the specification of *Targeted Outcomes* occurs through collaborative dialogue with the identified community members. In this stage it is vital that as many members of the identified community as possible are involved in the conversation and development of the proposed solutions. At this beginning stage of the process, establishing shared values and common interests is most important and critical to create positive energy towards the targeted outcomes.

Important activities in the Creation stage are:

A) Create a representative project team. Societal values regarding elders in a society range across the four stages as delineated by Moody (see Chapter One): Rejection, Social Services, Participation and Self-actualization. The ultimate goal is to develop an empowerment culture that begins by promoting inclusion of all people (vs. rejection of any particular group), and finally realizes self-actualization for all community members over their lifespan. To start the process, a project team should be established which includes various community stakeholders – including community members, local authorities such as the leader(s) of any local associations, professionals from the community in the specified area of focus (i.e., health or technology), and academic authorities. In this way, multiple perspectives on the *Targeted Outcomes* are included, and community members have confidence that their voices are being heard and incorporated from the initial stages. It is vital that all team members identify with the goals of the project team and feel a strong investment in future community development. This also helps to share the load of responsibility, develop mutual cooperation and eventually create an interdependent basis for the ongoing functioning of the new processes put in place.

B) Utilize a scientific approach to evaluation. The development of individual and community empowerment draws strength from a foundation built on reliable and objective data. This addresses people's concerns that decisions or directions are being set by someone with an outside "agenda" that is not realistically based on what is happening in the local circumstances. The reliable data of the information about the empowerment activities makes it easy for people to accept the program. The incorporation and utilization of data are examined in each chapter, ranging from very local data to comparative national and international data.

C) Establish a new program(s) for meeting targeted outcomes. After a needs assessment and system development process of whatever length (from a few months to a few years), some clearly identified place/program/process must be constructed as the core of the empowerment-related activities. The purpose of this focal point is to facilitate true empowerment of the people, not just at the "participation" level of social values, but also at the "self-actualization" level. The functions of the focal point must be based on the input of the residents themselves, the data analysis of what factors are related to the targeted outcomes, and the financial and organizational resources available through local

and national governments and other agencies (e.g., non-governmental organizations that may be operating in the community). Setting the place or program physically near people's homes, can help the residents easily notice the effects on individuals and the sense of empowerment that is emerging. This provides concrete evidence to motivate people to take advantage of the opportunities newly available to them.

D) Work with local authorities. Members of the local community should be involved in the initial stages in order to gain their cooperation and buy-in, to sensitize all members of the community to the importance of the targeted outcomes, and to solicit their input for appropriate ways to address the issue. Training of local leaders and the identification of a community coordinator or executive committee also need to occur at this stage. Empowerment will be much more effective if, from the Creation stage, local leaders, both formal and informal, are an integral part of the leadership of the process. As noted by Bartle (2008), awareness must be raised throughout the community of the targeted outcomes and the beginning of the empowerment process. This may include advertising, both formal and informal, in community settings, and through word-of-mouth by neighbors, service providers, etc. The utilization of multimedia messages is also helpful, as the various ways in which people process information (verbally, visually, etc.) must be incorporated into awareness-raising activities. In addition, an initial Community Action Plan (CAP) (Bartle, 2008) should be developed, as a primary guiding tool for priorities, specific activities and goals to accomplish those priorities and articulation of responsibilities and accountability for those priorities. Included in this Plan should be specific and concrete measures for progress and monitoring of the implementation of the Plan at all three levels of empowerment - personal, community, and systemic. A concrete worksheet for such a plan is presented in the final chapter of this book.

SECOND STAGE. The second stage, *Adaptation*, is when the initial ideas and programs are adapted or adjusted to local circumstances, and the first responses and feedback from the community members are solicited and analyzed. The community/executive team must modify and continue to develop the new empowerment systems. After setting up the program or focal point, systems to manage the functions of those more efficiently need to be developed to continue the process of empowerment. One key component must be an effective and clear set of *information systems*. Information is the lubricating oil for the total system, supplying the necessary means to keep the system fluid and working. Effective usage of information can be a proactive means to empower community members. In some community situations, it may be helpful to set up one core center and then establish several branches for information services or to have a "one-stop shop" for people to utilize throughout the empowerment process. Monitoring of the first stages of implementation must be done and reported back to the community as to the effectiveness of the programs is critical.

An effective information system must also have the flexibility to distribute and diffuse any data as soon as possible. Precise and up-to-date information are important to maintain the reliability and validity of the system. Again, concrete measures of progress on the three levels of empowerment must be included - personal, community, and

systemic. At this stage, *ongoing recruitment of community members* continues as many may still be reluctant to participate, or still don't understand the purpose of the given program. Sharing information gathered in the Adaptation stage will provide many community members with specific and concrete evidence that these empowerment efforts are worth participating in. Thus, it is important that communication efforts to share initial results are consistent and widespread, again including multiple methods of sharing out information – local newspapers, radio, television, and informal communication as well.

Another key factor in the Adaptation stage is *promoting mutual peer and community support*. Individuals in a society where cultural values support independence or interdependence may be able to establish a real mutual support system more easily, but it is much more challenging for a dependent culture such as Japan, a culture based on the historical “Mura” or village concept. As noted in Chapter 2, these social ties have been gradually disintegrating over time, especially in big cities, where most people have lost the old type of community spirit. As a result, in the past, dependence on family-oriented care has been the only choice for many people. Clear limitations of contemporary family care opened new fields in social support – e.g., “co-ops” and Public Long Term Care Insurance. Furthermore, a mutual support system is strongly desired not only by the government, but also by the people themselves now (Anme, 1993). To promote this mutual support system, methods must be developed such as education for volunteer leaders, information resources for volunteers, and establishing places for exchanging information. These methods create means and opportunities for community members to have to turn to each other for information needed for accomplishment of the targeted outcomes. This prevents the dependence on “professionals” only to provide information.

The *Adaptation* stage is a post-creation period and whether the new system grows stagnates, or shrinks depends on how much the individuals and the community stay energized in this stage. It is critical to provide participants with various images of how the empowerment activities are working for them, and for individuals to envision how their connections to other individuals and programs are occurring. Analysis of empirical evidence of their activities can increase confidence in the prospect of achieving their desired outcomes and create deeper relationships with others engaged in the same processes. Thus, empirical analysis that demonstrates the effectiveness of their chosen activities in terms of the targeted outcomes keep community members motivated and understanding the impact of their choices. This reinforces the reality of personal and community empowerment as effective.

THIRD STAGE. The third stage, the *Sustenance* stage, is when initial feedback has been incorporated and some sense of maintenance or steady state of the programs/initiatives has been achieved. This is the stage in which new collaborations between community organizations/agencies may emerge to meet the needs of the members in relation to the targeted outcome or new services designed to meet “next stage” needs of empowering individuals and the community. Clarification of roles and responsibilities can occur as refinement of methods to meet outcomes develops.

Specific activities at this *Sustenance* stage should include a *reiteration of the*

common values and targeted outcomes of the empowerment process and programs. Reminding individuals and community groups of the initial values and goals, and any that were added during the Adaptation stage keeps people mindful of the purpose and process. *Clear sharing of information* about progress with easy-to-understand formats is critical to motivating continued involvement and empowerment.

First efforts at *creating specific measures for evaluation* must be made and feedback from community members incorporated to devise a measure for ongoing evaluation. The various levels of the empowerment process and outcomes need to be delineated. First there is the *personal level* analysis, the individual client or community member, who must be evaluated in terms of whether targeted outcomes are being met. In addition, there is the community level that must be evaluated and then the systemic level which must also be assessed in terms of effectiveness. Specific methods must be assessed – are the particular activities aimed at the various levels of empowerment working efficiently and effectively? For example, are health programs successfully tailored to the individual? Is the program content consistent but also flexible to meet changing needs? Such questions allow uniformity of measurement across individuals in order to assess effectiveness of general program development.

At the *community level*, there must be some specific assessment of how the agencies (new or pre-existing) are actually functioning in terms of the targeted goals – how well are agencies communicating and collaborating? Are there the appropriate services/activities now being offered to individuals? Is there adequate representation of interested and identified community members continually involved in the emerging and sustained empowerment processes? The efficiency and effectiveness of any interdisciplinary team should also be included.

At the *systemic level*, similar questions of consistency yet flexibility need to be evaluated, as well as the ability of the organizations to secure adequate resources and make appropriate connections across the community to leverage resources to meet the personal level needs of individual members. System factors such as access, appropriateness of time, quantity and quality of services provided are also critical in the assessment phase.

Bartle (2008) also enumerates several elements of community strength that can be evaluated, including altruism, common values, information available to members, intervention services, networking opportunities, communication of information about services and their effectiveness, confidence (both personal and organizational), and broader contextual factors such as changes in political power, trust, unity, and control over local resources and wealth. Thus, evaluation methods should be multi-method and occur at multiple levels.

FOURTH STAGE. The fourth stage, the *Expansion* stage, is when more systematic and consistent evaluations must be formalized, with the goal of expanding and further defining the most appropriate and effective means to meet the targeted outcomes. Community members should be constantly informed about the evaluation processes, who

is involved, what is being assessed, and how they can participate to provide input and feedback. Evaluation of any empowerment process must take place at multiple levels, especially since, ideally, empowerment has been occurring at multiple levels, as well. As noted in the previous stage, there is the personal level of the individual, where each community member should be included in the evaluation process to see if their sense of personal empowerment has increased. There is the second level of the community, where community resources can be assessed to see if there are more resources available or the existing resources have become more effective in meeting the needs of members. There is the broader interdependent systemic level, where examination of whether policies regarding access to services, for example, have changed, or if funding systems have improved over time.

At this stage of *Expansion*, new strategies may be needed to articulate new *Targeted Outcomes* or new directions to move in. The community may have to redefine the new position and get community members' agreement. Thus, the participatory process begins anew. This may require the development of multiple structures, training new community coordinators and leaders, finding new ways to motivate people over a longer period of time, and creating new activities and ongoing programs to meet evolving needs. Systematic evaluation and sharing of information and outcomes is essential to moving into new areas of empowerment. For example, objective cost-benefit analyses can give community members strong motivation for continuing to invest in and work to advance past and future goals.

In the next few chapters, we will see how the CASE Model was initially developed in Japan and how it can be fruitfully applied in other countries – Sweden, the United States, Israel, and Australia. We then provide a counterpoint perspective on empowerment which reminds us that maintaining a broad view of how empowerment affects everyone involved (e.g., not just the elder, but their caregivers, families, etc.) is imperative to achieve the self-actualizing society we hope for.

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Part 2 International Practice and Application of the CASE Model of Empowerment

Chapter 4

A Community Empowerment Model for Healthy Longevity: The Japanese Experience

Tokie Anne and Mary E. McCall

This chapter outlines the work that was done in a small community in Japan that provided the basis for the development of the CASE Model. The focus of the empowerment process was to increase longevity and improve health and functioning in an agricultural village in Japan.

Demographic and cultural background

Demographic changes. As with many countries, Japan is also dealing with the aging of its population overall. The Japanese population is aging faster than other countries, and Japanese people enjoy the longest life span in the world. In 2006, the average life expectancy for females was 84.6 years and 77.7 years for males and almost 20% of the population were 65 years of age or over (Ministry of Health, Welfare and Labor, 2007). Recent changes in household structure, particularly the increase in households with old-aged single persons or couples, together with the increase in younger adult female workers, have made it difficult for the immediate family to take care of elderly people, as has been the cultural tradition. Income guarantees in the form of pensions will become a substantial burden on Japanese society and the needs for health and social services have increased dramatically, but the resources are limited, which intensifies the importance of empowering people and communities to meet their needs in an interdependent manner.

Cultural values changes. Historically, Japanese society has been based on Confucianism, similar to other northeast Asian countries. According to the historical concept of *mura* (a village-based society), all community members help each other meet all needs, with extraordinary pressure from both regional and national levels. Thus, it has been very natural for the Japanese to develop a community-oriented care system for older persons. But this community was not a real one, because complete mutual interdependence was never really developed in these so-called communities. This concept of *mura*, then, declined after World War II. Since then, the younger generation of Japanese adults has been moving to big cities and rural areas have remained a relatively stable, but closed section of Japanese society, with a high proportion of elders. These problems are placing tremendous pressure on Japan's traditional and culturally preferred family care system (Anne, 2001). The obvious way to ease these growing pressures is to introduce more formal, community-based services which can be provided at home to the older person and thereby supplement family members' limited resources to make the life of the elder as comfortable as possible. But this must be done with very special sensitivity to the individual and with the dignity and empowerment of the older person in mind. Japan is facing a turning point in changing societal values from a group orientation to an individual orientation. So, the useful utilization of power in a community is strongly desired and there is much research being conducted to find different ways to use limited resources effectively. It is not overstating it to say that empowerment for both the individual and the community is crucial to maintain a sense of social solidarity in this

fragile situation. This chapter explains how the CASE model for empowerment was developed in a particular Japanese community emerging from a clear local and regional social need related to its aging populace.

The CASE model in a Japanese village

There is a dramatic separation between the large urbanized areas where economic pressures and changing social values have meant a rapid decline in family-based care for elderly people, and the rural villages, which remain almost a separate, cloistered segment of society, but with a high number of dependent elders who need care and support. Thus, beginning in 1991, *The Tobishima Study* sought to investigate factors associated with longevity in elders, with the goal of creating a health-promoting program that would maximize quantity and quality of life for residents. Tobishima is a typical farming community in a suburban area of Japan, with a population of almost 5,000. All of the residents over 65 years of age were invited to participate, and all agreed. Follow up studies were conducted at 5 years, 7 years, and 11 years to investigate factors associated with longevity and life satisfaction. But the goal was not just increased longevity – it was also specifically to empower Japanese elders in the community to become educated about their own health, to both create and take advantage of options and resources for improving and maintaining their physical and emotional health, so that ultimately they could take charge of their own health choices and activities. The **process goal** was also to engage them in the empowering process of designing and building the community-based resources that they could use in the service of increasing the quantity and quality of their lives.

In Tobishima, we first needed to develop an “empowerment culture” for both individuals and the community to recognize the need to promote mutual help. By an “empowerment culture”, we mean a social and value context for developing empowerment. As noted in Chapter 2, existing cultural values are often a big impediment to overcome, and the idea of individual empowerment certainly was somewhat foreign to seniors in a culture where interdependence and family had been the foundation of society for their entire lives. But when shifts in cultural values are achieved, this can provide a strong means of influencing people. To alter the existing unsatisfactory situation, we needed to change the cultural attitudes that were perpetuating the unfulfilling circumstances. As a result, more community members at least started the process with a more positive attitude of “let’s see how it goes.” First developing an “empowerment culture” helped to begin the process of promoting the community goals of self-care and mutual-care.

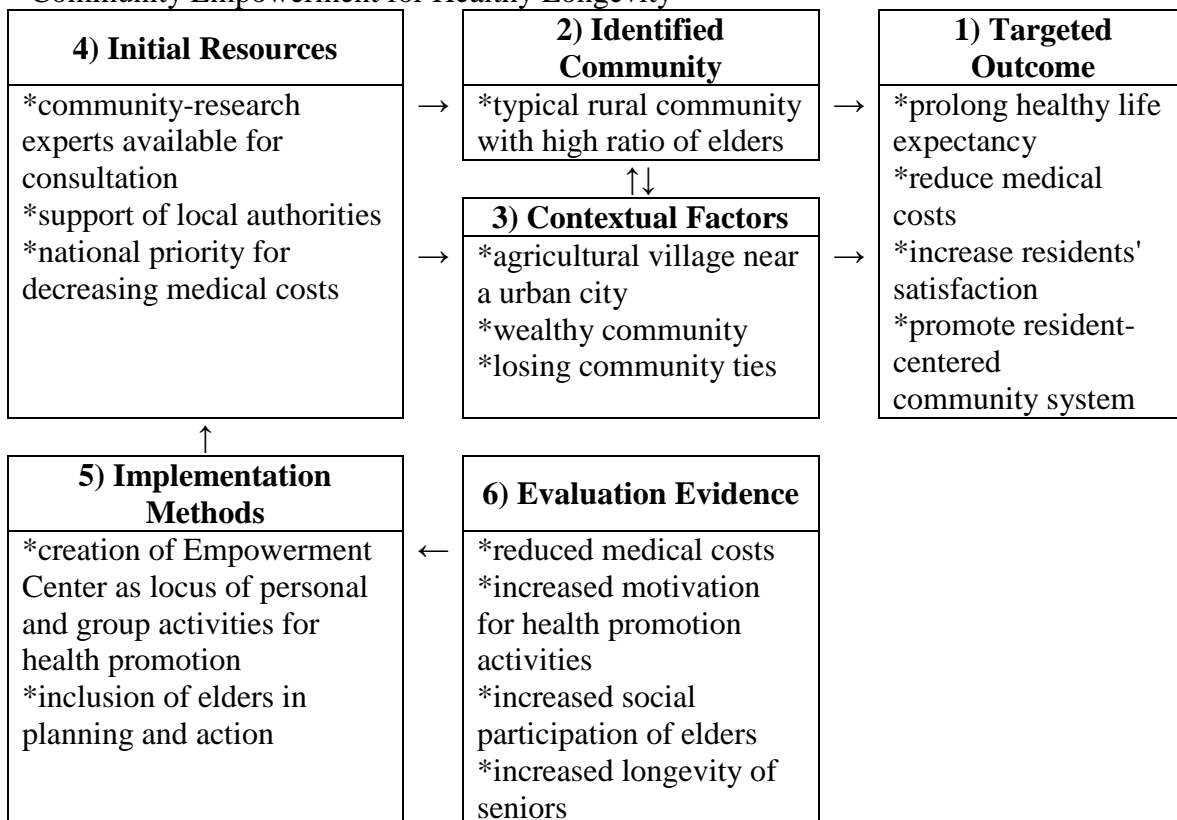
Fundamental factors for community empowerment. As outlined in Chapter 3, in the CASE model of empowerment, there must first be an *Identified Community* that can agree upon a *Targeted Outcome*, and then identification of *Contextual Factors*, and *Initial Resources* must be effectively included as the community moves through the empowerment process.

The Identified Community. In the case of Tobishima, the entire community was

identified and the initial goal was a comprehensive longitudinal study for developing and evaluating a “new model for community empowerment.” As stated above, this project began in 1991 and has continued every year since. The purpose of the project was to develop appropriate methods for motivating people in a community to become empowered. The *Targeted Outcomes* were to prolong healthy life expectancy, to decrease medical costs, to increase residents’ satisfaction, and to develop a resident-centered community system of supports. These targeted outcomes were a result of *Contextual Factors* such as the residents themselves recognizing that they were increasingly isolated from their families and younger adults, and had relatively low life satisfaction. In addition, in terms of *Initial Resources* there were broader governmental interests in this goal, as well, due to the higher medical costs being expended in this particular community relative to other similar communities. In the case of Tobishima, local village leaders, elders, were contacted, and local health officials, who had the respect of the residents, were also involved.

In Tobishima, it was especially effective to provide a logical process model to visually show the community members the process to achieve the targeted outcomes (see Figure 1).

Figure 1. A Process Model for Empowerment Skills:
Community Empowerment for Healthy Longevity



As presented in Chapter 3, the CASE model of empowerment has four stages: Creation, Adaptation, Sustenance, and Expansion. Each stage serves a particular set of functions, and requires a particular set of skills.

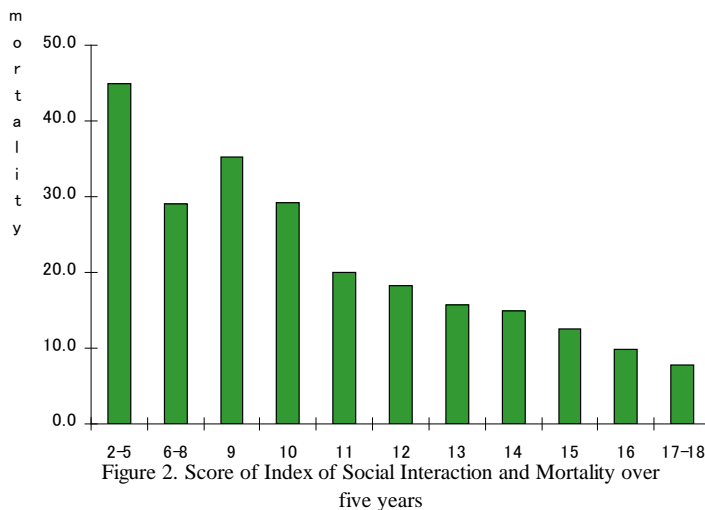
FIRST STAGE. The first stage in the model is the *Creation* stage, where the specification of targeted outcomes occurs through collaborative dialogue with the identified community members. In this stage it is vital that as many members of the identified community as possible are involved in the conversation and development of the proposed solutions. At this beginning stage of the process, establishing shared values and common interests is most important and critical to create positive energy towards the targeted outcomes. For example, in Japan, “Healthy Longevity For All” is an easy value to share in the community. Even if the value is somewhat vague at the outset it is vital to set a common foundation to have some attractive image to pull members of the community together. As outlined in Chapter 3, important steps in the Creation stage of developing such an empowerment culture were:

A) Creating a representative project team. To start the empowerment process in Tobishima, a project team was established which included local community authorities such as the chief of the Residents’ Association, health professionals in the community, and academic authorities. This was especially critical in Japan, where, traditionally, the notion of personal empowerment was an unfamiliar concept and to create an “empowerment culture” multiple perspectives on the mutual goal of increased health and longevity were required to establish the legitimacy of the methods being introduced. Thus, community members could see clearly that their experiences and opinions were being valued and included from the beginning. It took time for the team members, and other community residents to clearly understand and begin to identify with the goals of the project and then they could start to develop an investment in the process and outcomes. The shared responsibility and mutual cooperation that was initially developed eventually demonstrated the commitment to an interdependent process of empowerment.

B) Utilizing a scientific approach to evaluation. In Tobishima, using statistical methods, a variety of factors were analyzed to predict future physical decline and mortality based on current lifestyle components. For example, one of the factors examined was social interaction, which was measured by the “Index of Social Interaction” (ISI) (Anme, 1992, 1995, 1997a, 1997b). The ISI measures the amount and quality of interaction between the individual and the community. Other factors examined were health and lifestyle, people’s feelings about themselves, and their social activities. The Index of Social Interaction is divided into 5 subscales: Independence (having an active approach to life; being motivated to have an active lifestyle; being motivated to lead a stable and predictable lifestyle); Social Curiosity (using electronic equipment; having a hobby; reading books and/or newspapers; having a feeling of importance); Interaction (level of communication with outsiders; level of interaction with outsiders; frequency of communication within the family); Participation in Society (participation in social groups; participation in neighborhood affairs; watching television,; having an active social role); and Feelings of Safety (having someone to give advice; having someone to give support in an emergency). This measure demonstrated to the community

members that *realistic* components of their lifestyle were being used in predicting their futures.

In initial and ongoing studies, a lack of social integration was found to be significantly correlated with physical deterioration and mortality in the future (see Figure 2). For example, Figure 2 shows the statistical relationship between one’s ISI score, as a measure of social integration and activity, and one’s longevity over time. Clearly, the higher the ISI score, the longer one is predicted to live. Results also showed a statistically significant difference in survival rates over time between those older men and women who reported differing levels of types of social integration activities. Those with greater levels of activities lived longer. Cohort analysis revealed that interaction with the community decreased with age. In addition to the simple age factor, the nature of social interaction is changing in general because of the broader social and family changes that are happening in Japan that were discussed earlier. We see this in the findings that one’s sense of importance in society or in the family also decreased with age. Those changes also seemed to cause physical deterioration. For example, persons who reported that they were “losing their social role” deteriorated earlier than persons who reported still having roles in the community. Negative attitudes toward aging, such as “everything appears tiresome as one ages”, increased with age, and this feeling was also related to feelings of isolation from society. Self-reliance factors were also strongly related to physical deterioration and mortality, such as their assessments about whether they still had meaningful social roles and their feelings about maintaining good relationships with family members (Anme, 1997b; Anme & Shimada, 2000; Anme, Shinohara, Sugisawa, & Ito, 2006; Anme, Shinohara, Sugisawa & McCall, 2007).



As a tool, the Index of Social Interaction was found to be useful for predicting the future health and mortality status of elders and thus can be used to develop strategies for early intervention. Compared to scales measuring Activities of Daily Living (ADL), the predictive validity of the ISI is almost equivalent. Using appropriate measures will strengthen an individual’s and a community’s sense of empowerment. Understanding one’s present situation and the predicted future derived from the data will provide strong

motivation to individuals to take part in improving their situation.

C) Establishment of a new program for meeting targeted outcomes: The Empowerment Center. After a needs assessment and system development process of 3 years, an “Empowerment Center” was constructed as the core of the empowerment process. The purpose of this center was to facilitate empowerment of the people, not just at the “participation” level of social values, but also at the “self-actualization” level. The functions of the Center [see Figure 3] were based on the input of the residents themselves, the data analysis of what factors predicted health and longevity, and the resources allocated by local and national governments. Setting the Center physically near people’s homes, the residents easily noticed the effects on individuals and the sense of empowerment that was emerging from the Center. This provided strong motivation for the people to utilize the opportunities effectively.

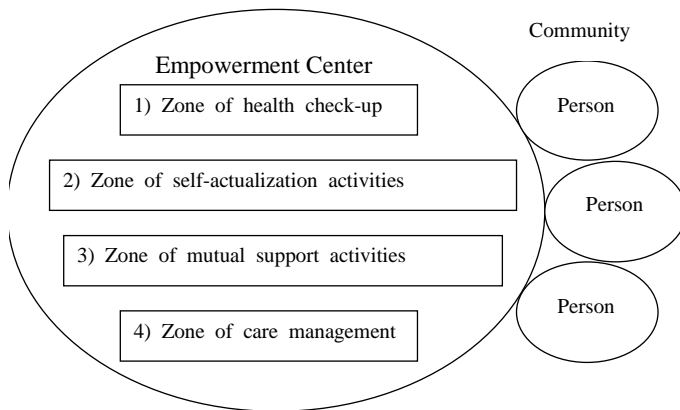


Figure 3. Functions of Empowerment Center

First is the “Zone of Health” which supports the idea of the correlation between strong health and personal empowerment. This was specifically named such to tie in the new cultural value of empowerment with the purposes of the new Center. Second is the “Zone of Promotion for Self-actualizing Activities” which contains a swimming pool, gymnasium, library and place for hobbies. Third is the “Zone of Promotion for Mutual Support Activity,” which includes several programs such as a volunteer center for facilitating mutual support in the community. Fourth is the “Zone of Care Management,” which utilizes a targeted systems approach by various professionals and others in cases where individuals need more comprehensive care and support. Thus, the conceptual and logistical formulation of the Empowerment Center was directly related to the three types of empowerment – personal, community, and systemic.

D) Work with local authorities. This stage, as noted in Chapter 3, included working with local professional and academic authorities to gain their coloration and investment in the project. We also worked to inform and include all members of the community so that the importance of the targeted outcome and the most appropriate methods to accomplish those targets were articulated. The lead project team was created

and training of involved community members occurred. Formal and informal community leaders were identified and included as an integral part of the leadership. Community awareness was raised throughout the community through a wider variety of advertising and the use of multimedia messages, such as community message boards, announcements in local newspapers and community agencies, etc. (see Figure 4).

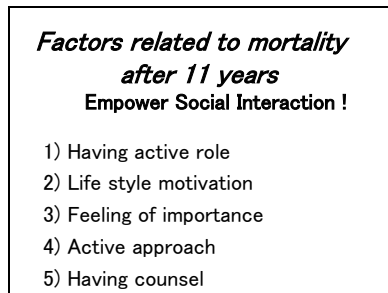


Figure 4. Easy-to follow information for the people

SECOND STAGE. In Tobishima, the activities that occurred at the *Adaptation* stage, with the goal of increased health and longevity, included:

A) Modifying and continuing to develop new empowerment systems. After setting up the Empowerment Center, systems to manage the function of the Center more efficiently needed to be developed to continue the process of empowerment. Key components were “information systems,” “a self-evaluation scale for future well-being,” “self-training programs to maintain well-being for each person, “promoting mutual support” and “self-checking and self-development programs.”

1) *Information systems.* Information is the lubricating oil for the total system, supplying the necessary means to keep the system fluid and working. Effective usage of information can be a proactive means to empower community members. In our community situations, it was helpful to set up one core center and then establish several branches for information services. Once calling to the core center – The Empowerment Center – people could conveniently get information and consultation for any need they have. An effective information system should also have the flexibility to distribute and diffuse any informational content as soon as possible. Precision and keeping information up-to-date are important for maintaining the reliability and validity of the system.

2) *Self-evaluation scale for individuals’ future well-being.* From the data analysis, a “self-evaluation scale for future well-being” was developed. In this scale, points are attached to each related item, such as healthy behavior and social interaction, which reflect the magnitude of risk for physical deterioration and mortality. Adding the points of all items, people get their own total score, which indicates the expected level of future well being. If the total score is lower than “standard”, people recognize that their life style must change to improve their future well being. This instrument is useful to review activities of everyday life and give people meaningful information related to their

ongoing lifestyle choices. Having their personalized information improved their sense of personal empowerment because they had access to data that they could then choose to act on, and take advantage of local resources to address any concerns.

3) *Self-training programs to maintain well-being for each person.* Individual action plans including a self-training program to keep well, and were designed based on longitudinal data collected from the community. Seventy-two patterns of action plans were developed and each person was given what was considered his/her most appropriate plan, according to their lifestyle. Each action plan has three parts: first is the self-training program at their own house; second is a training program including activities such as swimming at the Empowerment Center and third is the anticipated direction and effects of their (healthy) lifestyle. This individualized prescription for future well-being induces motivation and produces more healthy behavior amongst the people in the community.

4) *Promoting mutual support.* Individuals in a society where cultural values support independence or interdependence may be able to establish a real mutual support system more easily, but it is much more challenging for a dependent culture such as one based on the historical “Mura” or village concept. As noted earlier, these social ties have been gradually disintegrating over time, especially in big cities, where most people have lost the old type of community spirit. As a result, in the past, dependence on family-oriented care has been the only choice for many people. Clear limitations of contemporary family care opened new fields in social support – e.g., “co-ops” and Public Long Term Care Insurance. Furthermore, a mutual support system is strongly desired not only by the government, but also by the people themselves now (Anme, 1993). To promote this mutual support system, methods were developed such as education for volunteer leaders, information resources for volunteers, and establishing places for exchanging information. These methods created means and opportunities for community members to have to turn to each other for information needed for positive health practices and access to services. This prevented the dependence on “professionals” only to provide information.

5) *Self-checking and self-development programs.* The function of self-checking and self-development programs are to provide the foundation for efficient administration maintenance and to refresh and modify the system when needed. All programs should have clear, open, and specific feedback routines for further refinement and development. In this way, all community members are aware that the system is flexible and responsive, and inclusive of feedback for change. In Tobishima, a system was developed that will allow us to evaluate services and we plan to do so every three years. These procedures are essential to guarantee the system’s reliability and validity.

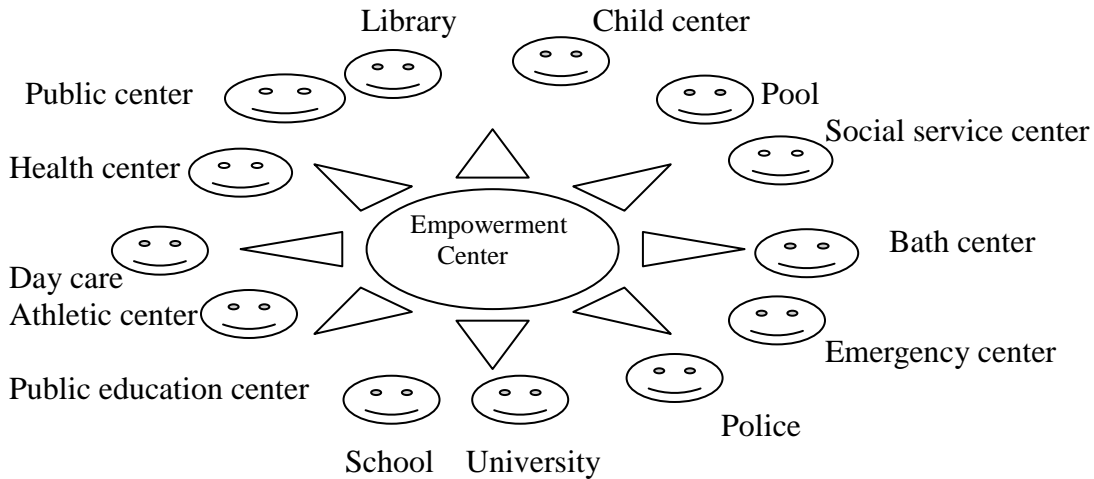


Figure 5 Interdependent Systems Matrix for Health Promotion in Tobishima

The *Adaptation* stage is a post-emergence period and whether the new system begins to blossom and develop relies on the level of investment by individuals and the community. A visual image of empowerment activities as networks (as in Figure 5), helps individuals to envision how their connections to other individuals and programs are actually happening. Evidence based on the evaluation of their activities makes them confident in the value of participating, strengthens relationships, and motivates them to make various opportunities to communicate with others. Figure 6 shows the significant difference in mortality rates for those over 75 years of age, between those who had higher ISI scores in the area of communicating with “outsiders.” Thus, empirical analysis that demonstrates the effectiveness of their chosen activities in terms of health and longevity keeps them motivated and understanding the impact of their choices. This also supports the development of personal and community empowerment.

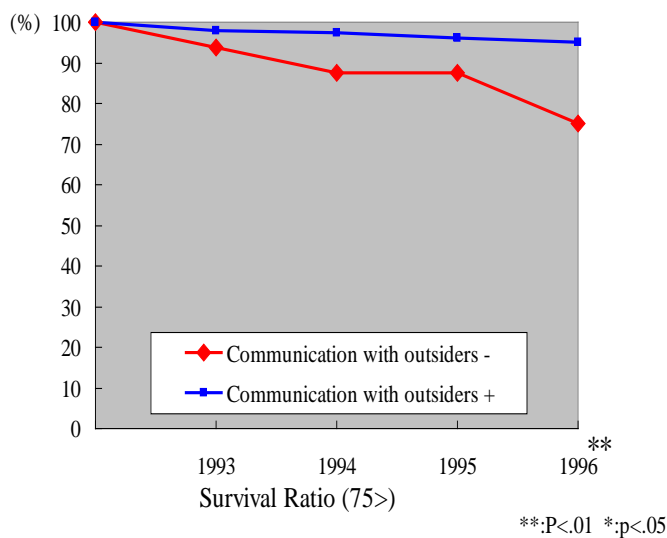


Figure 6. Communication and survival ratio over 15 years for those 75+ years

THIRD STAGE. The *Sustenance* stage is when initial feedback has been gathered and some steady state of the empowerment process has been achieved. As work moves forward and community members feel more ownership and local community agencies see the benefits, then new collaborations between community organizations/agencies may develop to contribute to the goal of the targeted outcomes. In Tobishima, the activities that occurred at the Sustenance stage included:

A) Reiteration of values and goals. Reminding individuals and community bodies of the initial values and goals, and any that were added during the Adaptation stage keeps people mindful of the purpose and process. Clear sharing of information about progress with easy-to-understand formats is critical to motivating continued involvement and empowerment.

B) Initial framework of evaluation. First efforts at creating specific measures for evaluation were created and feedback from community members was also incorporated to devise a measure for ongoing evaluation. Various levels of the empowerment process and outcomes were assessed. First there is the *personal level*, the individual client or community member, which must be evaluated in terms of whether *targeted outcomes* are being met. For example, is the individual participating regularly in the health activities? Are they realizing the positive effects of the participation, such as increased muscle strength and ability to perform daily activities of living? If not, why not – is there some underlying disease condition that must be addressed? Next, there is the *community level* of analysis that must be conducted. At this level, issues such as access to activities, appropriate transportation systems and information sharing systems can be evaluated. At the *systemic level* there are also outcomes which must be assessed in terms of effectiveness. Is the interdisciplinary team that is overseeing the program working efficiently and effectively? Are there appropriate financial and space resources to sustain the new programs and activities? Do local authorities continue to support the program and process? Is the process flexible enough to meet changing needs? Such questions allow uniformity of measurement across the various levels of empowerment in order to assess effectiveness of general program development, sustenance, and expansion.

Thus, evaluation methods should be multi-method and occur at multiple levels. In Tobishima, the activities that occurred at the Expansion stage included the specific measurement of the frequency and duration of individual sessions by older residents at the various public centers available to them. Did they take increasing advantage of the new resources? Were the targeted outcomes of increased life satisfaction achieved? Did people become more motivated to be involved in their community, to participate in neighborhood activities, and actually increase their physical and mental abilities, as measured by activities of daily living, etc.?

FOURTH STAGE. The *Expansion* stage, is when more formal evaluations must begin, with the goal of expanding and further defining the most appropriate and effective means to meet the *Targeted Outcomes*. Evaluation of any empowerment process must take place at multiple levels, especially since, ideally, empowerment has been occurring at multiple levels, as well. As noted in the previous stage, there is the *personal level* of

the individual, where each community member should be included in the evaluation process to see if their sense of personal empowerment has increased. There is the *community level*, where community resources can be assessed to see if there are more resources available or the existing resources have become more effective in meeting the needs of members. There is the *systemic level* of the broader interdependent systems, examining whether policies regarding access to services, for example, have changed, or if funding systems have improved over time.

In Tobishima, for example, analyses of long-term medical costs demonstrated the effectiveness of the Empowerment Center in lowering the actual money expended on health care expenses. Specifically, those community members who exercised regularly, across the age group of those in their 40s, 50s, and 60s, showed a significantly lower cost in medical expenses than those who did not exercise regularly. Figure 7 demonstrates the significant drop in medical expenses comparing Tobishima with the average of the prefecture, as well as the national average. Thus, evaluation can concretely occur, even at the regional and national levels to demonstrate the effectiveness of an empowerment process.

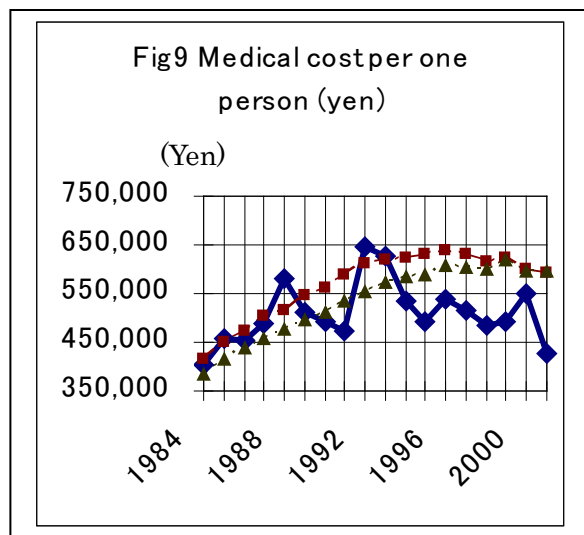


Figure 7. Medical costs per person from 1984-2000

◆—◆: Tobishima city ■—■ : Prefecture average ▲—▲: National average

At this stage of *Expansion*, new methods and approaches may be needed to outline new *Targeted Outcomes*. The empowerment process must again have the community engaged to define new positions/goals and acquire community members' investment. Thus, the participatory process begins anew. This may require the development of multiple structures, training new community coordinators and leaders, finding new ways to motivate people over a longer period of time, and creating new activities and ongoing programs to meet evolving needs.

Systematic evaluation and sharing of information and outcomes is essential to moving into new areas of empowerment. For example, the cost benefit analyses presented above can give community members strong motivation for continuing to invest in and work to advance past and future goals. One way to visualize this process is to think of aspects such as “availability”, “adequacy”, “appropriateness”, “acceptability” and “accessibility” which can enhance the empowerment of the people in the community (see Figure 8).

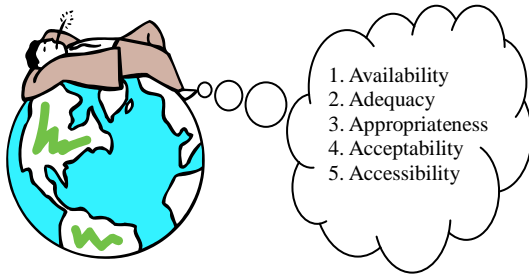


Figure 8. Image of empowered person

Conclusion

In conclusion, to develop an empowerment model in the community, the effective development of a supportive culture is indispensable. “Communication,” “Motivation” and “Scientific Evidence” are important elements to make real such a supportive culture. “Communication” must come with acceptance and understanding, “Motivation” must be through participation and an attitude of “we-can-do-it-ourselves,” and “Scientific Evidence” can capitalize on the respect for logical analysis and clear expectations which all make it easier to understand the factors and effects involved in empowering people in the community.

After more than 10 years of empowerment activities and processes, five points have emerged that we believe enhanced the specific empowerment project focused on the Targeted Outcome of increased longevity and life satisfaction: 1) prevention orientation; 2) effective evaluation; 3) investigation of needs; 4) utilization of information technology and 5) promotion of participation. A “prevention orientation” means that empowerment is developed by focusing on the prevention of decline over one’s life span. Even for frail elderly people, as well as for healthy ones, prevention of decline in physical or mental function is essential to expand their potential for becoming empowered. “Effective evaluation” means utilizing all facilities and resources to assess the available options and to maximize a person’s outcomes. “Investigation of needs” means providing formal and informal services with a clear articulation and understanding of their meaning and role in supporting the achievement of a desired level of personal independence in a flexible and accommodating way. “Utilization of information technology” is an issue of utmost importance for frail elderly people. Alienation from information is a key impediment to more enlightened and progressive forms of empowerment. “Promotion of participation” (with an eye on “self-actualization”) means to espouse true empowerment for frail elderly persons as consumers, allowing and encouraging them to understand and realize their

abilities and desires to meet their needs related to independence. It also means allowing elderly people to control their care planning and acceptance of services to the margin of their ability, desire and needs. Through these many years of work, we believe that empowerment has occurred and continues to occur in Tobishima, setting a role model for many other communities across Japan and across the world.

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This chapter introduces the application of the CASE Model to an empowerment process developed in Sweden called the “Future Workshop Method.” In the present case, the goal was to engage seniors in planning for an aging-friendly community, but it could be applied to any issue of interest. We describe a case study performed in a Swedish municipality, where the method continues to be implemented in connection to planning for a new kind of elderhousing. At the same time this is an example of the role of housing in community planning in line with the tradition and features typical of the Swedish welfare model.

Demographic and cultural background

Demographic changes. The development towards a greying society (*the aging transition*) is a global phenomenon. In the last phase of this development, *the phase of aging*, the population growth is concentrated to the oldest groups (65+ and especially 80+). The younger population remaining at this phase is constant or is decreasing as a proportion of population. Around 2030 the western part of Europe will be the first region in the world that enters the phase of aging (SOU 2002:29). Sweden as a country started to grow grey long before many other countries in the world. This was a consequence of positive economic growth and a high standard of living partly because Sweden did not take part in the Second World War. Today the group of elderly 65+ is about 17% of the total population in Sweden (in total about 9 million inhabitants). In the year 2030 the group 65+ is estimated to grow to 25% of the total population. In the same period the group 80+ will grow from about 500,000 people to 750,000 people. Starting in 2020, the aging boomers will contribute to the growth of the population, especially in the group 85+ (SOU 2007:103). The fact that there is some population growth in Sweden at the moment because of a rise in birth rates might change the prognosis but only at the margin, and the overall birth rate is not projected to significantly increase in the next 15 years.

Cultural values changes. Sweden and the other Scandinavian countries have been described as universal welfare states, characterized by high taxation, effective income redistribution and a system of benefits and services intended to cover the entire population at all stages of life based on uniform rules (Esping-Andersen, 1990 and 1996). Social services such as old-age care and child-care are financed, supervised and often delivered by the public sector. These services are broadly accepted and used by all social strata, and have wide public support (Szebehely, 1999). Thus, traditional cultural values have prioritized family and social needs as an overall societal goal, with equal investment and equal benefits across the lifespan. From the 1970s to the 1990s, there was an extensive expansion of home help services (community-based care) within the Swedish welfare system. Because it is universal, this set of services reached a large number of older people (Edebalk, 1990). In the 1990s some cutbacks were made due to recession in the Swedish economy. As a consequence, priority has been given to the group of older people with the greatest need for help. The content of the service provision has changed

and priority is now given to tasks focused on care for activities of daily living and physical care instead of more service-oriented tasks, or instrumental activities such as shopping, cleaning, etc. This development has had consequences for prevention-oriented care which has become less of a priority for the public sector. Requirements such as efficiency and cost-effectiveness have become more predominant within eldercare, and thus the priority has become those with the greatest needs.

The roles of the voluntary sector and informal caregivers have become more highlighted and recognized. Even though research and policy debates in Sweden have mainly focused on the public care system, several research studies have indicated that the informal civil society and the support it provides in Sweden is as extensive as that of any other comparable industrial country, whether measured in terms of unpaid help activities in voluntary organisations or informal care giving (Jegermalm 2005; Lundström & Svedberg 2003; Olsson, Svedberg & Jeppsson Grassman, 2005). Thus, even though over time, the formal and informal sectors have become more "distinctive" in people's eyes, the process in Sweden has not been the "crowding-out" of the formal sector to be replaced by the informal sector. Instead, the idea has been the "crowding-in" – that is, that the informal sector has been able to grow due to enhanced or supplementary support by the formal sector. The interplay between formal and informal care has become an important issue in connection to eldercare, and there is a vivid ongoing debate about how to share duties and responsibilities between the different sectors. The Swedish welfare model faces a period of transition towards a broader mix of providers in which the public sector (the state/municipalities) becomes less dominating. Market-oriented alternatives slowly are emerging and becoming more accepted, though some restrictions in the provider-purchase system that has developed in Sweden mean the system is still to some extent controlled by the state, since providers are paid partly through municipal tax revenues.

In 1992, the main responsibility for the management of all eldercare in Sweden was transferred from the county level to the more local municipal level.¹ This means that the municipality has the main responsibility for housing and care for chronically sick old people who are not hospitalized, who are living in ordinary housing, as well as in special housing (24-hours care alternatives that are accessible after a needs assessment is conducted). Hospital care and outpatient (primary) care remains as the responsibility of the larger county councils. In addition, by law, planning for different special housing alternatives for old people is a responsibility of the municipality (The Social Services Act, SOU 2001:453). The law also highlights the role of the municipality in planning for an aging-friendly community including ordinary housing alternatives (which do not require needs assessment) and a barrier-free, accessible environment.

The Targeted Outcome – Recent History in Housing Issues for Seniors. The development in Sweden towards aging in place started early. As early as 1984, an investigation initiated by the government came to the conclusion that this was a desired development for eldercare in the future (SOU 1984:78). Arguments that were used

¹ In Sweden there are three levels of governance: the state, the county (with the main responsibility for health care) and the municipality (responsible for other support services)

underlined that most older people wanted to stay in their current housing, but also that such an approach would be a less costly alternative for society compared to planning for large-scale residential care. These arguments were widely accepted among policy makers and decision makers as it was possible to claim that Sweden, at that time, had an extensive organisation for home help and also a good housing standard in general. Sweden also has a tradition of *Collective housing* alternatives which had already started in the 1930s linked to the social democratic political vision of the welfare state. Collective housing developed as an alternative for young families with children as a way to make women more independent from housekeeping duties and childcare. The idea was that this kind of housing alternative could facilitate women's equality as breadwinner. This old collective housing idea has lately become a growing popular alternative for older people in Sweden. The concept is understood as a housing alternative for people aged 55+. Houses are planned barrier-free and accessible with fully equipped private flats. Usually there are also facilities for common activities and a large kitchen for congregate meals.

One consequence of the aging-in-place policy is that many special housing alternatives for elderly either have closed or gotten transferred into ordinary housing. As a result of this development there is now a shortage of places in residential care. Many cases have been cited in the media of some old person who would like to move to residential care but who was denied by the authorities to do so. The needs assessment procedure did not find the person eligible in spite of old age (in some cases more than 90 years old), physical impairments, or feelings of loneliness or anxiety. Thus, the process and the outcome have been criticized. It is now obvious that the aging in place policy has gone too far in Sweden. A report from the Swedish Council of Health and Welfare in February 2008 highlights the problem of bed blocking in hospitals as a result of a decrease in half the amount of available hospital beds and one fifth of the open places in residential eldercare (special housing) during the 1990s. (Socialstyrelsen, 2008).

A recent investigation initiated by the government has explored the need of some kind of housing alternative between ordinary housing and residential care (special housing). The report from the investigation (SOU 2007:103) presents three different alternatives of what has been termed "Safety housing".² The term implies some level of available assistance for residents that would provide a greater sense of "safety" but that is not as intense as at the residential care level. Two of the alternatives have a common component of their definition of Safety housing in terms of tenureship, or renting one's living space, as opposed to owning it. In "Safety housing" the flats would be rented which makes them different from "Senior housing" which typically is defined as cooperatively or privately owned (even if there also are sometimes examples of rented living spaces). This underlines the need of a new housing alternative that could be affordable for everyone. Of course this does not exclude a growing marketization of the new elderhousing concept. But in the discussion about subsidies allocated to the

² One of the alternatives is described as *Senior housing*. As the definition of this alternative does not include any support from staff in house (except for individual home help at the same conditions as in other forms of ordinary housing) we don't include this as an example of Safety housing in our discussion in this article.

municipalities from the state, this will probably only be for Safety housing alternatives organized as tenements. In Safety housing it is compulsory to have facilities for common activities. The tenants must get empowered to make all decisions about management of the house. The municipality is expected to give subventions (or subsidies) to the common localities and also require that the different facilities be open also for older people from the surrounding community. There should be a possibility for congregate meals. The municipality should employ a coordinator for common activities. The need for home help should be allocated after a needs assessment on the same conditions as in other forms of ordinary housing.

In the debate after the report from the Delegation on Housing for the Elderly (*Äldreboendedelegationen*, SOU 2007:103) some researchers have pinpointed the need in Safety housing for more staff than just a coordinator of activities. It seems as if there is a need of two kinds of Safety housing in the future. One would be for healthier elderly and one type would be designed for more frail elderly (though not frail enough to be eligible for residential care after a needs assessment procedure). In the Social Services Act of 1980 (SOU 1980:620), a distinction was made between earlier legislation by introducing aims that were linked to the concept of empowerment. What is evident in the new concept for Safety housing is that it is based on a vision that encourages empowerment and freedom of choice. That is why it is important to stress that Safety housing is a form of *ordinary* housing alternative which is meant to promote older people's own initiative and responsibility in planning for how to live when getting old, while also providing an appropriate level of support without going too far.

The CASE model in a Swedish community

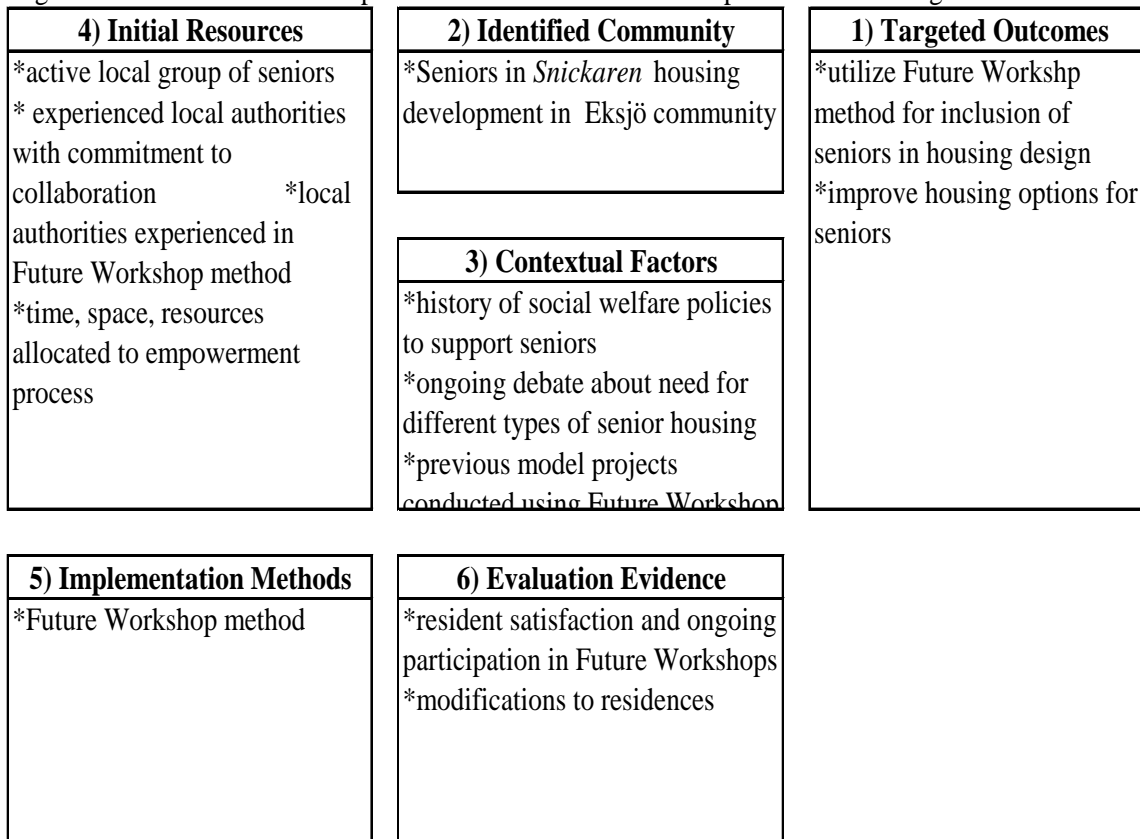
Fundamental factors for community empowerment. As outlined in Chapter 3, in the CASE model of empowerment, there must first be an *Identified Community* that can agree upon a *Targeted Outcome*, and then identification of *Contextual Factors*, and *Initial Resources* must be effectively included as the community moves through the empowerment process [see Figure 1].

The Identified Community. Eksjö has around 16,000 residents and is situated in the province of Småland in southern Sweden. The *Snickaren* elderhousing project in the municipality of Eksjö in Sweden can be described as an example of the new model of Safety housing, even though it is labelled as a type of Senior housing. *Snickaren* is a name that is basically translated as “the carpenter” invoking images of an active old age. The *Targeted Outcome* was identified because in Eksjö, as in many places across Sweden, it had become common knowledge that current housing arrangements would not continue to sufficiently meet the needs of residents across the country. Thus, for this specific place at this specific time, housing needs and desires were the *Targeted Outcomes* of the empowerment process. In terms of *Contextual Factors*, it is interesting to notice that the politicians in Eksjö developed this housing concept several years before the current debate concerning the need in Sweden of new housing alternatives for old people. Thus, the conceptual background and understanding of the issues was already present in the community. In addition, over the course of conducting various community-based research

projects, a group of investigators at the Department of Behavioural Science and Social Work at the School of Health Sciences in Jönköping, Sweden, developed a model for the integration of research, training, and social change work. An initial project was carried out in Eskilstuna (Bolwig, et al. 1999). After that, a project was initiated in Jönköping in the framework of an EU project with trans-national partners in Germany and Italy. The core characteristic of this international exchange was to share experiences of innovative methods of qualification improvement with a focus on quality and renewal (Henning, Johansson & Åhnby, 2000).

Snickaren had already been converted from a kind of residential care unit (special housing alternative) to a Senior housing facility in line with the philosophy behind the development towards aging in place. At the start of the empowerment project, *Snickaren* had been a kind of residential care facility that in Sweden is called *Service housing*. In this form of special housing the tenants have their own barrier-free apartments with a kitchen (usually one room and a kitchen), and there are also premises for common activities as well as around-the-clock staff. *Snickaren* elderhousing used to be redefined as a kind of *Senior housing* (Henning, Åhnby & Österström, 2008). But this was before the current and new discussion on the need and definition of Safety housing. In this chapter, then, we prefer to redefine *Snickaren* as an example of *Safety housing*. *Snickaren* consists of 54 flats, facilities for common activities and a restaurant. After the conversion there is no around-the-clock staff, just a coordinator for activities in the common facilities, who is employed by the municipal Social Services.

Figure 1. Process Model for Empowerment: The Future Workshop for senior housing in Sweden



The *Initial Resources* available included the local authorities in Eksjö who already had the goal to promote a procedure that could involve the elderly in this process of change. Staff and politicians from Eksjö had previously taken part in a project with Future Workshops together with researchers from the School of Health Sciences. Therefore the researchers (Cecilia Henning and Ulla Åhnby) were called upon to conduct a future workshop at *Snickaren* in the autumn of 2005. Thus, local residents, academic experts, and local officials all were invited into the process, with space, time, and resources allocated to the work.

As presented in Chapter 3, the CASE model of empowerment has four stages: Creation; Adaptation; Sustenance; and Expansion.

FIRST STAGE. In the initial *Creation Stage* in Sweden, there was no specific need to create an “empowerment culture” since local people were already envisioning that set of values into the work they wanted to pursue. What might be seen as somewhat unique about this process is that the “Future Workshop” method is one for facilitating learning processes about a specific topic in conjunction with the intentions of an *interactive research process*. It is a type of research process that has the aim of developing common knowledge acquisition between the researcher and those involved with and affected by the specific topic. Thus, this particular research process is also designed as an empowerment process for those directly affected by the outcomes. The starting-point is a common problem or task (the *Targeted Outcome* in the CASE model), and one for which the researcher and the practitioners may have different knowledge or investments. It is a process by which the development of new knowledge is facilitated through a dialogue offering contributions from two different perspectives. The aim is to promote the growth of theoretical development as well as practically useful knowledge (Svensson, Brulin, Ellström & Widegren 2002). The Future Workshop is a way of helping people to meet in a creative and constructive way with the aim of working together with common issues. The method is founded on experience of change work aiming at participation and on theories on communication, organisational development and leadership (Denvall & Salonen 2000).

A) Creating a representative project team. This activity from the *Creation Stage* is an integral part of the *Snickaren* Future Workshop process. The project started in the spring of 2000 with a planning and preparation phase involving several meetings with representatives of various pensioners’ associations, social services (eldercare) and politicians in the local authority of Eksjö. Thus, in the early autumn an orientation session was organised with an introduction of the purpose of the project and the Future Workshop method. Invitations were sent to the public, tenants, volunteer organisations, the housing company, out-patient health care representatives and others, again in order to develop a representative set of participants.

B) Utilizing a scientific approach to evaluation. Staff involvement in the change and development processes is part of quality improvement with the aim of promoting positive attitudes toward and effective strategies for collaboration. The Future Workshop is a method to bridge the gap between theory and practice and bring about better contact

between users, staff and other stakeholders in the formal as well as the informal sectors. Eldercare staff participation in the process launched in the Future Workshop promotes new knowledge and processes for working together. Thus, one of the components of the process, as well as an outcome, is resulting in the development of new ways of meeting the needs of elders.

C) Establishment of a new program for meeting targeted outcomes: The Future Workshop. During the *Creation stage*, a Future Workshop can be outlined in three different subphases: a) the critique phase, b) the fantasy phase, and c) the implementation phases, which occur during 1-2 days when individuals meet over the *Targeted Outcome*. The Future Workshop was conducted on 5-6 October, 2005, at the Snickaren senior housing facility. Participants were eldercare staff and pensioners living at Snickaren as well as in other parts of Eksjö. Other participants were representatives of various pensioners' associations and other volunteer organisations linked to the elderly. Staff were represented by nurse aids, kitchen staff, managers for elderly care, and personal benefit advisors. One person from primary care services and one local politician were also present. Altogether, there were 30 participants, all with some link to Snickaren. Managers of the Future Workshop were researchers from the School of Health Sciences, Jönköping University.

D) Work with local authorities. As outlined in the previous paragraphs, including local authorities in the Future Workshop empowerment process was an integral part of the process from the very beginning. One aim of the Eksjö project was to develop strategies for facilitating elderly people's aging in place with the help of the Future Workshop method in joint action with elderly residents, eldercare staff, and other key stakeholders. Based on suggestions put forward in the Future Workshop, concrete plans were developed to bring about improvements in the senior housing and the residential area in order to facilitate elderly people's aging in place. These plans included physical and environmental changes, as well as social programs and information exchange to promote a sense of community.

SECOND STAGE. Through the Future Workshop an initial *Creation* of a change and empowerment process was started. In the second stage, *Adaptation*, the new systems of empowerment need to be modified. For example, various theme groups (e.g., indoor improvements, outdoor improvements (in the garden), improvements for increased safety, and initiatives for common leisure time activities) carried on their work of clarifying specific goals and activities until a follow-up meeting 2-4 months later, attended by all participants. At this meeting the working groups report to each other, sharing important information about progress and development. This meeting can lead to other constellations and collaboration, which would be part of the *Adaptation stage* in the CASE model. The goal of a Future Workshop is not to start and finish a project but to initiate a process that can live on in the form of a "permanent workshop" (Denvall & Salonen 2000; Jungk & Müllert 1996). [Followers of Jungk see preparation and follow-up as separate phases and thus delineate the Future Workshop in five separate phases (Denvall & Salonen 2000).]

A) Information systems. At two follow-up meetings, in November 2005 and March 2006, the two working groups from the future workshop reported on the progress of the efforts to realise various suggestions concerning improvements of buildings and outdoor environment as well as development of common activities. At a meeting in June 2006, about 30 persons took part. Participants at this meeting were representatives of tenants and/or users, the Client Council, the National Federation of Disabled Persons and three pensioners' associations. Staff representatives were day and night staff and kitchen staff.

B) Promoting mutual support. Another aim was to let elderly people together with home help service staff and other stakeholders develop new forms of collaboration and coordination of formal and informal resources. The aim was also to encourage the participation of the elderly as well as home help service staff in processes to improve everyday life of the elderly based on a comprehensive view of housing and care.

Various aspects of the work precipitated by the Future Workshop seem to be operating at the Adaptation Stage, the Sustenance Stage, and the Expansion stage. An analysis of the accomplishments and remaining challenges below illustrate the dynamic nature of the CASE Model and how, in some situations, the stages may, in fact, be somewhat cyclical in nature, leading participants to cycle through various stages at various times. Thus, throughout the analysis below, the stages and activities will be denoted, with a summary at the end.

Much has happened as a result of the Future Workshop that was implemented in the autumn of 2005 and some specific *Targeted Outcomes* have been achieved. There has also continued to be follow-up since then within different working groups.

Physical Changes: Significant improvements have been made in the garden. New flower beds have been planted and overgrown shrubbery has been removed. In two large vegetable plots (elevated to facilitate for people in wheelchairs to poke in the soil), pensioners have planted herbs assisted by members of a local horticultural society. An asphalt path has been replaced by a gravel path along the river at the edge of the garden. Along this path, called "the promenade", there are now beautiful white benches facing the river. What remains to be done is a ramp from the dining-room into the garden. The patio outside the dining-room will be enlarged, and an awning will be installed to provide protection from the sun. The old pavilion will be renovated and lowered to make it accessible also to people in wheelchairs. Inside, building fixtures and the sauna have been repaired. Front doors have been equipped with spy-holes. Preparations have been made for the installation of cable TV. There are proposals for new furniture in the day-room, and a group will continue to work on this issue. Thus, there are some mechanisms for *Sustenance (Third Stage)* of the initial work.

New Services, Activities, and Information: An inventory has been made of overnight apartments adjacent to municipal senior housing available to relatives. Price lists from the youth hostel nearby have been posted in the entrance hall. A small kiosk has opened in the dining-room selling chocolates, stamps, etc. Volunteers have re-introduced

the popular afternoon coffee a few days a week; this used to be served by the staff. A representative of the municipal day activities for the mentally retarded was invited to another meeting to discuss whether they could take care of arranging the afternoon coffee. This might ensure greater continuity in the cafeteria, and at the same time the mentally retarded would have something meaningful to do. A group was appointed to monitor this issue. An open house was planned for the coming autumn where craftsmen would let the elderly coming to Snickaren try various creative activities. One group was appointed to plan this program. There were also plans for an exhibition showing eldercare “then and now”. This was thought to be of interest to the younger staff. A theatre company performing in Eksjö in July was invited to Snickaren. The local social services offered to pay the expenses. At the end of July, a local radio station visited Snickaren to broadcast an election debate about eldercare with politicians from various political parties. An information folder about Snickaren has been produced to be distributed in the municipality, reporting also about work in the future workshop project. New information systems, crucial to the *Adaptation* and *Sustenance* stages of the CASE Model, have been implemented.

Ongoing challenges. In the ongoing work there are some crucial issues that need to be addressed. At the level of *community* as well as the *broader systemic*, the local social services department is negotiating with the municipal housing corporation about the price of taking over Snickaren and determining rent costs to be charged for the common premises that the social services department intends to rent. This is to more easily enable the tenants, as well as various volunteer organisations, to continue to utilise these premises for free or at a minimal cost for various community-promoting activities. The local pensioners’ association, on the other hand, will have to pay rent for premises used as an office space. The politician who is taking part in these negotiations thinks he has much better data on which to base decisions because of participating in the Future Workshop. He says, “*I have gotten a truer image of reality for me to make decisions*”.

Another issue is whether the kitchen will continue to be run by the local eldercare services or by an external contractor is still open for debate. The social services department would prefer somebody else to take over, but the kitchen staff do not see any greater profitability in the dining room and meals-on-wheels programs. This is a price-sensitive business. On the one hand, the price must not be too high if you want to attract pensioners as guests. On the other hand, there is some pressure from local business not to let the municipality subsidise the kitchen too much.

At the meeting in June 2006 at Snickaren, an interest council was formed with representatives from the Municipal Pensioners’ Council, the Snickaren Client Council,³ and various volunteer organisations. This interest council is intended to encourage contacts with the volunteer organisations. An information folder has been produced with the aim of recruiting more volunteers. This is an example of the expanding arenas and

³ The Municipal Pensioners’ Council is a lobbying group organized by different interest organisations for pensioners’ on a municipal level. The Snickaren Client Council is an advisory board consisting of representatives of elderly tenants and staff. This is a kind of advisory board that is organised at all kinds of special housing units in Sweden.

people that have become involved in addressing the issue of empowering *persons*, *communities*, and broader interdependent *systems* around housing.

The meeting ended with a discussion about how to channel continued commitment from tenants and clients. The Snickaren Client Council is considered crucial in this process. At the same time, it is important to preserve the spontaneous engagement which is not always channelled through more formalised forums. A special working group with representatives of the elderly and the staff was appointed to monitor this issue. About this, one of the participating pensioners said, “The future workshop has strengthened democracy”. With the completion of a future workshop, a process for change has started. The outcomes are real and tangible measures based on the theme of the future workshop, but there are also consequences of importance for the individual on a more personal level. During 2006 the elderly (the seniors) at Snickaren began to ask for changes. New thoughts and ideas emerged which have led to improvements of previous suggestions. The elderly began to take a more proactive role and new networks were formed between various pensioners’ groups and local associations. These initiatives have resulted in new collaborations, knowledge and experience. All of these activities are found both in the *Adaptation* and *Sustenance* stages of the CASE Model.

Ronnby (1995) argues that development work should have its starting-point in local conditions and that local resources should be engaged in the work with a holistic view of society. He goes on to say that it is important to emphasise social and cultural aspects in social change work. Ronnby’s (1995) view corresponds well with how local competence may be defined. In the context of local competence we can also refer to the concept of *participation* (Madsen 2001, 2006; Stensmo 1991). This can be a matter of listening to an individual’s need for leverage and participation in decisions. This in turn means that staff must be sensitive to wishes and needs of users and be able to see the individual in his/her social context, which is also a component of local competence. It is important to have a *social education attitude* if you want to start from a user perspective. This line of argument can be traced back to Eriksson & Markström (2000), who, referring to Natorp, argue that one of the cornerstones in social education is that we humans need human closeness in order to develop. This approach is crucial when working with the users. With regard to helping people satisfy their overall needs as humans, having social and existential needs addressed may be just as important as getting assistance with practical chores. This is also emphasised by Blomdahl-Frej (1998) as an important part of social education work. A user perspective and social education both rest on a comprehensive view and the entire life situation of the user. This supports Moody’s model of a self-actualizing society, as noted in Chapter 1.

FOURTH STAGE. As community members continue to participate in the activities associated with the Future Workshop, *Expansion* activities also emerge. Thus, the community of care that is developing through new constellations of groups of people is the beginning of a long-term work with new ideas for further processes. For instance, the local newspaper has on a couple of occasions reported about what is happening at Snickaren. As a consequence, it has become easier to establish connections with various volunteer organisations, which means more help from volunteers who have begun to

commit themselves more than before. A certain change of attitude is now noticeable between groups as well as individuals. The Future Workshop has also led to the launch of several concrete projects. The relationship between seniors from different houses has also improved as they cooperate more on a regular basis. Furthermore, it is obvious that also those who have not participated in the Future Workshop project have become more active and discuss what is happening at the Snickaren senior housing.

As part of the *Evaluation* process, observations from the Future Workshop in Eksjö have been passed on to students in Social Work at the Department of Behavioural and Social Sciences at Jönköping University. Four of the pensioners from the Future Workshop took part in the latest seminar, which was much appreciated by both the students and the pensioners. During our focus interviews with staff and elderly residents we asked what the Future Workshop had meant to the people involved (Henning, Åhnby & Österström 2008). These are some of the answers from the *pensioners*:

“The future workshop has given me an opportunity to express my opinions. It has been fun discussing with others and hearing the views of others. It feels important to participate, to be able to be active.”

“It feels important to participate in thought, even if I cannot physically help. It is very important for one’s self-esteem. One gets knowledge, one can influence even at an advanced age.”

“The future workshop provides an opportunity to take part in a transformation. We have come to know each other”.

Statements also from the *staff* show that they have appreciated taking part:

“See this as a good start; this will not be completed in a couple of years. It’s a constant change, just as in life generally, after all...”

“We have come to know each other better; I’ve been able to inform about the staff’s situation from our perspective, and at the same time I’ve learnt about the conditions of others.”

“To meet users in a down-to-earth way has been important!”

The evaluation of the outcome of implementing the Future Workshop method, in connection to a transformation of *Snickaren* elderhousing to a kind of Safety housing, exemplifies different kinds of empowerment on various levels (Carras & Rosenlöf, 2007; Henning, Åhnby & Österström, 2008). At the *personal level*, for the staff, it has been an important improvement in quality of service. If the staff feels empowered the quality of care will be improved. But also it helps to make the staff aware of the importance of empowering the elderly and how they could be helpful in this process. Interviews with the elderly who took part in the future workshop show that this has been important for their self esteem and that they feel more powerful when they get a chance to be active in improving their life conditions in the close environment.

While the Future Workshop strengthens empowerment on a *personal level*, it is also a way to strengthen empowerment at the *community level*. Different stakeholders who have taken part in the Future Workshop express the importance when it comes to

promote community empowerment. The interplay has improved between different volunteer organizations in connection to activities that take part at *Snickaren* elderhousing unit. Ageism (negative attitudes towards elderly people) is a phenomenon that may be a hindrance for empowerment of the elderly on all levels including community empowerment (Jönsson, 2002; Kam, 1996). The Future Workshop is a method that aims to encourage good communication between the elderly, staff, and different stakeholders and contributes therefore to overcome *systemic* obstacles like ageism.

In addition, empowerment at the *Systemic level* occurs more easily in Sweden, because it is a concept already found in Swedish legislation (SFS 1980:620; SFS 2001:453). From a philosophical point of view empowerment can be described as an aspect of democracy and ethics in everyday life, and from a practical point of view as an opportunity to participate and be active. It is also important to convey a sense of having the right to participate. Empowerment refers to *personal, community and systemic* resources and opportunities, growth and development, and thus can be analyzed on individual, group, organisational and societal system levels. Resources can be physical, mental and/or social (Renblad, 2003).

When discussing empowerment as a concept a distinction can be made between individual and collective empowerment (Hyung Hur, 2006). This distinction could be fruitful when analyzing the outcome of the Future Workshop as a method for empowerment in planning for housing to promote the development towards an aging-friendly community. Individual empowerment is defined as how people look upon themselves as resources and what knowledge they have. Power, self-government, control, and self-esteem are some components which are central for understanding empowerment (Hagqvist & Starrin, 1996). On a collective level empowerment is associated with the idea of collective learning in promoting some kind of change to the better (Hyung Hur 2006). Many researchers highlight the importance of collective action to achieve change (Gutiérrez, 1990; Lymbery, 2005).

Empowerment of the elderly is an important means of preventive work (Anme, 2000). When implemented as a goal in the way as in the example of *Snickaren*, it is also a way to promote a planning process towards a more aging-friendly community. Housing is a central issue in planning for eldercare in the future. In this planning it is crucial to find ways of developing housing concepts that also promotes empowerment.

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This chapter outlines a project that was conducted in the United States to design, build, and manage affordable senior housing for Deaf, hard-of-hearing, and hearing seniors. The specific housing complex is called “Fremont Oak Gardens” and is located in the city of Fremont, California (which is in the San Francisco East Bay Area).

Demographic and cultural background

Demographic changes. As with many countries, the United States is also dealing with the aging of its population. The U.S. population is aging as fast as some other industrialized countries, though not as quickly as Japan and Canada. In 2006, the average life expectancy for females was 79.7 and 74.4 years for males and about 12% of the population were 65 years of age or over (U.S. Census Bureau, 2006). The fastest growing group is over the age of 85. In terms of hearing loss and deafness, about 2 to 4 of every 1,000 people in the United States are "functionally deaf," though more than half became deaf relatively late in life. Less than 1 out of every 1,000 people in the United States became deaf before 18 years of age. However, if people with a severe hearing impairment are included with those who are deaf, then the number is 4 to 10 times higher. That is, anywhere from 8 to 40 out of every 1,000 people have a severe hearing impairment or are deaf. Again, at least half of these people reported their hearing loss after 64 years of age. Finally, if everyone who has any kind of "trouble" with their hearing is included then anywhere from 37 to 140 out of every 1,000 people in the United States have some kind of hearing loss, with a large share being at least 65 years old. Estimates of the number of deaf and hard of hearing persons in the United States are typically based on one of two national household surveys conducted by the federal government: the National Health Interview Survey (NHIS) or the Survey of Income and Program Participation (SIPP). Based on these surveys, it seems that approximately 1,000,000 people are functionally deaf, with more than half of those over 65. About 8,000,000 are hard-of-hearing and half of those are over 65. These are based on self-reports rather than clinical diagnoses (GRI, 2007).

Cultural values changes. Historically, the United States has been a society of individuals who have been expected and assumed to be responsible for themselves. There is a long history of advocacy and social action for civil rights by various groups in the U.S. These groups range from those advocating for rights for people with mental illness, those with physical disabilities, children, ethnic and racial minorities, etc. In 1990, the American with Disabilities Act (ADA) was passed by the national Congress to prohibit discrimination against those with disabilities. The Act also established requirements for the modification of, and inclusion in new buildings of, designs that facilitated access for those with physical disabilities. These include such features as wheelchair ramps, accessible restrooms, widened doorways, etc. Thus, groups who before 1990 had had to work in a social and legal context that did not explicitly support their rights now had the full power of the federal government and the law behind their efforts at empowerment

and equality.

This chapter explains how the CASE model could be utilized to describe an empowerment process in a particular community of deaf seniors in the San Francisco East Bay of California. This particular cohort of Deaf seniors today has a unique history in the U.S. Many of them were placed in institutions as children – “sent away” from their families, schools, and communities. They have developed their own culture and even distinguish themselves within the population of people who are deaf or hard-of-hearing by capitalizing the word “Deaf” to indicate people who self-identify with Deaf culture, and not just the physiological status of being deaf. For some individuals in this generation of Deaf seniors they experience a range of being misunderstood by others and some have developed a sense of mistrust of others. They have, however, developed a very deep sense of pride and solidarity, which has helped them achieve goals for their community over the years.

In terms of housing options for Deaf seniors, there have been a few complexes that have been built in the U.S. in the last few years. Water Tower View senior housing in Greenfield, Wisconsin was built in 2005. It provides 43 units for Deaf seniors, even though market analysis showed about 350 eligible people in the local area and 500,000 deaf or hard-of-hearing seniors in the state of Wisconsin. Similar to Fremont Oak Gardens, the active advocacy group, Southeastern Wisconsin Deaf Senior Citizens prompted and participated in their design and implementation process (Thomae & Leiterman, 2005). Other senior housing complexes for Deaf seniors exist in Massachusetts, Texas, Nebraska, and Oregon.

The CASE model with Deaf seniors in the United States

Typically in senior housing projects, seniors with different types of abilities can often end up being socially isolated, which clearly affects their physical and mental health, which, ultimately, affect life expectancy. This has definitely been the case with Deaf seniors, who in typical senior housing facilities are isolated not just within their own living environment, but then are also isolated from their Deaf friends and community outside the physical environment (Thomae & Leiterman, 2005). Thus, while one longer-term goal might be seen as increased longevity – another ultimate goal was also specifically to empower Deaf elders in the community to become educated about their own housing desires, and to both create and take advantage of options and resources for improving and maintaining their physical, social, and emotional health, so that ultimately they could feel empowered in increasing the quality of their later years. The **process goal** was also to engage them in the empowering process of designing and building the housing and support services that they could use.

As stated above, there has been a long history of an “empowerment culture” for both individuals and the community to promote mutual aid in solving social problems in the U.S., so that was not the same challenge as it might be in other cultures, such as how it was discussed in the chapter on Japan.

Fundamental factors for community empowerment. As outlined in Chapter 3, in the CASE model of empowerment, there must first be an *Identified Community* that can agree upon a *Targeted Outcome*, and then identification of *Contextual Factors*, and *Initial Resources* must be effectively included as the community moves through the empowerment process.

Identified Community. In the case of Fremont Oak Gardens, the community of local Deaf seniors was identified as the community of focus. This was due to the fact that the California School for the Deaf has been located in the city of Fremont since 1980 (in California since its beginning in 1860). Thus, a large community of Deaf residents lived in and around the city of Fremont, and as they have aged, they have become concerned with their needs to age in place appropriately, within their familiar community. One of those concerns, the *Targeted Outcome* in this circumstance, was appropriate and supportive housing for Deaf seniors. Thus, a local advocacy group of Deaf seniors began exploring the idea of building senior housing many years ago. Their work was begun in a particular set of *Contextual Factors* such as an active advocacy group of Deaf seniors, as well as a city and surrounding community familiar with collaborative efforts with Deaf citizens, and an atmosphere of multiple funding streams available for such projects. One

Fig. 1. Process Model for Empowerment Skills: Community Empowerment for Deaf Senior Housing

<p>4) Initial Resources</p> <ul style="list-style-type: none"> *strong local group of Deaf seniors * experienced housing development organization *supportive local housing authorities 	<p>2) Identified Community</p> <ul style="list-style-type: none"> *Deaf seniors community 	<p>1) Targeted Outcomes</p> <ul style="list-style-type: none"> *prolong healthy years of life for Deaf seniors *design housing for deaf seniors *create community for all residents *utilize creative and new building design
<p>5) Implementation Methods</p> <ul style="list-style-type: none"> *collaborative and inclusive planning and design meetings *ongoing community involvement as project developed 	<p>3) Contextual Components</p> <ul style="list-style-type: none"> *history of Deaf advocacy *Fair Housing laws in play *multiple sources of funding <p>6) Evaluation Evidence</p> <ul style="list-style-type: none"> *resident satisfaction and participation in community activities *longevity of residence - "aging-in-place" *financial viability over time *development of new Deaf housing in other cities 	

other important contextual component was the set of laws pertaining to fair housing that exist in the U.S., and under which any housing development was operate. "Title VIII of the Civil Rights Act of 1968 (Fair Housing Act), as amended, prohibits discrimination in the sale, rental, and financing of dwellings, and in other housing-related transactions, based on race, color, national origin, religion, sex, familial status (including children under the age of 18 living with parents of legal custodians, pregnant women, and people

securing custody of children under the age of 18), and handicap (disability)” (Housing and Urban Development, 2008) [see Figure 1]. This law means that the housing developer could not *exclusively* rent to Deaf seniors, since that would be one form of discrimination. However, given the funding options in the U.S., there were options for obtaining funding from the State of California which did provide the ability to set aside 40% of the apartments for Deaf and hard-of-hearing seniors.

As presented in Chapter 3, the CASE Model of empowerment has four stages: Creation, Adaptation, Sustenance, and Expansion. Each stage for this project had a particular set of activities and skills associated with it, as outlined below.

FIRST STAGE. In the *Creation* stage, there was clearly a need for a multi-group collaborative effort to make real the goal of affordable housing for Deaf seniors. Thus, initially, a group of Deaf seniors (the DSHP – Deaf Senior Housing Project) talked with the city of Fremont to explore options for building new housing for their community. This initial group was composed of only about 10 older persons. They also began to address other issues of concern to Deaf seniors and eventually, over 10 years, became BACDS - the Bay Area Coalition of Deaf Seniors. Their membership now numbers over 500 and they have active chapters in 7 cities across the San Francisco Bay Area.

In 1999, the city communicated to the seniors group that they could not provide all the funds needed for such housing, so the city recommended that the group find a partner who specialized in affordable senior housing development. The group interviewed several housing development agencies, and ultimately chose Satellite Housing, Inc. Satellite is a non-profit housing development and management agency which has built and managed almost 20 different projects over its 40 year history of serving very-low-income seniors and adults with disabilities. They have recently begun building affordable housing for families and other special needs groups, as well. Given their reputation and capacity, BACDS chose them as their collaborative partner for designing, building, and managing the new housing.

A) Creating a representative project team. Once the initial collaborative relationship was established, other participants were invited in, and thus a *representative project team* was formed. This included a Deaf architect, the project development team from Satellite and representatives from BACDS. Initial activities included 6-8 design workshops which the architect held with various small groups of seniors, to solicit their ideas and desires for the new housing complex. During the pre-development phase, as well, much work with the city of Fremont had to be done to secure the needed financing and to qualify for required building permits, land use, etc.

B) Utilizing a scientific approach. In this case of Fremont Oak Gardens, the application of this factor of utilizing a scientific approach was not focused so much on evaluation as it was on utilizing a systematic and well-proven method for working with various groups to achieve a common goal of affordable senior housing. This methodical approach to all of the various steps of getting adequate funding, working with neighborhood groups to accept new housing, building and sustaining relationships with

city officials were all components that Satellite Housing, Inc. was very familiar with and adept at doing. Thus, this partnership between the Deaf seniors and Satellite allowed both to bring their best to the table to meet the desires and needs of the seniors.

C) Establishment of a new program for meeting Targeted Outcomes: Fremont Oak Gardens Senior Housing. The ultimate outcome of this empowerment process was Fremont Oak Gardens, which provides affordable, accessible, independent living housing to low-income seniors with amenities for the Deaf. There are 50 units, which house individuals and some couples. The physical layout of the complex is especially designed with sight-lines to enable signing communication between residents, lights that go on when the doorbell is pushed, see-through cutouts in the walls between rooms to facilitate signing and other cutting-edge design and technologies that support quality of life for Deaf seniors.

D) Working with local authorities. One of the greatest strengths that Satellite Housing, Inc. brought to this project was their history of success in working with local authorities to create new and innovative housing projects. While the Deaf seniors had been in communication with the city of Fremont, Satellite also recommended extending the scope of assistance, and established relationships with neighboring cities, which also had Deaf seniors living in their communities. In this way, greater funds could be gathered for the project. Other cities, such as Hayward, Livermore and Pleasanton also contributed money from their Community Development Block Grant (CDBG) funds. Alameda County (a larger region including several cities) also donated funds. There was also USD\$6.4 million from the state of California, and the city of Fremont allocated USD\$2.64 million from their Housing Redevelopment Fund. Another source of funding was private tax credits, where private investors contribute money to affordable housing projects and receive a national government tax credit for such investments. Altogether, there were 11 funding sources which contributed to Fremont Oak Gardens.

SECOND STAGE. For the Adaptation stage of the Fremont Oak Gardens project, there was a period during the development and building where ongoing meetings were held in order to *modify and continue to develop* the desired elements in the new housing. In addition, *information systems* were developed – through newsletters and through the Deaf seniors group – so that everyone could be informed throughout the building process. Ongoing and regular meetings helped people feel that they were still a critical part of the process.

In addition to the construction aspects of the project, there was also the need to begin to *promote mutual support* between the prospective residents (Deaf and hearing) and the Satellite Housing staff who would be working at the building. At Satellite the Resident Services Coordinator is the person who

“assists residents by researching what services are available in the local community and how to bring those services to their building. For example, residents can take exercise or art classes, attend workshops, or get answers to health questions on-site. These services improve

residents' quality of life, create strong communities, and offer opportunities to catch physical and mental health issues early.

Satellite Housing Resident Services offers one-on-one case management for disabled seniors and residents. It also collaborates with local service providers or families to link residents with home and community based resources and organizations that can improve their quality of life. Through our resident services, we prevent or delay the institutionalization of elderly and disabled residents by providing non-medical and in-home services. The Resident Service Coordinator educates residents on available services and monitors provisions of services, and also encourages residents to be proactive in meeting their social, psychological, and physical needs.

The Service Coordinators also offer a wide variety of opportunities for socialization on site such as weekly teas, art classes, and regular holiday celebrations. Several sites have hosted their own art galleries (with work by residents) with big crowds in attendance on opening day.” (www.satellitehousing.org/pages/residentservices.html)

Currently, there is a Satellite Service Coordinator who works two afternoons a week at Fremont Oak Gardens and focuses her work on the hearing residents. In addition, there is a full-time service coordinator who both signs American Sign Language (ASL) and reads lips, who focuses on the Deaf and hard-of-hearing residents. That position is funded by the local Deaf Counseling, Advocacy & Referral Agency (DCARA).

Another important factor, unique to this empowerment project, was achieving full residency – in other words, to have enough people applying for housing so that they could rent all the units. This was achieved, but not without effort on the part of Satellite staff, local housing authorities and early residents themselves. Fortunately, there is currently no vacancy in the building.

THIRD STAGE. The *Sustenance* stage is when initial feedback was gathered – in this case, when the housing complex had been designed and built, residents had moved in and some sense of a steady state could be achieved. One important factor here was *reiteration of values and goals*, since the housing had been built under Fair Housing laws, there was a necessary mix of residents – those who were Deaf, those who were hard-of-hearing, and those who could hear. Staff worked diligently to set a tone with all residents that the mutual goal was to build a supportive and empowering community for *all* residents. This seems to have worked well and has resulted in a level of social interaction and activity that has surpassed all expectations. Community activities are well attended and people report high levels of satisfaction.

This sense of community has been transmitted and developed not just *within* the building, but *between* the residents of the building and the larger community in the city of

Fremont. Thus, the community activity room at Fremont Oak Gardens has become a hub of activity for the larger Deaf community and events are held there, open to all residents.

In terms of *initial evaluation efforts*, the question arose of what would be realistic expectations for what would, in fact, define “success.” Full capacity of residents is one “objective” measure of success, and one that would help achieve financial sustainability – an important outcome. Beyond that, resident satisfaction is an important measure of success, as well. Satisfaction surveys can be done, and would need to be specifically designed for this building, to assess the effectiveness of the physical environmental factors, etc. to see if they are working in the ways imagined to increase the independence of the residents, and extend their years of aging in place. This is a longer-term and ongoing set of evaluations that should be put in place and conducted regularly as time goes on. Residents’ ability to stay in the building over long periods of time can be measured through a new system of resident tracking that Satellite has recently implemented. This system includes not just financial and contact information, but also allows for tracking the services that a resident uses and progress notes for the Service Coordinator to track changes in status and need over time.

FOURTH STAGE. In the *Expansion* stage, more formal evaluations should begin. As noted above, there were some questions in this project as to what exactly would constitute “success.” Certainly, some objective measures could be used, in terms of financial sustainability, and that would include how many of the units have been rented and remain rented over time. So far, into its third year, there is full occupancy, so that measure has been met. With full occupancy comes sustained funding for support services, which also contributes to the financial success of the project. As described above, residents report great satisfaction and participation in social activities on-site is high and representative of all residents, not just the Deaf or hard-of-hearing. In addition, the building has become a site for larger community activities, and that has certainly contributed to greater community empowerment. In addition, the collaborative efforts of the Bay Area Coalition of Deaf Seniors and Satellite Housing have created a new model for meeting the housing and support needs of Deaf seniors in an integrated setting. In fact, in August, 2006, Fremont Oak Gardens was one of 32 finalists featured in the August issue of *Affordable Housing Finance* where readers were instructed to vote online. The seven categories include family projects, historic rehabilitation/preservation projects, master-planned/inclusionary zoning projects, mixed-use projects, senior projects, special needs/SRO projects and urban projects. In *November 2006* readers voted Fremont Oak Gardens as the Best Seniors Project for the Nation’s Best Affordable Housing Development. Satellite was honored to be part of the effort to stress the importance of affordable housing needs for all low-income citizens in the U.S. and to highlight the different methods and techniques that developers are using today to meet various needs.

In terms of Expansion efforts, Satellite Housing has begun conversations with another city nearby, San Jose, about the possibility of building similar housing in their community. Since Fremont Oak Gardens could only provide 50 units of apartments, there is a much greater need that remains. Possible variations of this housing might include age-integrated housing, rather than limiting it to those over 62 (federal guidelines for

senior housing). This is especially important in these cities that are close to the California School for the Deaf, since graduates are seeking appropriate housing for them as they move into mainstream society.

CONCLUSION. In reflecting on the project of Fremont Oak Gardens, Ryan Chao, Executive Director of Satellite Housing, Inc. noted that the rewards of this kind of empowering process were to see residents thriving, not simply surviving, in housing that they had a role in designing and implementing. Having a wide range of their needs met – physically, environmentally, socially, and psychologically – creates a much higher quality of life in their later years than they might have imagined even a few years ago. Satellite Housing can know that they have made a concrete difference in people’s lives and contributed meaningfully to the empowerment of seniors traditionally marginalized in senior housing. In addition, they, in collaboration with the Bay Area Coalition of Deaf Seniors, have broken new ground – both literally and figuratively – in meeting the housing and support needs of a traditionally underserved group of seniors.

Some of the challenges noted were the care and sensitivity with which this kind of undertaking must be shepherded along. Working with a group who is culturally different from one’s own is a challenge and must be intentionally approached with an attitude of shared vision and shared worth in terms of contribution to the project. Specifically in terms of senior housing, factors such as ethnic and cultural traditions must be respected and appropriately addressed through support services (even elements such as food services) offered. Language differences should be addressed ideally through linguistically-appropriate staffing, but at least through the provision of adequate translation services. Any health services provided should be culturally sensitive, for example, including traditional Asian health models, practices, and beliefs. For immigrant populations, literacy levels and the possibility of having survived traumatic experiences in their native country are issues that deserve special attention and awareness. Intergenerational conflicts within some cultural groups can have a major impact on residents and is something that staff need to be aware of, as well. As an organization committed to helping seniors, and others, design and build housing that fits their needs, Chao states that Satellite must continue to be humble in its participation in these empowerment efforts, and recognize that their role may most often be to be a resource to others to accomplish *their* goals, rather than Satellite setting the agenda. Yet, the role of many of us in empowerment efforts is, in fact, to bring a level of expertise and advocacy to those who have been unable in the past to move closer to their goals. With the intentionality mentioned above, each of us can find our appropriate role and responsibility in any empowerment process.

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Chapter 7

Promoting Social Inclusion of Older People: Challenges for Policy on Ageing in Australia Helen Bartlett, Jeni Warburton and Chi-Wai Lui

This chapter presents a critical examination, from multiple perspectives, of the challenges of implementing a national social inclusion approach for Australia's older population aimed at reducing the problem of social exclusion. It considers the ways in which Australian national policy on ageing promotes social inclusion and the extent to which policy goals are being implemented. Recent examples of state and local government initiatives to combat social isolation, and to implement ageing well at the local level, are related to the CASE Model framework, and explored to highlight the barriers and facilitators of national policy development and implementation in this area.

Demographic and cultural background

Demographic changes. In Australia, the population aged 65 and over is projected to increase from 13.3% currently to 23.7% by 2036 (Australian Institute of Health and Welfare, 2007). In 2006, 29% of people aged 65 and over lived alone (Australian Institute of Health and Welfare, 2007) and the problems of loneliness and social isolation are increasingly recognised for this group (Steed, Boldy, Grenade & Iredell, 2007).

The risk of social exclusion for older people from culturally and linguistically diverse (CALD) backgrounds is particularly apparent both now and in the future as seniors with CALD backgrounds will comprise about 23% of the total older Australian population by 2011, which is a 66% growth since 1996 (Gibson, Braun, Benham & Mason, 2001). Research has identified that older migrants are particularly at risk of social isolation (Ip, Lui & Chui, 2007; Rao, Warburton, & Bartlett, 2006). Geographical location is also relevant as over 36% of people aged 65 and over live outside of major cities and this level is higher than the remainder of the population. This has implications for transport, access to health and a range of other services (Australian Institute of Health and Welfare, 2007).

Cultural values changes. The issues of social isolation and exclusion are significant for both ageing societies in general, which are faced with increasing dependency levels and the requirement to support older people who suffer from financial, health and social disadvantages, as well as for individuals and their families, who are unable to optimise their potential and suffer poor quality of life as a result. Exclusion of older people from mainstream society has been identified as a major social problem, increasingly recognised as an important policy issue both nationally in many countries, and internationally. The literature has identified multiple risk factors for social exclusion including socio-economic status, ethnicity, rural locality and chronic illness (Barnes, Blom, Cox, Lessof & Walker, 2006; Scharf, Phillipson, Kingston & Smith, 2001; Social Exclusion Unit, 2006).

While the risk factors for social exclusion are increasingly understood, less attention has been paid to what it means for older people to be 'excluded' or their

perceptions of 'social inclusion'. Interest in the needs and expectations of the babyboomer cohort is increasing and the findings of recent studies suggest that this group of the population may be different to previous cohorts and demand greater participation in society and decision-making generally (Quine, Bernard & Kendig, 2006). However, insufficient attention has been paid to the diversity of Australia's growing ageing population and the complex challenges for the policy agenda (Miller & Ahmad, 2000; Warburton & Petriwskyj, 2007).

Some progress in addressing the well-being of older people can be demonstrated in Australia, but ageing policies and legislation have fallen short of the UN ideal of 'a society for all ages' that builds upon respect for human rights, cultural diversity, social justice and democratic participation of all its members regardless of their age (United Nations, 2002). Over the past decade, Australia has introduced policies and strategies at all levels of government to address the implications of population ageing. Despite the focus on healthy ageing in such policies and strategies (e.g., Commonwealth of Australia, 2001; Prime Minister's Science Engineering and Innovation Council, 2003), its implementation has received far less attention. This is particularly so at the local government level, even though local Councils have the opportunity to take a lead role in building better local communities as a result of their closeness to the people and their governance role (Cuthill, 2003; Wills, 2001). Despite this policy action, a coherent framework for promoting social inclusion of older people does not exist. Further, the voices of older people are largely absent from the discourse about social inclusion, yet if effective policies are to be developed, older people's perspectives need to be included.

The Targeted Outcome - Social inclusion as a policy approach. According to the UK Centre for Economic and Social Inclusion (2007), social inclusion refers to 'the process by which efforts are made to ensure that everyone, regardless of their experiences and circumstances, can achieve their potential in life'. The rise in prominence of the concept of social inclusion in social policy signifies a paradigm shift in welfare philosophy from an emphasis on material deprivation to social exclusion (Byrne, 2005; Levitas, 2005). Social exclusion, the opposite of social inclusion, has become a central concept in developing public policy in the United Kingdom and European Union aimed at tackling social disadvantage (Department for Work and Pensions, 2003; McDevitt, 2003).

The idea has also stimulated much discussion and debate in other countries, particularly in Canada (Guildford, 2000; Policy Research Institute, 2005a; 2005b). Specifically, the discourse on social exclusion extends the understanding of social inequality by revealing that (1) social inequality is not confined to economic deprivation as people can be excluded from spheres of consumption, production, political engagement and social interaction; (2) social exclusion is not static and represents both an outcome and an array of processes; (3) social inequality is conditioned by a complex interplay of demographic, economic, social and behavioural factors that are linked and mutually reinforcing (Bradshaw, Kemp, Baldwin & Rowe, 2004; Burchardt, LeGrand & Piachaud, 2002; Social Exclusion Unit, 2004).

The focus on social exclusion as a multidimensional, dynamic and relational process highlights the imperative of a social inclusion policy. As a policy approach, social inclusion implies more than the elimination of poverty or material deprivation, it also signifies an attempt to strive for a balance between individuals' rights and duties and to increase social cohesion. This is the approach of personal empowerment as balance and interdependence discussed in Chapter 1. The approach thus conjures up the vision of a good society and addresses the wider aspects of social, cultural and economic participation and citizenship. The social inclusion discourse has provided the normative base for many research programs and policy responses in the United Kingdom and European Union (O'Brien & Penna, 2007). Inclusive practices derived from this perspective advocate a more strategic and life course approach to minimising social exclusion and enhancing life outcomes. They emphasize the use of 'positive' welfare investment in human capital, active health and lifelong education to prevent the emergence of social problems much earlier in the life course (Dewilde, 2003). Thus, the ultimate goal is the kind of self-actualized society that Moody (see Chapter 1) describes.

Social inclusion and older people. The social inclusion/exclusion approach has been applied to tackle a wide range of issues in the United Kingdom and Europe including poverty, youth education, unemployment, fear of crime and homelessness. In recent years, some research and policy attention has turned to issues of social exclusion in relation to the ageing population (Abbott & Sapsford, 2005; Barnes et al., 2006; Ogg, 2005; Phillipson & Scharf, 2004; Scharf et al., 2001; Social Exclusion Unit, 2006; Walker, Barnes, Cox & Lessof, 2006). This body of work, while firmly embedded within European experience, highlights the specific risks faced by older people in relation to social exclusion/inclusion. These include (1) people who are socially isolated in mid-life will usually experience further exclusion when they grow old; (2) key life events or transitions in later life like losing a partner can lead to social exclusion; and (3) age discrimination inherent in social attitude and institutional arrangement can intensify the exclusion of older people (Social Exclusion Unit, 2006: 8).

This evidence suggests that when applying the social inclusion approach to the situation of older people, there are a number of specific issues that needed to be considered: (1) the process of social exclusion of older people is less dynamic as the lack of material goods and economic resources is more likely to be a permanent than temporary situation in later life; (2) cumulative disadvantages like social and economic hardship or limited opportunities in the early part of the life course increase the risk of social exclusion in later life; (3) older people are in general less geographically mobile and thus local community may play a significant role in shaping their experiences of inclusion; (4) social participation and civic engagement are important dimensions of social inclusion for older people because most of them are no longer in the workforce (Phillipson & Scharf, 2004; Scharf et al., 2001; Walker et al., 2006).

Overall, existing literature highlights the importance of ageing as a special case in relation to issues of social exclusion/inclusion. It points to social exclusion of older people as a form of 'institutional disengagement' (Scharf et al., 2001: 307) caused by social and physical barriers like poor transport, local health services and fear of crime.

These barriers relegate seniors to the margins of society and deprive them of the opportunity of full social engagement. If older people are to be valued and included in mainstream society, these barriers have to be removed. Furthermore, it is essential for policy makers to explore what social inclusion means to older people and to use their lives as a starting point to plan and evaluate services and interventions (Joseph Rowntree Foundation, 2004).

The Australian Context. In Australia, recent projects with a social inclusion focus can be identified and offer lessons for linking policy and practice. The next section explores two such initiatives, recently developed in Queensland, that attempt to target and engage older people at the local level.

1. Prevention of social isolation: demonstration projects in Queensland. The Queensland Cross-Government Project to Reduce Social Isolation of Older People was a state government initiative that employed a community development approach to create opportunities for social networking and interaction between older people in Queensland. The project commenced in 2001 and was led by the Seniors Interest Unit, a steering committee of representatives from different government departments, the Ministerial Advisory Council for Older Persons, and the Australasian Centre on Ageing at the University of Queensland. [Thus, the *Targeted Outcome* was prevention of social isolation, while the *Identified Communities* were contrasting rural, regional and urban settings in Queensland.]

The first three stages of the project involved an exploration of issues associated with social isolation identified from the international literature (Findlay and Cartwright, 2002), as well as a series of local forums and a broad consultation process across Queensland in which 630 individuals participated. A series of key success factors for community interventions was identified, including a whole of community response, healthy and active ageing, meaningful and purposeful occupation, access to the community and skill development. The importance of developing a community partnership approach that promotes networking and cooperation across all stakeholders was fundamental to the overall project (Queensland Government, 2006). Clearly, here, the activities of the *Creation* stage were utilized – creating a representative project team, establishing new programs for skill development and healthy and active ageing, and working with local authorities in a collaborative way.

In what can be an illustration of the second stage of CASE, *Adaptation*, the findings from the first three stages informed the fourth stage which involved a series of interventions in five different locations, all funded for one year over 2005-2006. The five locations were selected based on feedback from the community consultation that older people in these places are at higher risk of social isolation and loneliness. A wide range of group activities and services were delivered in each location with the aim to create meaningful social networks and close relationships among older people. The programs were designed and implemented in partnership with community organisations and councils. Older people living locally were consulted or involved in the process of planning and service delivery. A brief outline of the programs is presented in Table 1.

<p><i>Seniors Connecting</i></p> <p><i>Management:</i> Greenvale State School Parents and Citizens Association.</p> <p><i>Location:</i> Small rural community (population 150) approx. 300 kms west of Townsville.</p> <p><i>Objective:</i> Integration of local district seniors with those who lived in the town in order to establish a community network of seniors. To target mature aged persons 55 years and over and, in particular, socially isolated mature-aged graziers.</p> <p><i>Model:</i> Focus on positive ageing activities. Regular fitness program including exercises, a swim and an arts program. Focused on building individual and community capacity by providing transportation, upskilling and self-governance for older people.</p>
<p><i>Connecting Points – Connecting People</i></p> <p><i>Management:</i> Hervey Bay City Council.</p> <p><i>Location:</i> Hervey Bay, a popular Queensland coastal retirement destination.</p> <p><i>Aim:</i> To develop a collaborative partnership approach with key agencies and with socially isolated people. To identify available resources and services and strengthen the direct access of socially isolated people to existing services and activities.</p> <p><i>Model:</i> Principles underlying this project included inclusion, participation, involvement, independence, acceptance of responsibility for oneself, and empowerment. Community forums were conducted, development of an action plan and resource kit and the implementation of a ‘buddy’ system.</p>
<p><i>Culturally Appropriate Volunteer Services (CAVS)</i></p> <p><i>Management:</i> Multicultural Development Association.</p> <p><i>Location:</i> Brisbane.</p> <p><i>Aim:</i> To support agencies (both multicultural and mainstream) to develop and expand culturally appropriate volunteer services and to recruit and skill volunteers to support older socially isolated people from culturally and linguistically diverse backgrounds (CALD).</p> <p><i>Model:</i> Central point of contact to link referrals for agencies, potential volunteers, clients and carers. Developed a model of volunteer service provision, which could be transferable to other CALD communities and community organisations.</p>
<p><i>Linking Seniors Social Isolation Project</i></p> <p><i>Management:</i> Brisbane City Council.</p> <p><i>Location:</i> Brisbane North corridor.</p> <p><i>Aim:</i> to enhance the whole of community response to socially isolated older people.</p> <p><i>Model:</i> Consolidation of established community networks, increasing referral pathways and training and linking local gatekeepers (such as churches, funeral services and home services) with the existing infrastructure. A project manual was developed that concentrated on strategies to foster independence and enhance natural social networks of older people.</p>
<p><i>Steady Steps Falls Prevention Program</i></p> <p><i>Management:</i> Fitness Queensland.</p> <p><i>Location:</i> Three contrasting sites: Logan, Townsville and Toowoomba.</p> <p><i>Aim:</i> To increase regular fitness instructors’ knowledge of social isolation issues and improve their skills in mentoring, friendship development and building social connectedness</p> <p><i>Model:</i> Focused on the existing 10 week Steady Steps gentle exercise and falls prevention programs. Registered fitness instructors delivering the program received additional training.</p>

Table 1. Queensland Cross-Government Model Projects to Reduce Social Isolation

Qualitative and quantitative evaluation data were collected across all the programs to assess the impact of the interventions on social isolation and loneliness and the findings will be released later in 2008, illustrating the importance of *utilizing a scientific approach to evaluation and information sharing*. Preliminary reports of *initial feedback* suggest positive outcomes, but also many lessons. As the first government initiative of its kind in Australia, this project is expected to offer a model of collaboration which empowers local community organisations and older people to collaborate with government and other agencies in tackling the problem of social isolation and finding sustainable solutions.

2. Implementing Ageing Well at the local level. This Queensland-based research project commenced in 2006 in partnership with the Queensland Government Department of Communities and two local Councils: Gold Coast City Council and Ipswich City Council. It is funded by the Australian Research Council and the three partners. The purpose is to develop and explore a collaborative approach to enhance “ageing well” within Australian communities. Based on action research within the two local communities (Greenwood & Levin, 2007), the project recognises that a whole-of-community approach is required if older people are to age well.

The intention of this project is to develop an effective model of collaboration, whereby governments, community organisations, service providers and older people can work together to achieve healthy and positive ageing for individuals as well as broader community wellbeing outcomes. Working across two sites provides an opportunity to develop and compare local community-based strategies, and to help build a sustainable approach.

Stage 1 – Developing the model [Creation Stage].

The first stage of the project has involved identification of factors that act as either a barrier or a facilitator to developing effective collaborations aimed at ageing well. Working together collaboratively or in partnership is increasingly central to all areas of Australian social policy, and viewed as a more effective way of meeting complex policy challenges, such as those posed by an ageing population.

The model was developed initially through an extensive review of the literature, which was then explored in relation to data acquired through interviews and workshops held at both sites in the first year of the project (Warburton, Everingham, Cuthill & Bartlett, submitted). The model included six key factors:

1) *The context* - specifically, the history of the community and a culture of collaboration (e.g., Bolda, Saucier, Maddox, Wetle & Lowe, 2006). There was general agreement amongst participants that ageing is recognised as a priority issue, whilst at the same time, many pointed out that there were inconsistencies in the way ageing policies and programs are delivered. Most participants recognised the importance of collaboration, and some gave examples of targeted collaborative efforts, for example, the development of a local mobility office for older people without access to transport.

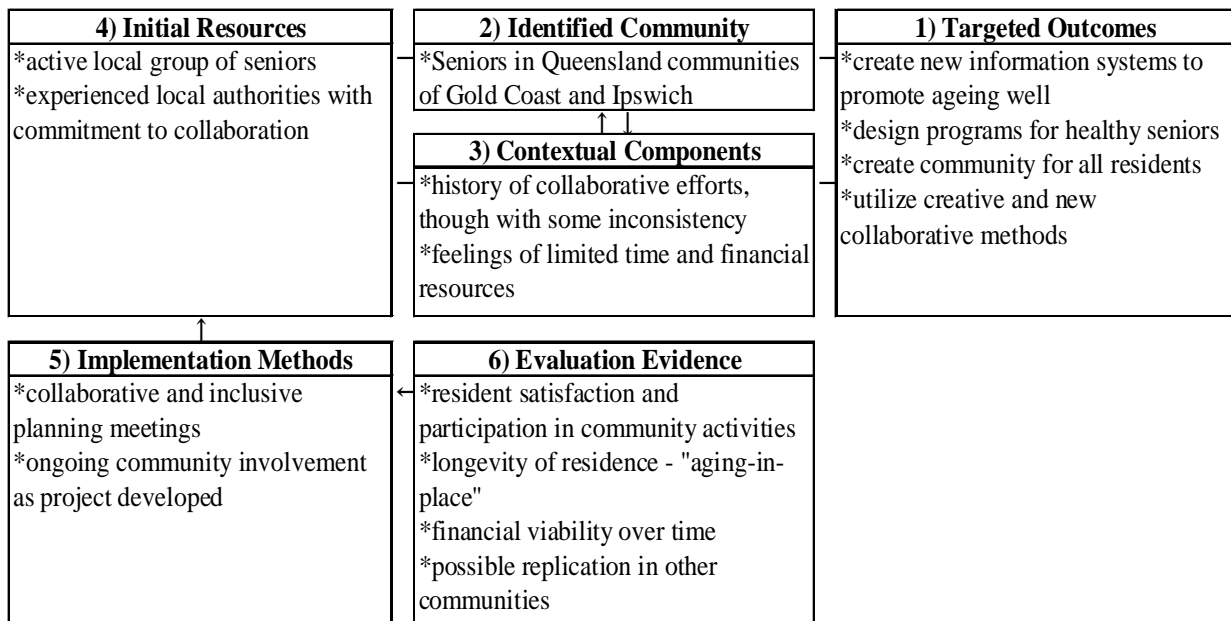
2) *Characteristics of members* – widely regarded as the primary asset of any partnership (e.g., Foster-Fishman, Berkopwitz, Lounsbury, Jacobson & Allen, 2001). Members should bring diverse skills and partnerships, and imbalances of power and capacity should be acknowledged. Most participants in the Ageing Well study described positive experiences of working with others, and suggested important characteristics included being a good listener and being client-focused.

3) *Procedures* – members need to feel ownership of the group (e.g., Dowling, Powell & Glendinning, 2004) and communication must be open (e.g., Jones & Thomas, 2007). A number of good, regular communication practices were identified by participants, with many noting the importance of agreeing practices and processes and building equitable relationships.

4) *Structures of collaboration* – the structure should be adaptable and not too bureaucratic (e.g., Kernaghan, 1993). Some participants in the Ageing Well study stressed the challenges of working with government partners who were too bureaucratic, reporting that informal arrangements can achieve good outcomes. Flexibility, it was suggested, was particularly important in the current context of ageing, which was facing dynamic and profound changes.

5) *Purpose* – partners need to develop a shared vision and agree on concrete and attainable goals (eg Dowling, Powell and Glendinning, 2004). A common vision associated with ageing well was identified by participants.

6) *Resources* – collaborations need to be supported by financial resources, as well as non-financial ones such as knowledge and time (eg Buchanan and Carnwell 2005). Resources were noted as very challenging in the ageing field, with many community participants highlighting that their resources, both time and finances, were often stretched.



In Figure 1 above, we place these important steps in the same Process Model for Empowerment that is utilized in other chapters to demonstrate the similarities in components of the process.

Stage 2: Action research with the two communities [Adaptation Stage]

The model is being used as a framework for developing the collaboration aimed at fostering ageing well in the two target communities: Gold Coast and Ipswich. The two sites were chosen for their contrasting characteristics. Both sites are cities in the populous south-east corner of Queensland, Australia. The Gold Coast is a popular retirement destination, with a growing older population, whereas Ipswich is a more traditional area characterised by a high level of ageing in place. The two sites have been incorporated into the project in order to develop a sustainable model capable of being applied across the broader Australian context.

Collaborations involving local older people, members of seniors' organisations, service providers, and local government officials have been established at both sites. Community workshops have been held at both sites, and after considerable discussion, both sites have chosen the issue of information dissemination as their target issue aimed at ensuring local people age well. At this stage, both collaborations have been meeting regularly for six months, and the research team has documented the process, as well as conducted individual and focus group interviews to explore the experiences of those involved in the collaborations [*Sustenance Stage*].

Discussion and policy implications. An important aspect of the establishment stages of both of the Queensland projects outlined is the importance of drawing on the theoretical and research evidence base about social inclusion and social exclusion. The social isolation project was informed by the literature and consultation and led to funded demonstration projects that appeared to address some of the causative factors for social isolation through collaborative efforts at a local level. The Ageing Well project was informed by the evidence on building collaboration and facilitated local communities to identify and problem-solve their own priority issues. Nevertheless, the projects also demonstrate that the goal of social inclusion of older people is not easy to achieve. It requires careful local consultation, clarity of purpose, adequate time, training and resources. The multiple stakeholders and the heterogeneous nature of the older population mean that there are many challenges to achieving inclusion, particularly in relation to building the appropriate model of collaboration and who should be included. Projects such as those discussed here are vital to document how social inclusion can be advanced at a community level and to systematically explore the challenges and strategies for overcoming them.

Policy on ageing in Australia increasingly recognises the need to address the issue of social exclusion of older people and a greater understanding is demonstrated of the multifaceted nature of the issue, including the importance of ethnicity, geographical location, socio-economic status and health. There is nevertheless, an absence of a

dedicated strategy for reducing social exclusion of older people, and this has not yet appeared as an area of focus in recent Australian government policy effort on social inclusion. While policies promoting healthy ageing have been developed, less attention has been paid to how healthy ageing can be achieved at the local level. This chapter has identified two recent Queensland initiatives that involve innovative models for translating policy into action at the local level.

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Chapter 8

Intergenerational Family Relations and Social Support in a Comparative Perspective: The OASIS Project and Care Networks in Israel

Ariela Lowenstein

This chapter examines how the CASE Model can be used to analyze the development and implementation of policies at a national level over a period of decades. This is an unusual opportunity for insight into the unfolding of a new state from its inception, that of Israel, and the intentional creation and adaptation and expansion of policies and programs focused on the area of family care-giving of elders in the socio-historical context of a particular set of cultural values. Thus, the empowerment process described in this chapter is seen more from a “top-down” perspective, originating at the national level, rather than from a more “bottom-up” perspective, based on a local program that then informs and shapes larger national policy. Interestingly, while Israel began developing services from the “top” – the institutional end of the care continuum, the starting point today is the individual and the community.

Demographic and cultural background

Demographic changes. The 2006 census showed the population of Israel to be close to seven million, of whom 80% are Jews and 20% non-Jews – Moslems, Christians and Druze. The aged (65+) comprise about 10% of the population (numbering close to 700,000) (Central Bureau of Statistics, 2006). Differences exist between the Jewish and non-Jewish aged populations. Within the Jewish population, the percentage of the aged has almost tripled since the creation of the State of Israel in 1948 and is now close to 12%. Among the non-Jews, however, the elderly comprise only 4.1%, due to higher fertility rates (Brosdsky, Shnor & Be’er, 2006).

The aging of Israeli society is related to increased life expectancy, which is currently 79.8 years for men and 82.3 for women, and to the composition and the aging of cohorts from previous immigration waves. The immigration waves, especially during the decade of the 1990s from the former Soviet Union, have brought a high percentage of aged people – around 13%. Close to 17% of the Jewish elderly are disabled in activities of daily living (ADL). The percentage is higher among new immigrants (close to 19%) and even higher among non-Jews, nearing 23%. Regarding family status and living arrangements, almost twice as many elderly men (81%) than women (44%) are married. Among immigrants, over three times as many women (52.2%) than men (14.8%) are widowed. However, the majority of the aged live with a spouse, and the percentage of those living alone is 28%. Among the population of aged new immigrants, 70% live with their children due to housing and financial difficulties especially during the five to seven years after immigration (Katz & Lowenstein, 1999; Lowenstein & Katz, 2005).

In Israel, there is a strong emphasis on the role of the family in caring for its elderly members. This is reflected, for example, in the low rate of institutionalization - 4.4%. Most of the aged have an informal support network, with spouses as the main source, followed by children (Habib & Tamir, 1994). For the future, we can anticipate

that changes in the composition of the aged population will result in continuing growth of the “high-risk” groups: the 75+ elderly, women, those of Eastern origin, and new immigrants. These projections mean that needs for long-term care services will rise and that more resources will have to be allocated to develop community services and to support family caregivers.

Cultural values changes. A country’s social system and professional practice are affected by the particular society in which they operate and reflect related historical, religious, and cultural forces. Political structure and population heterogeneity also shape the form of service delivery. Thus, any analysis of the social service system must be based on the principles and values that were used to guide its development. In the case of Israel, which is a pluralistic, democratic society, these are mainly threefold:

First, Jewish values, religious laws, traditions, and ethics place great emphasis on social and familial responsibility and the commitment of Israeli society towards the aged stems from such Judaic sources regarding filial responsibility and filial piety (Lowenstein, 1998). Most relevant is the commandment “Honor thy father and thy mother” which is the only one of the Ten Commandments that contains a reward for its fulfillment. Thus, contrary to most Western countries, in which care and support for the elderly is voluntary, there are laws which outline the obligations of adult children to provide care for family members - the “Alimony Law-1958”. This law specifies the obligation of adult children to provide economic support for parents and, if necessary, for grandparents. Circumstances granting dispensation from care-giving are also clearly specified (Abramowitz, 1992). In addition, the commitment of Israeli society to the aged stems from the Judaic sources on filial responsibility (Lowenstein, 1991). Second, the principle of unlimited immigration for all Jews is no doubt a central determinant of Israel’s existence (Bergman & Lowenstein, 1988). Third, the principle of cultural and ethnic pluralism stemming from the ongoing waves of immigration creates a diversity of cultural, ethnic, and religious groups (Lowenstein & Bergman, 1988). The cultural component, with its varying interpretations of the role of the aged, the family, and the formal network, is thus an important factor in service delivery (Litwin, 1994). This diversity of the population and the aged among them affect needs, expectations, and patterns of support for the elderly. Since the couple and family orientation of social life and the value attached to sociability make the family a main reference point in the aging process, aging needs are best understood within the context of the family (Lowenstein & Katz, 2002).

The CASE Model in Israel. As noted earlier, the following discussion of how the CASE Model can be used to understand social policies and empowerment of elders in Israel is different from previous chapters in that the level of analysis is at the state level and over a longer period of time, where we can view the long term development and implementation of social policies related to care-giving that were based on, from the start, the intentional inclusion of older persons in the design of policies and programs. This chapter is also in the context of a conceptual model, similar to the CASE Model, which has been used to study intergenerational relationships in several countries. Thus, the basics of that study will be presented and then focus will shift to the situation of family

care-giving policies in Israel.

The OASIS study* – “Old Age and Autonomy: The Role of Service Systems and Intergenerational Solidarity” - covered a diverse range of welfare regimes and familial cultures in five different countries: Germany, Norway, Spain, England and Israel. The research focused on three prominent dimensions that influence healthy aging and coping of family caregivers: mixes of informal (family) and formal (services) care, family norms and transfers and coping with beginning dependency.

The study adopted a cross-national, cross-generational perspective using a multi-method design. It combined quantitative and qualitative methods. The cross-sectional survey collected information from 1,200 respondents (800 aged 25-74 and 400 aged 75+) in larger urban areas in each country (totaling 6,000). These data allowed the identification of elders at risk of becoming dependent, and selected a sample of dyads of elders and their “primary adult child care person” in each country. Data from the dyads were collected through in-depth interviews. The study allowed comparing and testing the impact of intergenerational solidarity on the one hand, versus intergenerational ambivalence on the other, on family bonds and quality of life of elders and the family caregivers (See for example final report: Lowenstein & Ogg, 2003; Lowenstein, 2007).

The study had three main objectives: (1) to provide a knowledge base of how support autonomy in old age to enhance quality of life of elders and their family caregivers. (2) To analyze the interacting roles of families, service systems and individual coping on quality of life in old age. (3) To learn how different family cultures and different welfare systems promote quality of life and delay dependency in old age (Lowenstein & Ogg, 2003). The study is based on the conceptual model illustrated in Diagram 1. As can be seen from the model, family norms and preferences, service use and family solidarity and ambivalence are the intervening variables. They are linked to the three clusters of the independent variables (individual, familial and societal levels) and they impact quality of life of elders and their caregivers. In the Diagram, one can also see the similarity of the model utilized in the OASIS study with the CASE Model.

Fundamental factors for empowerment. As outlined in Chapter 3, we can see the conceptual model used in the OASIS study delineates the *Identified Community*, which, in this case, are family caregivers. The *Targeted Outcomes* are increased quality of life for both the older person *and* the caregiver, including outcomes of maintaining autonomy and potentially increasing life satisfaction and emotional (affect) balance. The *Contextual Factors*, as outlined in the model include family norms, family transfers of goods and support and coping skills, as well as the community-level resources of access to various kinds of services. There are also *Initial Resources* specified at the *Personal, Family/Community and Systemic levels*.

* The OASIS study was supported by the European Commission, Quality of Life and Management of Living Resources Programme (1998-2002), Fifth Framework Programme, Contract number: QLK6-CT1999-02182

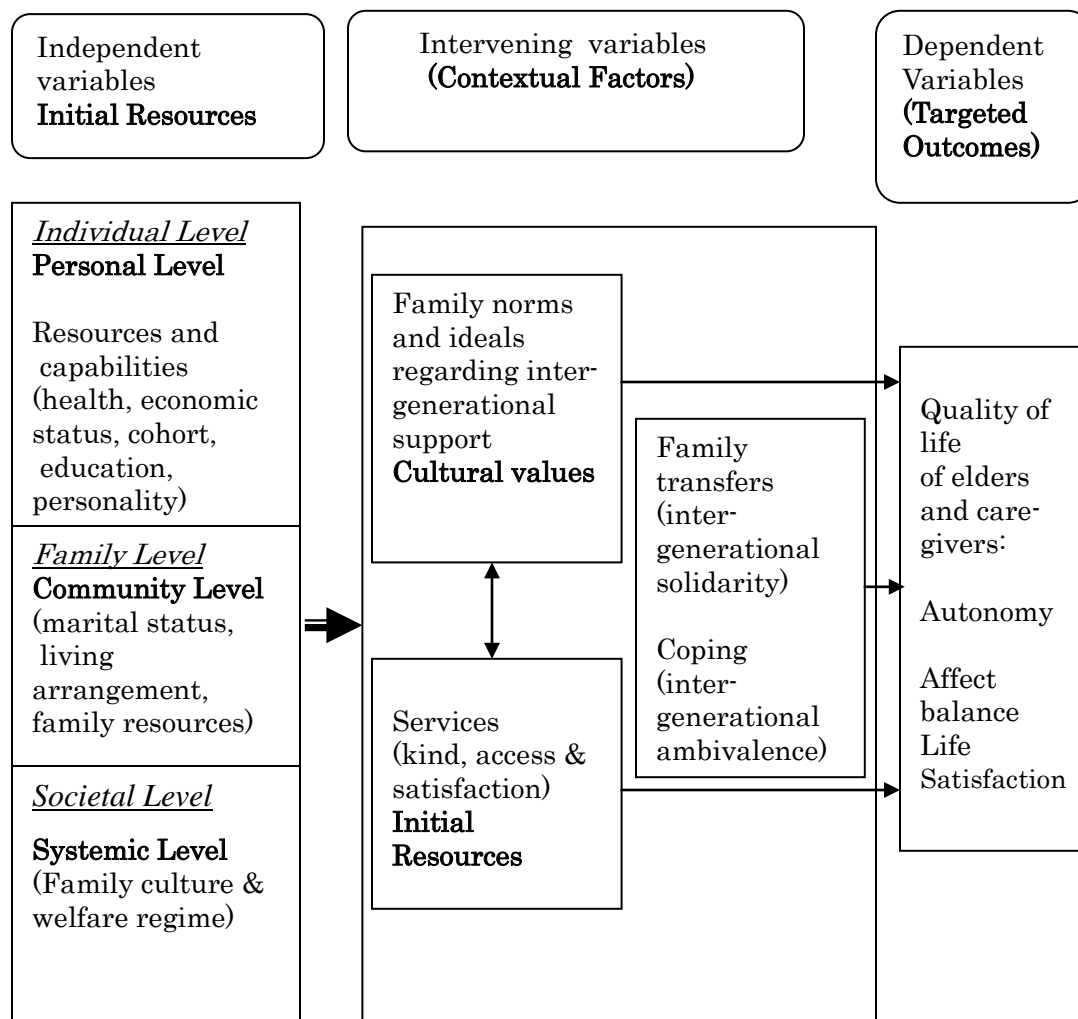


Figure 1. The conceptual model of the OASIS Study

The discussion will turn now to the specific situation of family care within Israeli society. Israel is an urbanized welfare state that relies on a mixture of governmental and market forces that shape its welfare policies. The basic goals of policies for service delivery to the aged in Israel have been intentionally focused on independence and empowerment and are twofold: (1) to enable them to maintain maximum self-sufficiency and continue to live in the community as long as possible; and (2) to allow them to participate actively in society, while considering their diversity and heterogeneity. Even long-term care of the frail elderly focuses on continuity in lifestyle, shifting away from early institutionalization.

Four major sectors are involved in service provision in Israel, reflecting the growing understanding that *Systemic level* action must occur for empowerment of individuals and communities. Thus, currently, government agencies, trade unions, voluntary organizations, and the private sector are all involved in the area of services.

The three major governmental providers are the Ministry of Social Welfare, the Ministry of Health, and the National Insurance Institute. Minor service delivery roles are played by the Ministry of Absorption, which provides services for a defined period to aged immigrants; the Ministry of Housing, which is involved in special housing for the aged; and the Ministry of Education, which offers adult education. The National Insurance Institute (Israel's social security system) has become the core policy instrument for social protection. Currently, the system includes the following programs for the aged: old age and survivors insurance, disability insurance, and the Long-Term Care Insurance Law. Old age and survivors insurance is universal in coverage and its benefits are not income-tested. Pre-retirement incomes are not taken into account in calculating the pension amounts.

Historically and currently, social and welfare services for the elderly were and are not based on specific categorical legislation. They are covered through the General Welfare Services Law of 1958, under which each local authority is charged with establishing a local welfare office to provide services to the needy, including the aged. Thus, though the initial impetus came from the "top-down," the local welfare office is the major provider of services for the elderly in the community. It was found that in many local welfare offices the aged compose close to 40% of the client population (Litwin, 1994). The welfare offices provide services such as household maintenance and home management services after a needs assessment by social workers. It also includes home-delivered meals-on-wheels. Thus, *Community Level* empowerment is supported by the higher *Systemic Level* resources allocated to the local level.

The Ministry of Social Welfare, through its Services for the Aged Department, establishes national policy principles, sets eligibility guidelines and national priorities for service development, provides professional supervision and budgetary participation, and conducts surveillance and supervision of independent and frail elderly in residential settings based on the Law for Supervision of Homes (1965) (Lowenstein, 1994, 1998).

The Ministry of Health, through its Department of Geriatric Medicine, is in charge of public health services in the community and family health clinics, mental health clinics, institutional placement, surveillance and supervision of nursing and mentally frail elderly. Primary and acute health care are provided by five different Sick Funds (HMO's), through primary health clinics that are located in every neighborhood. Home-nursing programs include a service of professional nursing visits to homebound or bed-bound elderly. The visiting nurses help the sick elderly by monitoring their health following surgery, and performing routine nursing activities.

Initially, during what might be considered the *Creation Stage* of policy development, there was no official structure for coordinating the activities of the different Ministries. Consequently, there was no national-level planning body to evaluate needs and services or to prepare blueprints for future service developments. This was remedied in 1969 through the creation of ESHEL, the Association for Planning and Development of Services for the Aged in Israel. ESHEL represents a partnership between the Israeli government (three Ministries – Health, Finance and Social Welfare) and the American

Joint Distribution Committee (JDC). ESHEL was charged with the promotion of service planning, on a national level, and with the encouragement of partnerships between the public and voluntary sectors. Other tasks that ESHEL undertook were in the areas of manpower development, facilitating and operation of services, advocacy, and quality assurance. A series of 5-year plans were introduced which resulted in the rapid development of new services to the elderly. The unique form of partnership of ESHEL, involving both government and voluntary organizations, has filtered down to the level of local and regional associations for the aged (Guttmann & Lowenstein, 1991, 1993). This is a wonderful illustration of the benefits that can be reaped when the activities of the *Adaptation, Sustenance* and *Expansion Stages* are performed with intentionality and conscientiousness, keeping the *Targeted Outcomes* in mind. Working with collaborative teams, monitoring progress, and including many levels of policy and program implementation, have all allowed Israel to continue to shape social policies that appropriately meet the needs of its citizens over time.

During the last election (about two and a half years ago) a major break through has occurred when the Senior Citizens party has gained 7 seats in the Parliament and consequently the Ministry of the Senior Citizens was established. It is a focal point for developing programs for the aged and fighting for their rights. This will support empowerment at the *Personal* and *Community Levels*, as well as at the *Systemic Level*, since there is representation of elders and their concerns at the national governmental level. As for non-governmental participation, the General Federation of Trade Unions has played an important role in both direct and indirect service provision. It operates several major pension funds, the General Sick Fund, a network of social clubs that are neighborhood based, sheltered housing, and residential facilities. The voluntary sector operates direct social services for their aged members, through immigrants associations (Landsmanschaften) and other agencies, providing mainly social clubs and homes for the aged. While, the private sector used to be involved mainly in the provision of institutional care, recently, this sector has seen a proliferation of sheltered care facilities, life-saving communities, and home care services. The *establishment of such new programs and services (Creation and Adaptation stages)* illustrate again the activities that continue to emerge throughout the different stages of the CASE Model.

Legislation and its Impact on the Care of the Aged

In recent years, there has been a major conceptual shift in the grouping of services. A basic policy goal has been to move away from the use of residential facilities towards the development of a diversified community-based service network (Lowenstein & Yakovitz, 1995). The point of departure now is the home of the older person, followed by the community and then by residential services. Community-based services are geared to assist frail and homebound elderly to remain in their homes as long as feasible. To this end, the community Long-Term Care Insurance Law was enacted in 1980 and implemented in 1988, under the auspices of the National Insurance Institute. More recently, in 1995, the National Health Insurance Law was enacted to provide health insurance coverage for all Israeli residents with no discrimination for age or disability. This law instituted a universal program of health coverage that guarantees hospitalization

and delivers a defined basket of community-based medical services through the voluntary Sick Funds.

The Community Long-Term Care Insurance Law. The Long-Term Care Insurance Law is one of the most important and innovative pieces of legislation for elders. The Law presents a unique model for service provision to the elderly in the community, with case management playing a central role. An important element in the implementation of the law is the integration of all stage agencies operating in the sphere of long-term care for the aged. This is another example of the *Systemic Level* of empowerment.

The law is characterized by the following aspects: First, it is a social insurance law that recognizes the right of the aged to receive *personal level services* in the community according to assessed needs. Second, it has a *community level* orientation intended to assist the elderly who live in their homes, so as to delay or even avoid institutionalization. Third, the benefits are for the very dependent elderly in order to assist family caregivers and ease their burden. The family, however, does not receive payment. Fourth, the priority for service provision is in the form of in-kind services that are universal, egalitarian, and implemented according to uniform rules. Fifth, it is geared to *using the existing infrastructure and integrating it with additional services*, thus incorporating the *mutual responsibility* of the government and the Sick Funds. Sixth, it transfers service provision to non-governmental organizations, both non-profit and commercial, thereby allowing entry of the private sector into home-based services. Seventh, it sets standards and norms that are accepted by the professional community, thus strengthening the interdisciplinary treatment approach. Eighth, it provides *more efficient service management* by the local service systems. [The primary goal of the Law is to improve the quality of life of the elderly and their families who need support by providing more service choices. The main care provided by the law includes personal care and homemaking services, day care center services, emergency buttons, and absorbent undergarments for the incontinent. The majority of recipients use personal home care services (an average of 10 hours per week, 15 to 18 for the mentally infirm) (Katan & Lowenstein, 1999).]

The extensive contribution of the Long-Term Care Insurance Law is reflected in its expansion of the scope of the needy population from a projected 10,000 in 1980 to close to 90,000 in 1999 (Katan & Lowenstein, 1999) and today to 130,000. It also created the needed legal infrastructure for developing and implementing case management projects through the work of the *representative and interdisciplinary local teams*.

The overall responsibility for the Law's operation is vested in the National Insurance Institute, which shares administrative and service responsibilities with local interdisciplinary professional committees. This kind of *Systemic Level* of collaboration is the work that can sustain empowerment efforts over the course of time and across levels of program and policy development and implementation.

In contrast to the formal care systems, in informal care relations, the variables of gender, relationship of caregiver to care recipient, types of residence, e.g., co-residence,

race and ethnicity and the care-giving context should be considered. Accordingly, we have to assess the heterogeneity and variability of families within different societal and group structures when providing care to family members and then study the outcomes of that care. In Israel, several studies had demonstrated the above issues by examining coping with caregivers' burden caring for Alzheimer's patients versus chronic diseases such as cancer (Lowenstein, 1999; Lowenstein & Gilbar, 2000) as well as comparing different care-giving patterns within the Jewish and Arab sectors of the population (Lowenstein, 1999; Lowenstein & Katz, 2000; Katz & Lowenstein, 1999). These studies show the importance of cultural context and ethnicity on coping patterns as well as the relation of the caregiver – spouse versus child.

The massive assistance of the formal system raises the issue of the balance between formal and informal support. The Long-Term Care Insurance Law, for example, reflects the changing social and political conceptions regarding the division of responsibility between the family and the State for care of the elderly, and the sharing of that responsibility. Many feared that the activation of the Long-Term Care Insurance Law might “remove” families from providing care to their disabled members. However, several studies had found the following: First, the services provided by the Law helped to alleviate instrumental and personal care burden of families. Second, the services provided did not cause changes in the amount of help provided by family members. Third, the Law helped many families to establish closer contacts with local welfare offices and social workers. This provided them with the opportunity to obtain information and counseling. Fourth, the families continued to provide more emotional assistance to their elderly parents (Beitz-Morai & Morgenstin, 1992; Brodsky, Naon & King, 1993; Katan & Lowenstein, 1999). Thus, it seems that the balance between formal and informal support can be properly maintained with intentional and cooperative efforts between *personal, community, and systemic levels*.

In summary, Israel has maintained a commitment to the welfare of its aged citizens, which is demonstrated by an array of programs and services and the operation of the different sectors – government, public and private. The system is unique in its philosophy of community care and community responsibility for dependent elderly. This trend is especially expressed by the Long-Term Care Insurance Law. Whereas Israel started developing services from the institutional end of the care continuum, the point of departure today is the home and the community of the older person.

For some time, we were ‘captives’ of the myth that the family abandons its members, which was proven otherwise. Then we were ‘captives’ of the myth that all families caring for frail elderly members are overburdened, depressed, and unable to function. Again we were proven wrong, as it is critical not to assume that strain and burden are the essential, or sole, outcomes of care-giving and to realize that reward and meaning play important roles as well. Such myths stem from the stereotyped images of aging and ageism that dominate the modern technological society. This brings us to the third goal of the paper: to identify policy-related issues and discuss some future developments and implications for macro-level systems.

Implications and Policy Issues

The pace of social change in the 20th century has been phenomenal. Perhaps it is the science fiction writers of today who would make the better attempt at predicting the future for older people. However, if history tells us anything, the quality of life is unlikely to improve unless, as Maddox (1985) said, ‘the revolution of possibilities and hope’ will take place.

The institution of marriage and the family will continue to be popular along with divorce and remarriage. These social trends will have important implications for aging families. However, divorce might restrict access to grandchildren by grandparents, leading to further developments in intergenerational ties and care-giving patterns and styles. In the new millennium, a given child might have any number of parents, grandparents, and great- or even great-great grandparents. Technological developments should thus be sought to assist health care and welfare organizations to deliver services more efficiently and to foster independence among the frail elderly. As new generations of elderly will be better educated and will have higher incomes, and as most families will be composed of four and five generations, care demands in the 21st century will be different. On one hand, there will be more elderly and very old people – the ‘two-generation geriatric family’ – who might need care and assistance. On the other hand, these elderly will demand better care and will be able to purchase many in-home and community services.

The rising levels of affluence and the introduction of state welfare provisions will allow the operation of choice in family relationships. Thus, sentiment rather than obligation might increasingly govern ties between elderly parents and younger generations. Not many role models of care-giving have existed until now, and there is a need to develop new models. In addition, as care-giving has evolved for some into ‘care-giving careers’ (Aneshensel, Pearlin, Mullan, Zarit & Whitlach, 1995), albeit sometimes unexpected, more educational programs and preparation to fulfill such roles are needed. In parallel, we need better socialization into grandparenthood because of the great diversity associated with that role (Strom & Strom, 1996). Education will increasingly become a lifelong process and we need to educate, in addition to professionals, also family members, and caregivers, and the general public to change their attitudes towards aging.

It is today well established that in modern aging societies, the quality of life in old age rests on the relationship between intergenerational family solidarity and the responses of the formal service systems. In addition, data show that as a result of the increased availability and social acceptability of public services, there is more willingness by the elderly and their families to use public services when dependency starts (Daatland, 1997). Thus the care of the aged is a public/private mix, with the exact amount of this mix varying according to country. The specific mix is related to two factors: (a) the family culture that guides the level of readiness to use public services; and (b) the availability, accessibility, quality and cost of those services. The data from the Oasis study shed light on some of the above issues.

One of the basic policy debates in this regard is whether formal services shall substitute informal family care or complement it. The substitution argument rests on the idea where families and services have similar tasks, and that services will crowd out and make family care unnecessary. Complementary theory has two versions: (a) family specialization theory, which assumes that the two partners take upon themselves different roles and tasks; and (b) family support theory, which assumes that services support family willingness and ability to provide care (Lingsom, 1997). However, after evaluation of the families' ability to provide care, the question is how services should respond when families refuse to fulfill their obligation to provide such care. In parallel to these two basic approaches are the principle of willingness and the principle of compensation. This means that services have to help the family to define its willingness to participate in caregiving. Also, the second issue is how families should be compensated for the care they provide.

Due to the wider range of functions that the family now fulfills, governmental concern for the well being of the family is also more evident. As early as 1982, the following editorial appeared in *New Society* in the UK: 'As a general election approaches, the family is once again unwrapped, patched up and worshipped to assure the electorate that politicians are in favor of all things good' (14 October, 1982).

Several models are followed in providing services and support for families with elderly members. The one emphasizing the substitution approach is the Scandinavian social democratic model, which favors more direct governmental involvement, supplying rather generous services that are predominantly public. Other welfare regimes like the conservative model of continental Europe lean heavily on insurance-based arrangements, whereas the liberal regime of the US is characterized by a limited residual state responsibility. These two other models are more inclined to private solutions through non-profit or private (for profit) companies or heavier reliance on the family. Those countries and welfare systems that have adopted the substitution model, like the Scandinavian countries, the Netherlands or the US, provide a wide range of in-home services and base their social policies on individual rights without imposing any legal obligations on adult children towards older parents.

On the other hand, countries with a more 'traditional-familial' perspective and a family-based social policy hold the complementary approach whereby the responsibility is shared, and services are developed to assist families in care provision. In the OASIS study it was found that both the younger and older generation preferred complementarity with expansion of public services (Daatland & Lowenstein, 2005).

In light of rising costs of welfare and health services, it seems that a balance should be found between these conflicting perspectives. In a study in Israel, where children are legally obliged to financially support their parents, on the impact of the Long-Term Care Insurance Law on care relations, data have shown that the involvement and care of the families was not reduced, but that the nature of care might have changed in some cases towards providing more emotional support (Katan & Lowenstein, 1999).

Thus, it seems that more emphasis should be put on services that strengthen and complement family care and increase 'cooperation' between care-giving families and the available service systems. Furthermore, we must find ways to assess what is considered good quality care, both from the familial perspective and that of the formal service systems, as well as to study the relationships between family networks and the above policy-related outcomes.

Like service systems, the family works best when there are open boundaries, open communication and openly discussed problems and conflicts within an open system. The next millennium confronts us with many challenges and opportunities regarding the aging societies and ageing families. As David Ben Gurion, the first Israeli Prime Minister once said: 'he who does not believe in miracles in the Middle East is not a realist.' So must we believe in miracles but try to be realistic and work towards improving the quality of life of the older population and older families and enhancing intergenerational family relations.

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Chapter 9

Counterpoint: Empowerment of Whom? An Emergent Debate in Sweden

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(with Mary E. McCall)

This chapter provides a counterpoint to the previous chapters in that we discuss the implications of empowering older persons in their care for those who are providing the care. It presents the results of a study aimed at uncovering the perceptions of care providers in the context of a growing social and policy emphasis on empowering the care user to state and advocate for their needs and desires. Thus, the analysis of the CASE Model is expanded to include those who are impacted beyond the individual older persons themselves, to those who are in a relationship that will also be affected by the empowerment process. This analysis comes from Sweden, and given the history of social welfare in that country, as described in the Chapter 5, it is helpful to gain insight into the complementary roles of care providers in the service of helping elders maintain their independence as long as possible. This chapter raises some important issues for consideration and reinforces one of the bases of the CASE Model that inclusion of all members of a community, or a relationship such as a care-giving one, is crucial. Empowerment cannot be a zero-sum game – it is not just the empowerment of one or a group of persons, at the expense of others. Thus, the discussion in this chapter reminds us of the care needed when embarking on an empowerment process.

Background of debate

As noted in the previous chapter on Sweden, the Swedish government has invested a large amount of capital over the last many years in the improvement of eldercare. This is a national investment and it aims to support research and development in the eldercare field. One major goal is to increase the competence of the workforce. The idea is that the advanced competence and skills of the workforce in the care service market will improve the situation for the elderly users, their families, and people working in the eldercare market. Another central aim is to take advantage of the new theoretical models and knowledge that emerge from research and use them to implement new organizational practices.

As people around the world continue to age, there is a growing need for different kinds of services including, for example, complex health care services at home. This requires new competencies from eldercare providers because people are not only living longer; they are also demanding a higher level of life satisfaction, and Quality of Life (QoL) has become a popular term for measuring the effectiveness of services or programs. For many elderly, this means having the opportunity to stay in their own home for as long as possible and to live an active life under their own individual set of circumstances. But there is also a growing group of elderly that are frail and unhealthy and in need of more intense assistance to manage their daily life. It is important that the nurse assistants and the paramedics possess appropriate medical qualifications but it is also essential to combine this with social and cultural competence. By gaining awareness of and developing the skills to accomplish these goals, it is possible to work at a higher skill

level which will increase both the quality of life for the elderly and the work situation of the workforce. So, there has been a transition from a focus on the more material or technical skills and resources in eldercare to a focus on “new” skills that are more social and emotional. Both at the individual level and the organizational level there is now a new focus on commitment, feelings and other features related to the individuals involved in the care relationship. So, it is critical to begin to adopt a holistic perspective on eldercare that includes a broader view with both the elderly users’ and the care workers’ experiences included.

As we mentioned, one of the aims of this large investment in the eldercare field is to increase the competence of workers to meet the needs, the demands and the requests from a new generation of elderly people. In this field there are two kinds of competence discussed: care competence and service competence, including the competence to develop the needed services. To manage the daily care of some elders, it is necessary to have the competence to provide such care with high quality. This competence includes the more formal qualifications like knowledge about different diseases, but also how to treat the social and emotional needs of the family of the elderly. Service competence is focused on developing new methods and models to expand people’s skills, working continuously to develop and increase of the quality of care services. This cannot be done without involving the older person and their spouse/family. The elderly person must have a clear influence on the development and improvement of their own care (Anbäcken, 2004). *“The objective of elderly policy is for elderly people to lead active lives and have influence on society and their own everyday lives; for them to be able to grow old in security and retain their independence; and for them to be treated with respect and have access to good health and social care services”* (Ministry of Health & Social Affairs, 2007). Thus, in concert with the development of the technical care and service skills of the staff, the concept of “user influence” has become central in the Swedish discussion of improving elder care.

What is user influence? Empowerment by another name?

“User influence” is something that many organizations in the social services emphasize as important to strive to attain, but it is also a complicated concept that provokes many questions. Within the Local Elder Council there are regulations about what should be incumbent on the municipality to offer to care users and what service guarantees they can expect. In the Act of Social Services it declares that the efforts from the care provider are going to be shaped after consultation with the elderly user and, if required, also with other public institutions. In 1998 the government proposed a national plan of action and national goals for the elderly, by stating that the elderly were going to have the possibility to have an active life and have influence over their everyday life. Several municipal goals and policy papers have been developed to strengthen and concretize the national terms of reference. This is an excellent example of the consistency of empowerment across *personal, community, and systemic levels*. Those aims include, among other things, the elderly user’s experience of participation and access to information. User influence exists on different levels, according to Moody’s model [see Chapter 1] and can vary from being a part of one’s own framing of their total care to only

receiving information. User influence does not center on a collective influence; it is about the individual potential to influence his or her personal experience of care (Anbäcken, 1985).

In the current situation around eldercare in Sweden it's popular to see the user as a customer. The opportunity to make one's voice heard can increase in such a context, though it puts a higher pressure on the care providers to deliver what the user wants in a way that may be assessed more qualitatively than quantitatively (i.e., the number of care hours given). There has been a shift in power since the market for care providers has expanded and today there are more private care organizations that compete with the municipal care providers. There has been a change in perspective to where the care providers have to answer to the user's desires. The elderly users have the option to choose which care provider is going to carry out the desired service and care. This also means that the users have the opportunity to reject a certain care provider. Consequently, this shift in power affects the traditional relationship between care provider and care user, and understanding the impact is important if we are to design and implement policies at national and/or municipal levels that best meet the needs of the individual, as well as the organization and worker.

User influence can be seen as operating on different levels including the national level, the local or municipal level, the organizational or institutional level, and the individual everyday level (in interactions between care worker and user) [See Figure 1]. For example, at the *Personal, Individual level* we can see that empowerment might appear as increased personal and professional competence of the staff, as well as clarification of care planning procedures that each person can follow. These *Targeted Outcomes* can be achieved through the *Implementation Methods* of appropriate introduction and orientation processes, dialogue between staff and between staff and the older person and their family. At the *Community level*, or Organizational level, the outcomes might be the specification by the municipality of tasks to be performed and assignments given to various staff. This is accomplished through communication and collaboration between the User Council and the local municipal authorities, as well as through family meetings with staff and care provider agencies. At the *Systemic level*, laws and outcomes of local and national elections can be achieved through the mechanisms of active Pensioner organizations and Elderly Councils.

From the perspective of the CASE Model, with the *Identified Community* as the care providers, and the *Targeted Outcome* of increased quality of care as well as increased job satisfaction for providers, an initial step would be investigate how the care providers feel about the movement towards empowerment of the user. This was the exact focus of the study described here, entitled "Managing Everyday Life." While the focus of the study initially emphasized the personal perspective of the care provider and the social/community perspective of the organization, there are valuable lessons to be drawn from the results.

The *Managing Daily Life* study (Dannapfel, 2006), was made possible through the investment in research concerning elder care, and focused on the organizational and

everyday personal levels of care. The center of attention was what happens in the interaction between the care worker and the user in everyday life. Another focal point was the institutional level. The purpose was to explore care workers' orientation around the future concerning working under conditions with more user influence. Thus, the *Targeted Outcomes* in this case were 1) to improve relationships between care provider and care user, and 2) to understand more fully what issues and challenges were occurring at the organizational/institutional level that would also impact the care relationship. The *Identified Community* was a sample of care providers.

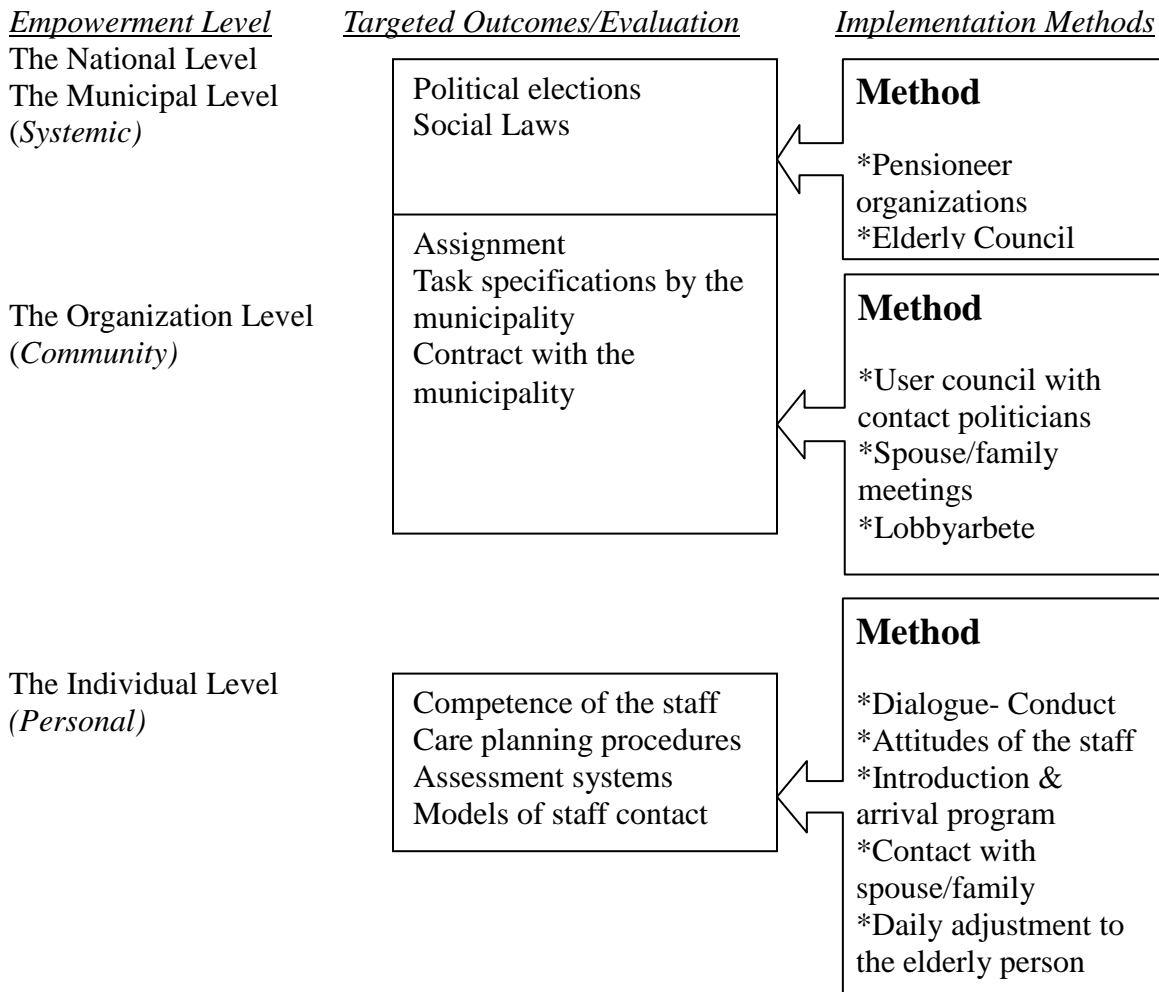


Figure 1. Levels of influence in eldercare.

One of the *Contextual Components* in this study was realizing that the workforce is part of the competitive strength of an organization and thereby it is important to examine and improve the situation for the workforce and not only the elderly users. One intention for the use of the results from the study *Managing Daily Life* is to use the dynamics of the social shaping, the thoughts, and the “apprehended experiences” related to the job to create a greater understanding of the complexity of care for the elderly.

Elderly users and care workers are not antagonists but rather two sides of a coin. In recent history, the spotlight has been on the elderly users and the care workers' situation has been put aside. The purpose of the study was to give greater voice to the workers in order to improve the overall situation.

The aim of the study was to investigate how care workers in a private sheltered house describe and feel about user influence and the care profession in the future. The study took a set of social, relational and emotional points of departure and dealt with questions like: What do the care workers experience concerning their influence over their work situation? Is there any resistance to working under more user influence? Do the care workers see this as an opportunity to develop their competence, both formally and informally? Personal growth is an essential dimension in feeling content with one's work and this will give return to the organization in many different ways. Having a workforce feel that they are appreciated for the work they perform may make them more likely to get engaged in their work. The care is not only about the formal care; the emotional or subjective state involving what the care worker feels, wants, and thinks are also important factors to take into consideration when developing greater competence and skills in elderly care. One intention is to emphasize a more contextualized approach taking into consideration the relations between the organization and the care workers and the relation linking elderly users and the care workers together. The study also demonstrates that emotions are an important aspect to understand how this professional group acts and also what their motives are for acting in a certain manner. The conclusions of the study can be used as a benchmark for broader analytic generalizations of care workers conditions and practice.

Procedure. *Managing Everyday Life* was a qualitative study that used focus groups as the data collection method. The study was located in an eldercare unit financed by the municipality but operated by a private care-giving organization in a mid-sized city in Sweden. Focus groups are a research method where data are collected through group interaction where participants discuss one topic chosen by the researcher for a limited time. The focus group for this study involved care workers, both day and evening teams. All together there were twelve participants and they were interviewed two times each. The discussion had the starting point in three attitude components (also see Wikstrom, 2004):

To think is to be able to interpret or to reflect on. Concerning the ideas around a special intention, situation or individual: How does the care worker picture the idea of an increasing level of user influence?

To feel is to desire. Concerning which feelings we have towards the recipient: Which emotions get aroused when it comes to the idea greater user influence?

To act is to risk. Concerning how willing we are to act in a certain manner in an interaction with a certain person or situation: How prepared is the care worker to work in a way that strengthens user influence?

After *analyzing the empirical data*, four problem areas were identified where the care workers' thoughts and feelings around user influence were especially substantial. Generally the results concerned the care workers' emotions around having power and

control over their work situation. In the study it emerged that the notion of “user influence” involves dynamic relationships characterized by tension. These were categorized as:

- 1) Power and control over everyday life: the tensions between care workers, elderly users and the organization in terms of daily tasks to be accomplished.
- 2) Flexibility: the tension between flexibility and routine in tasks.
- 3) Corporate care workers and elderly users: conflicting goals and methods.
- 4) Competence: the tension between formal and informal competence.

The first tension between *power and control* concerns the care workers’ fears that their influence will decrease when working under conditions of greater user influence. The care workers assume that there will be a shift in power though they now experience being the ones possessing the power. This belief reveals a feeling of losing control over their work situation when it comes to resources and planning. They also feel concern that user influence will demand a closer relationship with the elderly users and thus diminish their professional status and image. Care work is surrounded by explicit and implicit rules, norms and behavioral codes. Today you still can see a focus on the more material side of the work. The emotional aspects of their work do not have the same value yet. One aspect of this is the care workers’ fear to be exposed to social sanctions from co-workers or the elderly users’ families. This could be the case if the care worker, for example, chooses to take time to comfort the elderly instead of doing the cleaning, which was on their schedule. This choice of focus based on an emotional perspective may seem like invisible work to other co-workers. For the elderly person, however, it could make a major difference in their day. The care workers are afraid that this will lead to social sanctions from the co-workers when cleaning is left for the next care-worker that visits the elderly. In this situation it is obvious that what the elderly needs is consolation rather than cleaning. Thus, circumstances that at first sight seem to be uncomplicated are loaded with complexity, which can be an obstacle with regard to the work and care relationship under empowering user-controlled conditions.

A care relationship involves relative power, where the provider may be more dominant than the receiver of the care (see Szebehely, 1995 & Wærness, 1983). Providing care often implies that the care provider is the one that assesses what the receiver of the care is in need of. With greater user empowerment and influence there will be a switch regarding this power sharing. Both conditions of relative power may become problematic. From a provider perspective, the user may simply become an object for other people’s beliefs concerning what’s the best care for the individual. This reflects the “Social Service” perspective on elders as outlined by Moody in Chapter 1. The empowered user perspective postulates that the elderly person takes responsibility for and is capable to be in charge of and draw conclusions about how much care and the nature of the care she/he needs. However, as noted in Chapter 1, there are inherent risks in true empowerment of elders, because they may make choices that others disagree with, or they may, in fact, not really be able to make sound choices for themselves or understand the implications of certain options. This brings up the challenging and difficult need for

balancing for the care workers not to step on the user's integrity but still to watch over that the elderly person receives quality and relevant care. In the study, the care workers expressed mixed feelings – the sense that users have the right to make decisions involving their own life situation, but on the other side the care workers feel a resistance against abandoning their power.

The reality is that people with various roles in the empowerment process may view what is appropriate or inappropriate for a particular older person from different perspectives. We must commit to the goal of learning how to *interdependently and in collaboration* meet the needs and desires of the older person *within the social and relational context* in which they live. As noted before, empowerment cannot be a zero-sum game – where the empowerment of one person *necessarily* implies the *disempowerment* of another. A win-win perspective implies the need for establishing boundaries of what is possible to accomplish within the boundaries of regulations and policies but also in the more informal situations of interaction. In this case the care workers had little information about the concept of user influence and this is part of the study although the thought was to let the care workers in a free manner relate to the concept *user influence*. The anxiety they felt concerning a higher degree of user influence can be related to their cognitive ideas, knowledge and information they have about this subject.

The second tension between *flexibility and routine* considers different aspects of both individual and organizational functioning. Set personal and organizational habits, routines, and procedures can be seen as obstacles against working in a more flexible way. Another barrier can be the safety felt by care providers while working under fixed rules and time frames. The prime obstacle against working under more user influence conditions is *time*. The care workers report the experience of being short of time. Today they only have the time to satisfy the needs that are most elementary and thus, their freedom of choice and action are limited. At the same time there is a feeling of protection working under fixed rules and a strict schedule. In case of a conflict with the elderly user about what to do or not to the care workers can refer to the regulations and this makes it easier to resolve any difference of opinions. Working more under standardized regulations could also make it easier to distance oneself personally from the individual care receiver and to focus on the content of one's job performance. This also can help care workers avoid more emotional connection and commitment to their client. The care worker could objectify and distance the elderly receiver and mentally create the image of having given the perfect care. To focus on the more material side of the work and avoid commitment can ease the burden of feeling that she/he hasn't done enough and thus be able to maintain a good conscience.

The third tension reflects the *conflicting goals and methods* that corporate care workers and elderly users might each express or pursue in the care-giving context. In the contemporary Swedish context care provision has assumed a more business market character, where private producers operate more elderly shelters (see Wikstrom, 2005). The concept 'customer' is more often used instead of care receiver. So elderly persons have a choice about which care provider they want to use for their support. One of the

most important competition tools for the care providers is the human capital of the care organization. It is the care workers' appearance the elderly care users see and it is the quality of their performance and ability that is measured when making that choice. Under more business-like relations, the care worker becomes a salesperson and this demands both a higher degree of professionalism, as well as a strong sense of personal connection and individual attention. One component of this may be related to appropriate surface displays of "right" feelings (also see Hochschild, 2003). The care worker's *emotional work* is thus judged as a measure of social competence. The more business-like the care sector becomes the greater the demand on the care workers to control their own feelings more. The care providers want care workers who are always smiling and pleasing in interaction with the elderly users. The care workers have an option when it comes to whom they give a little extra care - it could be a receiver that the care worker feels a little bit extra for on a personal level. Today the care workers feel that there is little time to get to know the users more closely and have a greater understanding about the user's background and needs. This is an obstacle partly due to businesslike organization arrangements, though emotional work cannot be timetabled and there must be space for extra time and flexibility.

As Bond (1992, cf Tout, 1995) noted, "Time is crucial in creating a therapeutic relationship. Professional carers in group settings are unlikely to have enough time to do the things they would like with residents at their own pace and at the moment when intervention is most needed." However, in her interviews with staff, she found that they were suspicious of potential changes and sometimes just overwhelmed with getting the basic physical care tasks done in time. And, in the current study, care workers here discussed factors like personal chemistry and the ability to adapt and adjust to the elderly user's different personality and requirements. Thus, their social competence, as a relatively new component of overall professional competence, must be acknowledged as being situated in a particular context and emerges from that set of circumstances, when professional knowledge is handled in a specific work situation (see Brewster & Holt Larsen, 2000).

And so the challenge is laid out for professional workers to perhaps view this change in power and perspective as an opportunity for further personal and professional growth and development. There is a need for a paradigm shift in carers' views of their role in providing care while also supporting the empowerment of their older clients. Beckingham and Watt (1995) challenge providers to ask, "How can I enhance this person's power to improve his or her life situation?" while respecting that person's capabilities and limitations.

The fourth tension between having *formal or informal competence* relates to whether it is relevant to have required education and training or not for this type of care provision. The care workers argued that they seldom use their formal training and competence as the care work mainly focuses on household tasks, including cleaning and shopping. To perform more nursing-targeted job assignments is something that they want. Focusing on the more medical parts of the work and performing tasks related to this would contribute to an increase of status in the care work. This would also increase their

sense of usefulness and accomplishment, which might elevate their commitment to this work. Another type of competence, discussed earlier, is the social competence that is important since they work in care and service professions. The care workers assume that more user influence would increase the household related tasks, and thereby decrease the technical and social competencies the workers possess. This is what they hope does not happen. There is an anxiety among the care workers that they will not be able to perform a professional job if there is an escalation of the everyday household jobs. Their feelings are twofold in the sense that they consider themselves as overqualified to do simple household jobs, but at the same time are concerned that the elderly person will become the direct purchaser of service, which will turn out to be difficult because most older people don't have the technical or professional knowledge needed to make such decisions.

As Kodner, Sherlock and Shankman (2001) found in their analysis of the challenges faced by a managed care organization in the United States when they formulated a new home-based approach to chronic care service provision, empowerment, autonomy, and choice are relative concepts. These occur in the context of a given care situation and relationship and in a moment in time in which cultural and organizational changes are occurring. What educational and technical requirements are most appropriate for the vast range of support needs that older persons will require as many countries around the world face larger populations of older and older citizens, some with greater and greater frailty? How can we consciously and intentionally work towards designing systems of support and care that empower all contributors to the self-actualizing societies we hope for? There is no doubt that there are various costs and inefficiencies (e.g., more time) to pursuing that type of society...but is it worth it? We think it is, and want to ensure that *all* members – older persons and those who support them – have the opportunity for a high quality of life – personally and professionally.

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Part 3 Overview of International Applications

Chapter 10

Conclusions and Next Steps: Empowerment Across Cultures

Tokie Anne and Mary McCall

*I am enough of an artist to draw freely upon my
imagination.
Imagination is more than knowledge.
Knowledge is limited. Imagination encircles the
world.
Albert Einstein*

As discussed in Chapter 1, the concept and implementation of empowerment has matured over the many decades of work in this area in different countries around the world. The work has moved from special, highly focused areas of concern (such as education) to the realization that empowerment can only truly occur and be sustained when it is supported at multiple levels (personal, community, and systemic). Thus, the CASE Model introduced and illustrated throughout this book is a useful framework for both organizing empowerment efforts, as well as evaluating their effectiveness. The CASE Model contains both elements of empowerment *over time*, through the four stages of Creation, Adaptation, Sustenance, and Evaluation/Expansion, as well as elements *across levels* of society, from the personal to the systemic. It also outlines the *Critical Components* that those involved in empowerment efforts must be mindful of as they work through time and across levels. We place this all very intentionally within the particular cultural context that the work is occurring. Thus, the efforts presented in this book range from Japan, where the CASE Model was formulated, to Israel, Sweden, the United States and Australia. In this final chapter, we approach the topic of empowerment from a much broader and global perspective of what overarching skills must be utilized to ensure the success of empowerment work, whatever the cultural setting.

We believe that the CASE Model presented in this book, and illustrated with examples from different cultures, is applicable at local level with particular small groups, even those with special interests and needs (Sweden, U.S.), but also at broader levels of community (Japan, Australia), and the most interdependent levels of national governments (Israel). And we must not forget to include multiple perspectives in designing and implementing empowerment efforts so that those who are most closely impacted by the initial targeted outcomes (e.g. care providers of empowered elders) are also included in all stages of the CASE Model. Throughout each stage of the CASE model of empowerment – Creation, Adaptation, Sustenance, and Expansion, the critical components introduced earlier in the chapter must remain in focus, and, as noted, there are specific activities that will most likely take place in each stage, as well. Table 1 outlines those critical components and activities, providing a framework for anticipating future foci and to facilitate planning processes and resource allocation decisions over a period of time. Together, keeping one's focus on these activities and critical components in successful empowerment processes can help any community work towards the empowerment of their individual members, their local social community, and, ultimately, the global community of which we are all a part.

Table 1 - Critical Components and Activities by CASE Model stage

	Targeted Outcomes	Contextual Components	Implementation Methods	Evaluation Evidence
CREATION	1) identify common targeted outcomes from a collaborative and inclusive process	1) learn profile of community 2) understand local history and values 3) identify local resources available	1) create representative leadership team 2) create programs for targeted outcomes 3) outline data needs	1) determine initial sources of evidence 2) create measures for targeted outcomes 3) identify potential data sources
ADAPTATION	1) clarify relevance of initial outcomes 2) prioritize outcomes for specific phases over time	1) assess level and effectiveness of local resources	1) create open and clear information systems 2) promote mutual support 3) continue recruitment of participants	1) gather initial evidence for evaluation 2) distinguish evidence at personal, social, systemic levels
SUSTENANCE	1) reiterate targeted outcomes 2) continue to communicate priorities for outcomes as they change 3) identify emerging and new outcomes based on feedback	1) continue communication about impact of program on local context - agencies, programs, etc. 2) inclusion of local authorities in ongoing program/policy development	1) create ongoing evaluation instruments for assessment at all levels of analysis - personal, community, systemic 2) create inclusive evaluation methods 3) add new programs for empowerment as identified	1) create ongoing evaluation processes 2) maintain inclusive evaluation methods
EXPANSION	1) identify new and ongoing outcomes based on feedback and analysis of effectiveness	1) assess local and broader collaborative efforts and successes 2) assess cultural shifts that may be occurring in attitudes	1) continue sharing evaluation information through a variety of methods and venues 2) increase number and levels of collaboration across society to achieve targeted outcomes	1) expand measures and methods of evidence collection 2) systematize evaluation methods at broader systemic levels

As a more practical way to organize these kinds of activities we also offer an analytical worksheet that can be utilized in any empowerment process using the CASE Model. This worksheet articulates the *Critical Components* of any empowerment process *across* the three levels of empowerment – personal, community, and systemic. Thus, any project can maintain a clear sense of what they are working with, and working towards. This helps to focus multiple perspectives on common goals and to maintain a sense of openness with others about what is occurring (see Table 2).

In Table 2, we outline the main points of each of the empowerment projects discussed in this book to demonstrate how it can be utilized. Whether the *Targeted Outcome* is something very specific and local to begin with, such as the health promotion activities in Japan or the housing design projects in Sweden and the U.S., or something at a much broader level such as the national policies discussed in the chapters on Israel and Australia, the articulation of those outcomes is important for all to see clearly. *Contextual Factors*, such as the level of local and national support for such efforts may change over time, as outcomes or attitudes shift, and thus can be clarified as they unfold. In addition, *Implementation Methods* may also change over time, moving from initial workshops to national policies, as progress is made on different levels. *Evaluation Evidence* is critical to an open sense of what information and evidence is being collected, for what purposes, and what the methods are for gathering data. Again, each of these *Critical Components* is at play at the personal, community, and systemic levels, so those must also be tracked.

For example, one can see in the table that the *Targeted Outcome* of improved length and quality of life, the goal for the Tobishima project in Japan, is paired with its contextual component of initial physical abilities (though there are many more discussed in Chapter 4), and with its implementation method of personalized health programs. The evidence for evaluation at the *personal level* would be increased longevity. At *community level*, the outcomes would be increased communication among community members and a greater sense of mutual support. At the *systemic level*, outcomes would include a clear and focused intentional planning process for social services and integrated care teams and plans. Thus, each chapter is very simply represented here in this table, using only one example. However, the table format should be used for an entire project, with each Critical Component being linked with its level of empowerment (personal, community, and systemic) in order to track progress and maintain objectivity about goals, methods, and outcomes.

Table 2 Critical Components of Empowerment by Level of Empowerment

	Targeted Outcomes	Contextual Components	Implementation Methods	Evaluation Evidence
Personal Level	Improved length and quality of life Involvement in housing design for Deaf Increase quality-of-life for family caregiver Choice of desirable/appropriate housing Reduced social isolation in Australian seniors	Physical abilities Active Deaf Senior coalition in area History of family-friendly social policies Social-welfare state history Local support of leaders and some national policy support for inclusion policies	Personalized health programs Collaborative design/planning process Modifications to social policies over time Future Workshop planning process Establishment of local community networks for seniors, including culturally appropriate volunteer services	Increased longevity Resident satisfaction; ongoing participation Measures of caregiver stress level and satisfaction Concrete changes in housing Decreased social isolation and improved social relations with other seniors
Community Level	appropriate support options increased communication increased collaboration common values and priorities mutual support systems	existing resources access to transportation supportive physical environment supportive local authorities	inclusive/representative leadership collaborative decision-making processes regular communication strategies consistent and open evaluation methods	assessment of leadership team shared information about decision-making assessment of communication success
Systemic Level	intentional planning integrated service models Accountability self-actualized society members interdependent lifespan approach to society increased effectiveness of expenditures	cultural values history of efforts roles of government vs. family vs. individual existing relationships between agencies	Complementary laws and policies financing mechanism cost-benefit analyses	satisfaction with laws and policies by citizens new, more efficient systems created cost-savings

From a much broader perspective, though, there are several issues and factors that will affect the success of any empowerment efforts, no matter the cultural context. We outline these here, in the form of probing questions, in the hopes that those involved in this work can be aware of them from the start of any process and can intentionally address them as best as possible to ensure the greatest success for all.

1. Is there an existing foundation for an “empowerment culture?” In other words – do the cultural values support empowerment efforts, as in the social democracies of Sweden, Israel, and Australia, or a capitalist society such as the United States, or is there work to be done on this fundamental level, as discussed in the chapter on Japan? A related issue is whether cultural values are in a steady state (as in the U.S. or Israel), or in a process of major change, as in Japan, or even some slight modification, as in Sweden, to some extent. We believe that the CASE Model demonstrates that in order to develop an empowerment model in the community, the effective development of a supportive culture is indispensable (see Figure 1). “Communication,” “Motivation” and “Scientific Evidence” are important elements to make real such a supportive culture. “Communication” must come with acceptance and understanding of each person and what they are bringing to the empowerment process, as well as communication of important information to people about what is happening during the empowerment process; “Motivation” must be encouraged through active participation and the development an attitude that “we-can-do-it-ourselves”; and “Scientific Evidence” can capitalize on the respect for logical analysis and clear expectations which all make it easier to understand the factors and effects involved in empowering people in the community.

Figure 1. How to Empower the People in the Community?

1. Communication: Acceptance, Understanding
 2. Motivation: Attendance, Decision Making
 3. Scientific Evidence: Logic, Validity
-

2. What is the cultural context within which work is being done? This was very well illustrated in Chapter 4 on Japan, which noted that a sense of personal empowerment was not a familiar one to Japanese elders, but one which could be discovered and nurtured through good communication and patient work. In contrast, the chapter on Israel documented clearly the long-standing national positive attitude towards empowerment of older persons, and that the current work was simply a focusing of those cultural values on the group of caregivers in their society. An interesting challenge was also discussed in the chapters on Sweden (5) and Australia (7), where the authors noted that there were changes in national attitudes about empowerment or the understanding of how that affected a particular group or issue, such as the social isolation of elders in Australia. Having a clear sense of where a culture or society is at any given time can help develop appropriate methods for working in that setting.

The role of cultural values and basic human values is critical in guiding human actions. It is the things that we value that motivate us to participate in various aspects of social and community life, and that gives us each purpose to our days. Keeping a focus

on what people value, within their specific cultural context, will ensure the success of empowerment activities. This is important not just for the short-term goals and stages of empowerment, but the longer-term work as well. Maintaining a clear sense of the values incorporated into empowerment activities will help sustain interest and involvement over time.

3. Is there intentional promotion of inclusive and representative participation at all stages of empowerment? It is fundamental to empowerment processes to engage various groups of people in participation. One model is to think of there being five kinds of members involved in empowerment processes (see Figure 2). These would include:

- a) Coordinator: A person who takes the role of coordinating/managing the process.
- b) Core member: A person who is closely involved with the plan and activities.
- c) Reference member: A person who offers professional information and technology if necessary.
- d) Active member: A person who is routinely involved and active.
- e) Surrounding member: A person who has not yet or rarely participated, but participates at times with interest or who may participate at some point in the future.

It is important to create an open and welcoming environment where all the members of any level consider they can have a central role anytime, anywhere and move through roles as seems appropriate for them at any time. It is crucial not to force participation or belonging, but to make the atmosphere pleasant and naturally attractive. In addition, all members must feel that they can maintain a flexible participation style so that anytime if they want, they can take the role of as the core/active member.

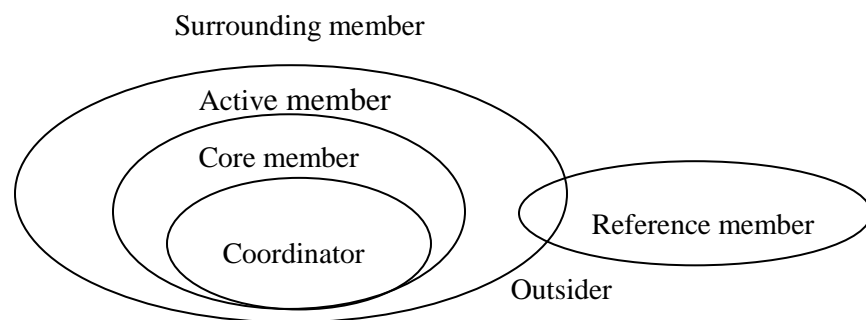


Figure 2. Flexible and open roles for participation over time.

4. Are programs/policies designed specifically and appropriately to address targeted outcomes? When engaged in empowerment processes it is crucial that the new programs and policies being developed be specific to the needs/concerns of the identified

community, and not be driven by political or financial motivation. One danger of good intentions is that “professionals” arrive in a community and decide for them what is “best.” This must be guarded against and the conscious evaluation of needs can assist in keeping focused on the needs at hand. For example, in Israel, initial policies for elders needed to be modified when there was an increase in the immigration of other older persons and some of the existing programs did not most appropriately meet their needs. In Australia, while initial evaluation indicated very positive outcomes, there appears to also be information that will help in refocusing efforts to be most appropriate. In the U.S., housing for Deaf seniors must be designed very specifically to meet their physical and social needs – without their input, most architects would be unable to imagine what those needs might be or how they could be addressed through the physical environmental design.

5. Is there effective utilization of information technology? Communication and keeping people informed throughout the empowerment process is essential to its success. For each specific cultural context, there may be variations in the manner of communication, but the fundamental need for clear and consistent and accessible communication of information is the same. For some local contexts, such as in Japan, Sweden, or some of the projects in Australia, local newspapers and flyers may be the most appropriate way to share ongoing information and activities related to the empowerment process. In other circumstances, such as the U.S., the use of technologies such as the internet and web pages might be more appropriate. In the case of Israel, where changes and activities are occurring on a national level, broader information systems such as television, print media, and the internet may be the most consistent and efficient way to share information. But for each setting, some consistent method must be chosen, so that citizens have a clear sense of where they can go to get updated and ongoing information.

6. Are comprehensive evaluations using multiple empirical methods conducted regularly? Empirical evidence makes it easier for people to accept the projected benefits of the project. Comprehensive scientific data, analyzed by well-established methods, confirm for people the merits and limitations of the project. Evidence-based results will give people security and confidence in the programs and, therefore, encourage continued investment in the project. Evaluation helps to clarify the effectiveness and value of various empowerment activities, which clarifies the meaningfulness of the relationships and work being developed. Evaluation may be a series of processes producing the desired goals, as specified by an activity outcome, information about costs or cost-savings, etc. It is vital that members clearly know about and understand the value of community efforts and outcomes continuously, so that consistent efforts are made along the way. Evaluation can also help clarify the actual status of progress towards Targeted Outcomes and the prediction of future Targeted Outcomes and programs needed to address problems in an objective manner. And, it is necessary to have evaluation not only by internal persons, but also by outsiders who can see more clearly the progress of the community in evaluation.

7. Do the new systems created provide both consistency and flexibility in responding to needs? System consistency promotes confidence by community members

in the function of the new programs and policies. Working toward consistent and common goals through mutual support expands the empowerment of people in the community, because it requires their participation to realize their goals. With consistency, people can plan for ways in which to become involved. In addition, consistent evaluation makes clear the distinction of various goals and the ways to reach them in a systematic manner. Realistic prospects for project outcomes, based on evaluation research, provide guidelines to people as to what to choose and what not to choose. On the other hand, system flexibility cultivates greater support in the community for the projects as it allows for better responses to individual needs. Flexibility includes adaptability to various individuals, issues, methods and timing. Effective utilization of services depends on system flexibility, because people are more likely to use such a system. Flexibility prevents the stagnation of a single type of system and will promote ongoing interest in continued project development.

8. Is there a clear commitment to continuous development and sustainability? As noted previously, empowerment is not just a goal, but a process, and hopefully a lifelong process. As new members enter a community system – either locally or nationally – there must be an ongoing system of continuous development of empowerment activities and understanding by all, so that people can be empowered throughout their lives. This calls for ongoing flexibility by all involved in empowerment work as it continually adapts to changing circumstances and contexts and individuals. To sustain such efforts over time also calls for a commitment across multiple levels – personal, community, and systemic. Appropriate resources – staff, space, financial – must be committed to these efforts for them to continue. Eventually, such practices will become institutionalized and the “standard operating procedure” for individuals, systems, and societies.

9. Has a friendly and stimulating environment been created? It is possible to create in the community both a friendly and stimulating environment, namely the relaxed security feeling of being connected to and empowered by and with others, and the stimulating aspects of problem-solving and working together collaboratively. People want to feel connected to others, but also to feel actively engaged in meaningful pursuits. If the personal relationships of individuals are strong then the whole community becomes stronger, as well. It is reasonable to expect a bidirectional effect of personal relations and community activities, all leading to greater empowerment on different levels.

10. Is there an underlying empathic orientation to people and mutual cooperation with goal of self-actualization? The most fundamental aspect of human experience, if we are to live together in a society is empathy. Without empathy we cannot create a social system that appropriately supports people at all stages of life; we would simply be motivated by our own unique experience. Thus, empathy for others as other human beings is the final, yet most fundamental requirement for successful empowerment efforts. Through individual empathy for one another, we can begin to build mutual cooperation, which is another activity that directly contributes to empowerment and increases public responsibility for a project. Mutual cooperation toward common goals requires good interpersonal communication, which will also contribute to empowerment within the community. Community discussion is one of the important methods for enhancing

empowerment, promoting the notion of empowerment as a social process and as an interdependent balance, according to Clark (see Chapter 1). Through this mutual support, the environment of reciprocity will develop the confidence of each person to feel that they have someone to help and they are not alone. Confucius told us, “One who only knows it is no match for one who likes it. One who only likes it is no match for one who enjoys it.” Thus, we hope that all who participate in empowerment processes can truly enjoy the relational aspect of the experience, which will enhance all our lives and move us toward the self-actualized society we aspire to.

Conclusion

Kukai, a Japanese Buddhist, 1200 years ago, said all the five components of the universe - earth, water, fire, wind, and sky - have rhythms. Understanding, accepting, and working with various rhythms is the essence of promoting empowerment in various contexts. In terms of empowerment, it may be useful to think of two types of rhythms. One is the "rhythm for change" – the need to innovate, to grow, to develop and expand. We see this everywhere in nature – each annual season and over the entire existence of the universe. The other is the "rhythm for order" - the need for consistency and predictability, which allows us to adapt to our context and environment. We believe that both rhythms are necessary and are encompassed in the CASE Model of empowerment, which delineates the steps necessary to allow every person, community, and system to achieve the goals of self-actualization and true empowerment.