

“It’s a community thing!”: Decolonising Struggles of Taiwan’s Indigenous Elderly Care

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Abstract

Drawing on qualitative interviews, this article explores decolonising struggles and emancipatory knowledge within Taiwan’s Indigenous elderly care services within the context of neoliberal policy restructuring. Informed by anti-oppressive practices, the article captures how increasingly marketised and commodified care policy reinforces the individualisation and isolation of care workers and elders within contested and politicised time and space domains. Workers sought to challenge the individualised trend by integrating the community into the care provision process and viewing care as a collaborative practice, including community engagement and collective political action. This article contributes to the decolonising debate and anti-oppressive practices by analysing empirical experiences in Taiwan and further examining the intersection of aging and ethnicity.

Keywords

Elderly care, decolonisation, long-term care, anti-oppressive, Taiwan, community

Sheng-Pei Tsai: “It’s a community thing!”: Decolonising Struggles of Taiwan’s Indigenous Elderly Care.

Introduction

The era of post-colonialism and globalisation has seen a consistent move towards decolonisation in the domains of social work practice, education, and research (Gray et al., 2016; Ibrahima & Mattaini, 2019). Without sufficient cultural awareness and sensitivity, social work can inadvertently act as an instrument of colonisation by propagating inappropriate mainstream values, theoretical frameworks and practice models (Gray et al., 2016). The central argument of decolonisation in social work focuses on the need to challenge the ongoing dominance of racism, whiteness and Eurocentric ideologies that operate within an individualistic paradigm and further to work to dismantle the oppression of colonial legacies within hegemonic knowledge systems, institutional structures and academic narratives (Gray & Coates, 2010).

While no singular definition can fully capture the depth and layers of decolonisation needed in social work and the extensive variation across the globe and within multiple cultures, a substantial body of knowledge focuses on Indigenous perspectives, including Indigenous ontology and epistemology as part of practices, research and knowledge-building (Gray & Coates, 2010). Some adopt a more extensive scope, focusing on the interwoven context of local indigenisation to develop population-specific, culturally-based approaches in post-colonial, non-western societies (Das et al., 2022; Lin, 2022). The primary objective of both approaches lies in the cultivation of culturally sensitive and contextually appropriate social work practices while simultaneously challenging Eurocentric knowledge as the sole, unquestioned authority.

Although the significance of decolonising social work has been widely recognised, the input from non-western practice settings has been relatively small (Kreitzer, 2016; Lin, 2022). Increased focus on place-based practice and local knowledge has the potential to enhance the decolonisation discourse

Sheng-Pei Tsai: “It’s a community thing!”: Decolonising Struggles of Taiwan’s Indigenous Elderly Care.

domestically and internationally (Tefera, 2022). This article seeks to highlight decolonising and emancipating insights drawn from data collected in Taiwan, an Asian island country that experienced colonialism from Western and Eastern powers for over four centuries.

This article examines how Indigenous elderly care workers in Taiwan expand the notion of care to include Indigenous perspectives even while working under the Westernized care system and with a neoliberal context. Informed by anti-oppressive practice (AOP) (Baines et al., 2022; Dominelli, 2002a; Kennedy-Kish et al., 2017), this article explores the power structure within care policy and poses the following questions: What is the tension and disjuncture between state regulation and local practice in Indigenous elderly care? What is the form of oppression in the context of Indigenous elderly care? How do frontline workers demonstrate resistance through practice at the individual and organisational levels? How can advocacy and collective actions be initiated among organisations and communities? This article contributes to the less-researched scholarship of AOP in aging and gerontology (Hulko et al., 2022) and shows care work to be a site of decolonising struggles, resistance and emancipatory knowledge creation.

The next section, briefly outlines the context and theory that frame this article in the literature on (de) colonisation of care, restructuring care policy in Taiwan, and highlights AOP as the theoretical frame for the analysis. The article then discusses the study and methods, followed by a section in which the findings are presented, including *individualisation of care* as oppression, *caring collectively* as resistance, and *politicising care* as critical decolonising struggles. The article ends with further discussion and conclusions.

Sheng-Pei Tsai: “It’s a community thing!”: Decolonising Struggles of Taiwan’s Indigenous Elderly Care.

Context and Theory

De-colonization of Care

Braun et al. (2014) noted that the positivistic research paradigm, embedded in the Western lens, creates a construct of aging that alienates Indigenous Peoples. Without enough awareness to examine the intersectionality of aging, care and ethnicity, colonial thinking is deeply embedded in gerontology research (Berdai Chaouni et al., 2021) and elderly social services (Hulko et al., 2019; Wang, 2019). For example, a number of authors argue that the pervasive biomedicalisation that treats aging as an individual's irreversible decline and care as an instrument to delay physical decline is one type of hegemonic colonialism manifestation that ignores the larger societal, cultural and political context (Chang, 2018; Tang, 2020; Umin, 2018).

A rich feminist body of knowledge has conceptualised the multifaced complexity of care and the influence of the power structure that shapes the practice of care (Duffy, 2005; Mahon & Robinson, 2011; Tronto, 2015). Care is a labour that includes not only biological, observable, and material actions but also intangible, affective, emotional and relational elements (Day, 2013). Care provision is embedded in time, space and lived context and understood as fluid, with meanings that shift in different practices and localised encounters (Armstrong & Day, 2017; Diamond, 1995; Funk et al., 2011).

Feminist studies also emphasise that care is a relationship characterised by power and inequality (Baines & Daly, 2015; Banerjee et al., 2015; Daly & Armstrong, 2016). Policies and logistics associated with neoliberalism and managerialism are the larger political and economic context shaping the formal care sector (Baines, 2010; Baines & Kgaphola, 2019; Charlesworth et al., 2015). A significant body of research has identified formal, paid care sectors are in adherence to scripted,

Sheng-Pei Tsai: "It's a community thing!": Decolonising Struggles of Taiwan's Indigenous Elderly Care.

standardised, rationalised, outcome-oriented practices that aim at basic individualistic biomedical needs, eclipsing the space for workers to address social, relational, open-ended and creative practices (Armstrong & Day, 2017; Aronson & Neysmith, 2006; Baines & Daly, 2021). To uphold relational, social, and ethical care, care work has historically been a site of feminised resistance, encompassing both individual practices, such as unpaid care, and collective actions, like union negotiations (Aronson & Neysmith, 1996; Baines & Daly, 2021; Neysmith & Aronson, 1996).

Similar patterns of conflict, systemic oppression, and contextualised resistance have been observed in Taiwan. State regulations and political and economic processes have shaped local Indigenous organisations' everyday care practices, including the lack of capital to compete in the quasi-market, the subordination of social care to medical care, and the marginalisation of local context and cultural sensitivity (Chang, 2018; Umin, 2018; Wang & Yang, 2017). These intertwined systemic barriers are embedded in the frontline workers' experiences, reflecting the dominant colonised care policy and the disregard for the local context of each Indigenous community (Wang, 2019).

A few critical ethnographic studies have identified how these organisations struggle to create alternative ways of care through the crack of neoliberalism. For example, Tayal people interpret care from a wholistic perspective that expands care provision to the integration of people, community, spirit, and land (Silan et al., 2022). Kaaviana (2015) provided Indigenous elderly care through traditional farming systems rather than biomedical interventions. Similarly, Huang (2018) documented how local Indigenous organisations provide care collectively through mixed economics and the traditional mutual help system.

Sheng-Pei Tsai: "It's a community thing!": Decolonising Struggles of Taiwan's Indigenous Elderly Care.

Restructuring care policy in Taiwan

Taiwan's formal elderly care policy has changed drastically in the past two decades. In 2007, a national, tax-based financing Ten-Year Long-Term Care Project (LTC 1.0) was introduced (Ministry of Health and Welfare, [MOHW] 2007). Several primary principles of formal elderly care provision have been established and continually adapted, including (a) centring long-term care budget and funding mainly on home-and-community-based services (HCBS), (b) care services eligibility is based on age and disability assessment, and (c) services fee is based on the mixture of public subsidise and copayment (MOHW, 2007; 2017). Along with the implementation of LTC 1.0, some key challenges have been identified, including a shortage of budget, insufficient service providers, concerned care quality, and the lack of care workers and care managers (MOHW, 2007, 2017; Wang & Tsay, 2012)

In 2017, the Ten-Year Long-Term Care Project 2.0 (LTC 2.0) was launched as a response to the expiration and challenges of last decade's long-term care policy, with the aim of "providing a universal, integrated, affordable continuum care system" (MOHW, 2017). Besides expanding services and service population and massive budget growth, a series of restructuring policy and regulation unfolded. Before the restructures, care provider organisations were commissioned to non-profit organisations through competitive bidding. Under LTC 2.0, in order to "facilitate care provision and coverage" (MOHW, 2017), for-profit industries and companies are encouraged to join care provision as a strategy to raise the quantity of service provision. The commissioned bidding system was transformed into a direct-contracted system (Yang et al., 2019), which allowed multiple, unlimited service providers to exist in the same area as an approach to "promote service users' choices and autonomy" (MOHW, 2017). Furthermore, for "the efficiency of resources and quality of control" (MOHW, 2017), a complicated three-layered care provision system was created (Hsu & Chen, 2019). The system

Sheng-Pei Tsai: "It's a community thing!": Decolonising Struggles of Taiwan's Indigenous Elderly Care.

hierarchically separates care assessment, care plan design, and care provision across public and private sectors as a tactic to attain budget and resource control.

While LTC 2.0 contains seventeen types of services, this article mainly focuses on two services- home care and family care home (FHC). Home care is provided by home care workers, including support services, personal care and household help (Chen & Fu, 2020). Historically, home care has been the most widely used service since Taiwan launched its national long-term care program (MOHW, 2017). In LTC 2.0, in order to create economic incentives to facilitate frontline care worker recruitment and retention, care workers' wages were transferred from paid-by-hour to paid-by-task. The minimum service time for each service user was cancelled to maximise the efficiency of service provision and the circulation of the workforce (Hsu & Chen, 2019). In other words, the more "efficiently" a worker is able to attend to clients, the greater the number of clients they can accommodate within a given work hour, resulting in a more direct wage return.

In LTC 2.0, service users are subsidised a lump sum for service payment based on economic status and disability assessment. Users can choose among different personal services according to their needs and preferences. However, the change to paid-by-task has negatively impacted service users' willingness to use home care. Before the policy restructuring, service users could ask for necessary care content during the given service hour and workers get paid based on work hours. Yet, in LTC 2.0, service users are charged based on each task. For example, in LTC 1.0, a care worker would prepare meals and do chores in an hour and get an hour's payment. However, in LTC 2.0, a client must pay for both meal preparation and chores fees if they intend to use both services. As Chen and Fu (2020) noted, such policy restructuring not only discourages workers from spending time engaging in social interactions with clients since there is no economic incentive, but it also impacts clients' willingness to use service

Sheng-Pei Tsai: "It's a community thing!": Decolonising Struggles of Taiwan's Indigenous Elderly Care.

under the impression that “every task costs.”

Family care home (FCH) is another significant HCBS in LTC 2.0. Based on a “micro daycare unit” blueprint, FCH is provided by experienced licensed care workers in their households with a maximum of four elders and ten hours of services daily (Chen, 2011; MOHW, 2017). In the era of LTC 1.0, FCH was operated in collaboration with non-profit organisations and care workers. While FCH provided direct service in their households, the non-profit organisation was in charge of supervising, administering, and supporting FCH workers. Nevertheless, in LTC 2.0, FCH is operating solely by workers and FCH was discursively shaped as a “business model” to enhance the creation of female-led small enterprises with underpinning marketisation narratives.

The LTC 2.0 is described as a result of the diffusion of policy innovations- a Western institutional design that is grounded in the East Asian context (Yeh, 2020) and served as a successful example of expanding service frame and provision in a relatively short period (Chen & Fu, 2020). The present study seeks to investigate the neoliberal ideology and marketisation narratives that form the basis of the restructuring framework and simultaneously explore the Indigenous perspective on care provision, which has been marginalised within the mainstream context.

Theoretical frame: Anti-oppressive practice

Grounded in multiple critical social work theories and social justice-orientated approaches, Baines & Sharma (2022) describe AOP with two distinct features. First, AOP draws on intersectionality theory to theories that inequality and injustice take place at the intersection of numerous social forces and social relations. Secondly, AOP recognises that multiple critical theories are required to guide practice and to provide the strongest strategies in pursuit of social justice. AOP stresses the unequal distribution

Sheng-Pei Tsai: “It’s a community thing!”: Decolonising Struggles of Taiwan’s Indigenous Elderly Care.

of power and resources in society. It acknowledges that power relations were constructed around social divisions based on identity traits like class, race, age, disability, and gender and used to oppress people or keep them in their place as passive recipients of social goodwill (Dominelli, 2012).

Oppressive social relations involve dominant groups attempting to retain legitimacy while gaining increasing control of resources through mechanisms of normalisation that promote dominant values and limit the agency and range of options that subordinated individuals and groups hold (Dominelli, 2002b). However, oppressive relations are not a one-way demonstration. Subordinated individuals and groups still exercise agency and attempt to shape their world as they envisage. For social workers who incorporate AOP, it is imperative to critically analyse the oppressions and inequality that power structure has brought at the micro, meso and macro levels and seeking for pragmatic solutions with larger activism and collective actions (Baines et al., 2022; B. Kennedy-Kish et al., 2017).

Drawing on AOP, this study employs feminist and Indigenous knowledge perspectives to investigate forms of oppression and injustice in LTC 2.0. Furthermore, it highlights the insights of Indigenous frontline care workers to demonstrate that there are alternative forms of knowledge beyond the dominant white, elite, Western perspective and to foster emancipatory knowledge inquiry.

The Study

This study utilises qualitative research methods and conducts in-depth interviews with three participants. Based on the principle of purposeful sampling, while the participants do not explicitly define their practice as AOP, they are recruited based on the researcher's familiarity with their decolonising thoughts and approaches from previous working experiences and research projects that the participants acted as either co-researchers or interviewees. The three participants have working

Sheng-Pei Tsai: “It’s a community thing!”: Decolonising Struggles of Taiwan’s Indigenous Elderly Care.

experiences across multiple Indigenous elderly care programs and settings, including frontline home care worker, care manager, coalition executive secretary and central government consultant in the Council of Indigenous People. All of the participants have been working in the Indigenous elderly care for more than ten years, which equips them with abundant knowledge and experience to share. Participants' intertwined social locations also provide this research with a holistic view of Taiwanese Indigenous care policy across multiple programs. The participants include two women and one man. All of the participants are Indigenous. Two of them hold social work degrees, and two of them hold graduate degrees.

The interviews were conducted virtually due to geographic location limitations and time differences. The interviews were audio-recorded with the participant's consent and transcribed verbatim in the source language, Mandarin. Through multiple readings of the transcription, until themes were discerned, the analysis-related transcripts were further translated into English. This process and timing of translation took place during data analysis, as Chen & Boore (2010) suggested as a practical way concerning time and cost concerns in cross-language qualitative research.

However, the researcher is aware of the challenges and barriers of cross-language qualitative research and acknowledges that there is a greater chance for some nuanced interpretations to be lost during the interpretation-translation process (Santos et al., 2015). The translation for the research is not only with respect to linguistic choice but rather in an understanding tied to social reality, cultural context, changing identities, and constant decisions about the cultural meaning language carries (Simon, 1996). To mitigate the interpretation gap, member checking was introduced in the multiple languages research process to ensure nuanced and interpretative representation (Tilley, 2016). After the initial themes were discerned, the researcher provided a summary of the findings, and all participants provided valuable

Sheng-Pei Tsai: "It's a community thing!": Decolonising Struggles of Taiwan's Indigenous Elderly Care.

feedback on the interpretation.

The limitations of this study include a relatively small sample size, the potential for bias in the convenience recruitment methods used, and the limited time frame for preliminary analysis. Though the findings and insights may be applicable in other similar contexts, the aim is not for generalisation.

I present this analysis as a cisgender, Han-Chinese settler whose ancestors mostly come from Mainland China, who lives through the structural privileges, and who is committed to the ongoing project of acting as an ally in the decolonising struggle.

Findings

The following themes emerged most strongly in the data and are presented with illustrative quotes. The findings include individualisation as oppression for both care recipients and workers, and frontline workers demonstrated resistance through collective and politicising care strategies.

Individualisation as oppression

Individualisation as oppression includes the individualisation of *service users, frontline workers and the isolation of space*. Individualisation in this analytical context represents the actualized process of isolating care from the larger societal connection and is characterized as individualistic problems and responsibilities rather than public practices.

For Service users

Much research has identified the contemporary care system as an individualised biomedical intervention focusing on health as personal or familial responsibility and overlooked the diversity and

Sheng-Pei Tsai: “It’s a community thing!”: Decolonising Struggles of Taiwan’s Indigenous Elderly Care.

heterogeneity among older adults (Hulko et al., 2019, 2022; Timonen & Lolich, 2019). In this study, the *individualisation of service users* has been reinforced through restructuring. The quotes below demonstrate the drastic change followed by the home care payment transformed from paid-by-hour to paid-by-task,

In the past, care workers would spend at least an hour with the elders. Workers would chat with elders while working or stay with the clients even if there was no “real work” to do. The elders enjoyed the accompany because it was a sense of socially engaged, bond and relationship. Now, everything changed. Workers are in a rush- 5 minutes for wound care, 20 minutes for meal preparation, and they are gone. They are rushing to the next household. They do not even talk to their clients because they are all in a rush now. Clients feel lonely and disengaged, and they can do nothing. The (new assessment) system is too complicated with too many layers for them to complain. It is the rule.

Another interviewee added, “Home care is like a commodity now, like shopping in a store. You know? A bath for 10 dollars, body rehabilitation for 15 dollars, and emotional support for 5 dollars.” Similar to Baines and Daly’s (2021) findings in Canadian care facilities, these quotes highlight that care provision has been commodified, politicised and contested by time and task in neoliberalism. In this context, whereas the macro politics of time (social policy) seems to provide more flexibility for workers, neoliberalism has driven care workers to achieve capital and performance and further led to the thinning out of the micro politics of time (individual care practice).

The first quote also indicates that the restructuring has jeopardized elders’ social engagement and positioned elders in a much more individualised position. Traditionally, home care has been a critical

Sheng-Pei Tsai: “It’s a community thing!”: Decolonising Struggles of Taiwan’s Indigenous Elderly Care.

site for elders to build relationships and acquire social connections in both Western and Eastern contexts (Aronson & Neysmith, 2006; Twigg, 2000). With the diminishing service time, it has been difficult for elders to build mutual, relational and reciprocal relationships with care workers.

The refined, complicated, three-layered assessment system claims to achieve better quality assurance and resource allocation. However, the fragmentation and separation of assessment-care plan-care provision have led to the silencing of Indigenous elders' voices. It has been difficult for elders to locate whom they can ask for help and express dissatisfaction. The question to be asked is whether the refined system indeed controls the quality or simply mutes the dissatisfaction of the elders to achieve quality at the surface level. Notably, the marketisation and commodified trends in the quotes reveal the dangers of marginalising not only the receivers but also the providers of care (Wilkinson & Kleinman, 2016), which are both generally the most vulnerable populations in regard to care provision. The isolation of the frontline workers is demonstrated in the following passage.

For frontline workers

The restructuring has also impacted family care home (FCH) workers through the much more isolated working environment. An interviewee mentioned the struggles of FCH workers, from working with organisations to working alone,

It is difficult for a single worker to take care of four elders alone at home without support from the organisation. It is hard to do all the administrative work independently with no peer worker or a supervisor to discuss all the stuff in FCH... Even though I have no official work relationship with them (FCH workers who were formerly supervised by the interviewee) right now, I often get calls from them to ask for suggestions.

Sheng-Pei Tsai: "It's a community thing!": Decolonising Struggles of Taiwan's Indigenous Elderly Care.

Though this research had not included the voice of direct FCH workers, the quote reported how FCH had been transformed from collaborative partnership to isolated “entrepreneurship” during the restructuring. The underpinning marketisation assumptions have materialized care provision as these female workers’ individualised responsibility. Additionally, how the working condition and income of workers have been changed remains unknown. In the next paragraph, I will further depict how individualisation manifests through the isolation of space and again reinforce the individualisation of both the workers and elders.

Isolation of space, isolation of workers and elders

According to the Regulation of Establishment Standards for Long-Term Care Institutions (MOHW, 2017) article ten, FCHs are provided in care workers’ private household setting in compliance with the Building Act and Fire Protection Act, and maintain high hygienic quality. The regulation explicitly involves safety management and risk control through infrastructure and hardware inspection. It also implicitly implies that the care setting of FCH is confined to a single household. A participant identifies the paradox,

They call it “family care homes.” You know, the concept of “home” in the law from the government is so much different from our local understanding. Here, in the tribe, the whole community is our family, and the whole tribe is our home! The community is where we situate and where we strive ... Community care should be based in the community. ... It means elders should not be trapped in a small house and should be asked what they want to do and where they want to go freely, as long as it is safe and in the “home”- our community.

The space domain is not a neutral backdrop in public care provision; instead, it is a contested terrain

Sheng-Pei Tsai: “It’s a community thing!”: Decolonising Struggles of Taiwan’s Indigenous Elderly Care.

shaped by political and social factors, thus further influencing the caring process (Mahmood & Martin-Matthews, 2008; Sims-Gould & Martin-Matthews, 2010; Twigg, 2000). Based on the regulation and the above quote, the space domain of FCH can be problematised in several ways. First, we can see how the state regulates workers' household settings as a place of public service provision and further stretches the regulation to the private sphere of workers. Second, it reveals the policy's narrow imaginary scheme of care setting (risk control, hygiene, appropriate infrastructure and hardware) while excluding Indigenous local knowledge and ways of doing and being. While one of the policy goals of LTC. 2.0 is to establish "aging-in-place services" (MOHW, 2017); the regulations reversely isolate workers and elders from the whole community. The exclusion and denial of Indigenous epistemology from the public service also shows the way that care can be a colonization projects and oppressive paternalism schemes (Narayan, 1995), even when aiming for benevolence and inclusion.

Caring collectively as resistance

One way the participants resisted the individualisation of care was to provide care collectively with peers, volunteers and the communities. All participants mentioned the experience of providing care outside of the formal, public, paid care system by fundraising, doing more than required, and even violating regulations. These behaviours have been categorised as "unpaid care" by a significant body of feminist studies, which symbolise female workers' elastic, boundless and over-stretched labour without pay or recognition (Armstrong, 2023; Baines & Armstrong, 2019).

A participant spoke about FCH workers incorporating community ritual and activity into service, which was forbidden by the regulations because the settings are viewed as outside of households,

They (the elders) would be happier to be out there. They can meet friends and do things

Sheng-Pei Tsai: "It's a community thing!": Decolonising Struggles of Taiwan's Indigenous Elderly Care.

they are familiar with in the community, especially during the ritual season. The workers would feel much more relieved as well. They do not have to do it alone all day long. It is a community thing now.

Integrating land as an element in Indigenous elderly care is broadly mentioned in the East and West (Hall, 2016; Huang, 2018; Hulko et al., 2010; Kaaviana, 2015). One participant talked about a unique volunteer-based land-framing program launched by her organisation,

The land was donated by an elder we cared for before he passed away. We opened the land to the whole community and encouraged people to farm together. Everybody can go there and farm, including the elders we care for. They would feel cared for even outside of the service time... The harvests from the land would be donated to the elder meal service.

These quotes demonstrate that workers expanded the notion of care while leveraging the assumptions of where, how and by whom care could be provided. According to bureaucratic assumptions, care service is constrained to a single household and provided by “professional” workers with body and personal care. These interviewees, however, broke down such care borders by utilising existing social relations and incorporating community connections into care settings. It transformed individualised providers'/recipients' identities and brought them back as a part of the community. The elders no longer passively receive service but actively participate and contribute to the community. Instead of being constrained by regulatory rigidities, workers have extended care relations and mobilised care as a “collective thing” with their lived experiences and understanding of the community to develop unique ways of caring that incorporate local context and place-based knowledge.

Politicising care as strategy

Sheng-Pei Tsai: “It’s a community thing!”: Decolonising Struggles of Taiwan’s Indigenous Elderly Care.

In addition to demonstrating resistance at individual and organisational levels, the participants also strive to search for more far-reaching, transformative social change at the policy level by initiating collective action, mobilisation and advocacy.

As noted in the previous section, after the restructuring policies, home care service fees were charged based on each service task. The shift changed elders' view of the service. They began to consider home care as a commodity purchase rather than public service and felt the pressure of cutting down on expenses. To do so, some elders refused to include essential but necessary service tasks, for example, vital sign monitoring. However, vital signs monitoring used to be a routine in-home care and has been the primary reference for frontline care workers to recognise elders' physical condition. A participant mentioned the process of politicising the commodification of home care tasks by publicly raising this issue in the seasonal administrative meeting among officers and care provider organisations,

We raised this concern in the meeting and explained why we still insist on providing vital signs to elders for free by bearing the costs on our own, even if it violates the rule... I know some organisations feel pressured because we provide it “almost” for free, but there has been another organisation that followed our model. They understand that without it (vital signs monitoring), elders' well-being could be in danger.

While the workers attempted to politicize the issue of commodification, they also recognized it would be difficult to disturb the regulation entirely. They compromised by selecting the most in-need elders to provide free service as a strategy to minimize the backlash from the regulatory sector and other service providers while struggling to decrease the impact of neoliberalism and as a stepping stone to connect to a larger agenda of forging solidarity among different organisations. Interestingly, the local officials seemed to acquiesce to such disobedience since the “almost-free” provision was controlled to

Sheng-Pei Tsai: “It’s a community thing!”: Decolonising Struggles of Taiwan’s Indigenous Elderly Care.

a certain extent.

Politicising at a larger scale could also be possible, though not necessarily succeed. A participant described the experience of engaging in a long-term care policy lobbying coalition. Though the coalition was formed by multiple advocacy groups targeting different issues and populations, Indigenous elders' rights were merely one of the issues among various aspirations,

They (other members in the coalition) are much more experienced than we are, and I learned a lot from them and knew how political it could be. It is impossible to change everything immediately, but every time we try, we learn more and make more allies.

These processes of politicising care demonstrate how the participants link everyday practice to the more extensive allyship from various sectors and backgrounds, especially the institutional laws and regulations that continually disadvantaged and marginalised elders, in this case, particularly Indigenous elders.

Discussion and Conclusion

This article adapts AOP as a theoretical lens and explores the decolonising struggle, creation and emancipatory knowledge-making through frontline workers' everyday life under the shifting long-term care policy. The findings show that under the impact of neoliberalism, the care policy has been increasingly marketised and commodified. The practices are heavily based on individualism and ignore the uniqueness of personal being and the complexity of care. This individualisation and isolation are embedded in the contested, politicised time and space domains and contribute to the worsening of the conditions of care for both parties- elders and workers.

Sheng-Pei Tsai: "It's a community thing!": Decolonising Struggles of Taiwan's Indigenous Elderly Care.

Nevertheless, the participants challenged the individualised trend by integrating the community into the care provision process and regarding care as a collaborative practice. The collective care process is driven by elders' engagement, local context, and place-based knowledge rather than the rigid, bureaucratic, hierarchical care policy. The article also finds that politicizing care is a strategy for workers to dismantle uneven social relations, oppressive resource distribution and dominant narratives.

Articulation of these tensions and disjunctures between policy and local practice is critical because it clarifies the dominant, mainstream depictions of care policy and how it jeopardizes workers and the older adults they care for. It likely applies to all older people in need of care but can be seen to be particularly acute for Indigenous peoples. Also, the resistance and politicising processes of care workers and Indigenous communities serve as the subaltern counterpublics (Fraser, 1990) that interpret care needs and provision differently and demonstrate that alternatives are always possible. While modern welfare systems and social services act as state hegemony that builds on individual-hood, decolonising practices can be created based on community-hood (Tang, 2020) and lead to strategic, pragmatic, heterodox and socially just practices (Baines & Clark, 2022).

This article contributes to decolonising debate and AOP by bringing empirical experiences from Taiwan as a nation-based and place-based study and further examining the intersection of aging and ethnicity. It also offers possible approaches for social service workers to engage in organic, community-based services even when facing high restrictions and management from neoliberalism. While this article draws experiences across different services, future research could focus on specific services in LTC 2.0. Moreover, in light of the jeopardy of elders found in this study, research that focuses on the standpoint of elders is recommended.

Sheng-Pei Tsai: "It's a community thing!": Decolonising Struggles of Taiwan's Indigenous Elderly Care.

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