AGING IN PLACE: THE PARADOX OF COMMUNITY ELDERCARE IN URBAN CHINA

by

YI YU

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Student: Yi Yu

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This dissertation has been accepted and approved in partial fulfillment of the requirements for the Doctoral of Philosophy in the Department of Geography by:

Xiaobo Su	Chair
Alexander Murphy	Member
Daniel Buck	Member
Eileen Otis	Member

and

Janet Woodruff-Borden   Vice Provost and Dean of the Graduate School

Original approval signatures are on file with the University of Oregon Graduate School.

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DISSERTATION ABSTRACT

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Population projections indicate that China will be the most rapidly aging country in the world in the near future. To meet the challenge of providing eldercare in a context of shrinking family sizes—where children are no longer able to care for their aging parents–-the Chinese government has selected community eldercare as its major solution. Despite the increasing popularity of community eldercare facilities, little is known about how they operate, their impact on the aging population, and their workforce. Drawing on qualitative date collected during six months of fieldwork in Beijing and Shanghai, this dissertation investigates how community eldercare facilities are established and operated, how they promote the Chinese government's "healthy aging" agenda, how and to what extent they replace home care, and what kinds of working conditions they create for their caregivers. Findings reveal that (1) The local government collaborates with NGOs to set up community eldercare programs. Instead of striving for autonomy, these NGOs enjoy positive and collaborative relationships with their local governments, which allows them to have access to more eldercare projects and to occupy (and build) the eldercare market to earn future profits. (2) The community eldercare programs support the government's "healthy aging" agenda, which promotes a lifestyle intended to facilitate independence

and mobility. The eldercare programs' support of this agenda allows the Chinese government to govern at a distance. (3) Community eldercare centers aim to provide a homely feeling for older adults in order to replace home care and facilitate aging in place; at the same time, they constitute a space of control. (4) Caregivers working to create homely feelings at community eldercare centers are required to work in accordance with care ethics, which places them in a "prison of love."

CURRICULUM VITAE

Yi Yu

GRADUATE AND UNDERGRADUATE SCHOOLS ATTENDED:

    University of Oregon, Eugene, OR
    Syracuse University, Syracuse, NY
    East China Normal University, Shanghai

DEGREES AWARDED:

    Master of Arts, Geography, 2014, Syracuse University
    Bachelor of Science, 2012, Urban Planning and Resources Management, East China Normal University

AREAS OF SPECIAL INTEREST:

    Care theory
    Home
    Social Welfare Regime
    China

PROFESSIONAL EXPERIENCE:

    Research assistant, Department of Geography, Syracuse University, NY, 2012-2013
    Teaching assistant, Department of Geography, University of Oregon, OR, 2014-2019

GRANTS, AWARDS, AND HONOR:

    The Society of Woman Geographers, Pruitt Fellowship, 2018

    Travel Award, China Specialty Group, AAG, 2018

    CSWS Jane Grant Dissertation Fellowship, University of Oregon, 2017

    Global Oregon International Research fund, University of Oregon, 2017

    APCG President's Award for an Outstanding Paper by a Ph.D. Student, 2016

    China and Inner Asia Council (CIAC) Research Travel Grant Award, Association of Asian Studies, 2016

    CSWS Graduate Student Research Grant, University of Oregon, 2016

Maxwell Dean's Summer Research Award, Maxwell School of Syracuse University, 2013

Student Scholarship, East China Normal University, 2009, 2010

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CHAPTER I

INTRODUCTION

Research Problem and Context

People my age have gone through similar experiences. We understand each other.
I have many friends here and the center makes lunch for us. Also, I can participate
in a lot of activities here. We also have a clinic. This community eldercare center
is small but it has a lot of services. Older people like me are very happy here. I'm
73 years old. I'm the youngest here. See that elderly women? She's disabled. Her
partner died two years ago and her daughter is very busy, so she has to come here.
Other older adults are like my mother. I do my best to help them. See that elderly
women in the red coat? She's very nice. People here help each other.

I think the eldercare center should extend their working hours, even just half an
hour. Also, it would great if they opened on Saturday. This eldercare center is
mainly for people who live alone or have other difficulties.

There are a lot of regulations here, like you need to arrive early to get a number
for lunch [or you might not get anything to eat]. You're not allowed to lie on the
benches and take a nap. You have to keep your voice down. People dress well
and respect each other. (Interview with Mrs. Li, May 2017)

I met Mrs. Li during my fieldwork in Shanghai. She is the most active older adult

at her local community eldercare center. Instead of staying home or spending time with

family members, Mrs. Li frequents the community eldercare center in her neighborhood

to interact with other older adults and social workers, as well as participate in a range of

activities such as crafts and singing. The center has become a second home for her, where

she sees friends, receives emotional care from the caregivers and social workers, and

participates in activities that help maintain her health and reduce the possibility of

needing to move to a nursing home. Still, she views the community eldercare center as a

backup choice for older adults. To her, only the oldest elderly or people with some type

of difficulty, such as having busy family members who can't care for them, go there.

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Thus, the center is both home and not home, with a mixed feeling of homely[1] and unhomely.

The community eldercare center that Ms. Feng frequents is part of the newly emerging eldercare strategy in urban China created in response to the nation's rapidly aging population. Currently, there are 194 million) people over the age of 60 in China (15% of the population, and this number is projected to rise to 491 million (33.9% of the population) by 2050 (United Nations, 2015). Facing this upsurge in its aging population, the Chinese government is actively collaborating with companies and nongovernment organizations to establish community eldercare centers. Community eldercare, according to the Chinese government, facilitates aging in place by allowing older adults to receive care from non-family members while still maintaining connections with family members in a familiar environment. In addition to enabling aging in place, these centers also promote healthy aging, the "process of developing and maintaining the functional ability that enables wellbeing in older age" (WHO, 2018). Healthy aging encourages independence and participation in community activities. This dissertation studies emerging community eldercare in urban China.

Earlier work by geographers on eldercare has focused on the distribution and accessibility of healthcare facilities (Conradson, 2003a; Kearns & Moon, 2002; Parr, 2003). Following the cultural turn in geography, research on eldercare shifted toward unpacking the influence of place and space on health and well-being, which includes examining older adults' adaptation to place, formation of place attachment, and

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[1] I use *homely* in the British sense of homelike: "simple but cosy and comfortable, as in one's own home" (Oxford Dictionary, https://en.oxforddictionaries.com/definition/homely).

therapeutic landscapes (Cheng, Rosenberg, Wang, Yang, & Li, 2011; Coleman & Kearns, 2015; Laws, 1994; McHugh & Mings, 1996). In particular for older adults, researchers have focused on aging in place constructions and representations of healthy aging, and the provision and experiences of care (Andrews, Cutchin, McCracken, Phillips, & Wiles, 2007; Cutchin, 2003).

While this research has generated insights into spatialities associated with aging and eldercare, it often lacks a critical lens to explore the paradoxical nature of care (Cutchin, 2009). Expressing the paradoxical, double-edge nature of care, Bondi (2008) writes that care "enables and controls, it is oppressive and inspiring, it can invoke love and hate, hurt and nurture, it both demeans and fulfills" (Bondi, 2008, p. 250). This statement has two propositions. First, care enables the care receiver to recover or accomplish a certain task or make the caregiver's work fulfilling. Second, care controls and is sometimes oppressive for both caregivers and care-receivers when one exercises power over the other. Drawing on Bondi's work, this dissertation examines the paradoxical nature of care not only from the individual experiences and practices of care, but also the broader social, political, and economic contexts that shape care spaces and care provision (Milligan & Wiles, 2010).

In China, for example, the government perceives eldercare as both a responsibility and a burden. By collaborating with NGOs, on the one hand, the government takes on the responsibility of eldercare, and on the other, it gradually transfers a portion of the eldercare burden to nonstate actors. Examining the paradoxical nature of eldercare requires recognizing how the promotion of healthy aging at community eldercare centers governs the aging population by shaping the aging process. Elderly people who are in

relatively good health do not want to be placed in highly-disciplined nursing homes, partly because of their good health and partly because of social stigmatization of these homes. But they can rarely rely on their adult children for care, and thus they prefer to attend day programs at community care centers or live in them temporarily (less than six months). There is a fundamental duality in the idea of aging in place at community eldercare centers, which seem to create a caring space that is both homely and unhomely, as care receivers develop a mixed sense of belonging and alienation, as shown by Ms. Li's words above. NGOs get involved in eldercare expecting profits from community eldercare services but are also motivated by the fulfilling work they perform.

For older adults, participating in community eldercare program facilitates social interaction, participation in activities, and remaining in their familiar neighborhood. On the other hand, it imposes controls on them by regulating how they should behave at the community center and putting pressure on them for healthy aging. One final paradox is that although the emotional work provided by caregivers improves quality of care and facilitates connections between caregivers and older adults, it also opens up the possibility of exploitation of caregivers. To care workers, eldercare is both emotional and exploitative.

With these variegated aspects of paradoxical care in mind, this dissertation examines the politics of eldercare to unpack the intersections between emotional labor and state governance in eldercare. By collaborating with NGOs, the state establishes community eldercare centers to supplement home care, demonstrating the affective dimension of how the state governs its population through cultivating community caring spaces (Anderson, 2017). The Chinese state manages one of its most vulnerable

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populations—older adults—through these spaces to structure homely feelings, dictate proper ways of aging, and provide eldercare. By focusing on the paradoxical nature of elder care, this dissertation explicates the affective and emotional dimensions of state governance of the aging population (Anderson, 2011; Tyner, 2013).

This project has two overarching objectives. First, it investigates the role played by the provision of care in population governance. Community eldercare helps the Chinese government both serve and govern its aging population by keeping tabs on who is aging and how they are aging. Similarly, the healthy aging discourse promoted at community centers encourages older adults to participate in community life, to maintain what I call a "busy ethic" after retirement, and sets health as the goal for retirees.

Second, this dissertation theorizes community eldercare centers as caring spaces where affective bonds and intimacy are cultivated, but sometimes at a cost to caregivers. Chinese centers provide eldercare but also attempt to supplement home care by cultivating a homely feeling away from home. Thus, the home becomes externalized to the community. The traditional Chinese model of care provided to elderly people at home by family members is accordingly giving way to a new space of eldercare involving an institutional complex of community centers, government officials, and service providers. This institutional home is used by older adults and their caregivers, who continuously make and remake the institutional home with their everyday practices. However, this institutional home is not without tension. Cultivating a homely feeling at the centers and providing services to individual homes both require care work performed by caregivers, whose work is often devalued due to its association with emotional work, bodily work, gendered work, and dirty work.

To address these issues, I ask four questions:

(1) How does the Chinese state collaborate with companies and NGOs to establish urban community eldercare programs?

(2) How does the state-NGO nexus facilitate population governance, primarily through the promotion of the "healthy aging" agenda?

(3) How do older adults make and remake community eldercare centers into places that challenge the spatial and conceptual limits of what constitutes home in contemporary China?

(4) How do the emotional engagements of care workers shape their working conditions, especially when understanding care work as bodily work, emotional work, and dirty work?

This dissertation is based on fieldwork I conducted in Beijing and Shanghai. These cities were selected for their large aging populations and their efforts to establish community eldercare programs. Chosen as experimental sites by the Chinese government, Beijing and Shanghai were among the first cities to promote community eldercare programs. If they are successful, community eldercare will be promoted in other cities. While this dissertation provides insights into the current Chinese social welfare regime, state-NGO collaborations, and the cultivation of caring spaces in Chinese cities, the findings of this study cannot be generalized to other settings or places without scrutinizing the local social and historical contexts. Even within Beijing and Shanghai, community eldercare programs vary across communities due to the different practices of local governments and NGOs.

Theoretical Contributions

Through the lens of care, this dissertation examines the paradoxical features of aging in place and healthy aging. It draws on the literature on state-NGO interactions, critical gerontology, home, and care work to examine community eldercare programs in urban China. It makes four theoretical contributions.

First, this dissertation sheds light on changing state-NGO relationships in the terrain of social welfare. Typically, the Chinese state deploys strict control of NGOs, leading to state-NGO tensions. However, the state actively collaborates and cooperates with NGOs on community eldercare programs, revealing a different picture of state-NGO relationships in China (Spires, 2011; Tang & Man, 2008). This new picture should be understood within the broader trend of socializing welfare provision or "privatization through NGOs" (Harvey, 2007, p. 177). NGOs share the responsibility of eldercare with local governments and facilitate governance at the community level by gathering information about the aging population (Rose, 1999). Hence, state-NGO collaborations both outsource eldercare services and facilitate governance through NGOs.

Second, this dissertation bridges two bodies of literature that have to date developed separately: gerontology and governmentality. Scholars in aging studies have developed indexes to measure healthy aging, active aging, and successful aging to help older adults be independent and free of illness in their aging process (Depp & Jeste, 2006; McLaughlin, Connell, Heeringa, Li, & Roberts, 2009; Rowe & Kahn, 1987). However, phrases like *healthy aging* shift the responsibility for eldercare to older adults by directing them to be healthy and independent (Knickman & Snell, 2002; Smith, Strauss, & Zhao, 2014). Drawing on Foucauldian governmentality, this dissertation further

unpacks the ways that healthy aging facilitates population governance, where ideas like healthy aging are used to produce independent and able bodies (Powell, 2009). By drawing on Foucault, this dissertation connects aging with population governance through theorizing community eldercare programs as environments that link "the individual's will to health to the state's population governance techniques" (Higgs, Leontowitsch, Stevenson, & Jones, 2009, p. 687).

Third, this dissertation proposes and develops the concept of an "institutional home" to theorize the externalization of eldercare into the community. Community eldercare programs facilitate aging in place by helping older adults to "live in their own home and community safely" (WHO, 2015). However, scholars studying aging in place tend to view the concept of home as having a clear boundary that differentiates the inside from the outside. Building on Blunt and Dowling's (2006) conceptualization of home, this dissertation employs the term *institutional home* to describe the hybrid space constituted by the private home and the community care center. The institutional home promotes mixed feelings of homeliness and unhomeliness; it is a space of care and a space of control at the same time.

Last, this dissertation questions advocacy for a social welfare system based on care ethics, which, according to many scholars, will result in a more connected and just society (Lawson, 2007; Massey, 2004; Popke, 2006; Raghuram, Madge, & Noxolo, 2009). In what follows, I unpack the influence of care ethics on care work by theorizing care work as bodily work (Dyer, McDowell, & Batnitzky, 2008; Twigg, Wolkowitz, Cohen, & Nettleton, 2011), dirty work (Ashforth & Kreiner, 2014; Ostaszkiewicz, O'Connell, & Dunning, 2016), and emotional work (Popke, 2006). This careful

examination of care theory reveals that weaving care ethics into the welfare regime may place caregivers in a "prison of love" (England, 2005), where being ethical means being willing to work long hours for low wages.

<center>Explanation of the Dissertation Format</center>

This dissertation consists of seven chapters including the introductory chapter. Chapter 2 introduces the research context and data collection. First, I describe the changing social welfare regime after the establishment of the People's Republic of China. Then I review the history of three major components of the Chinese eldercare landscape: institutional care, home care, and community care. I then focus on community care and document government policies aimed at promoting it. The second part of the chapter introduces the research method and the data collection process used in this research, and includes a summary of issues and challenges I faced doing the fieldwork.

Chapter 3 focuses on collaboration between the state and NGOs and their roles in urban governance. Recently the Chinese government has been actively collaborating with nonprofit nongovernmental units to provide social welfare services to older adults at the community level. In this way, the community becomes a significant site for social control, welfare provision, and NGO-local government collaboration. These NGOs use community care as a platform for resource integration and welfare provision, which further leads to community building and spatial disparities in welfare provision at the community level. Hence, a unique picture of state-NGO relations emerges, along with a new mode of urban governance through which local governments comes to know the community through the NGOs. Increasingly, a market ideology is being followed in providing eldercare services.

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Chapter 4 discusses governance of the aging population through community eldercare programs. The Chinese government has promoted the concept of healthy aging (Jian Kang Lao ling Hua 健康老龄化) to meet its long-term health goals. This has become the principal motivation behind community eldercare organizations' activities and services for the elderly in Chinese cities. The principles of healthy aging regulate older adults by encouraging them to participate in activities, perform volunteer labor such as organizing activities, and strive to improve or at least maintain their physical health. This chapter examines the discourses and practices surrounding the healthy aging paradigm in urban China and its role in governing the aging population. The chapter draws on Michel Foucault's work on governmentality to analyze the production, circulation, and implementation of healthy aging discourses in urban China. It argues that the concept of healthy aging requires older adults to set health as their primary goal and enables the Chinese government to govern from a distance by advocating healthy aging principles. This chapter aims to bridge the literatures on governmentality and critical gerontology to explore issues related to the aging population of urban China.

Chapter 5 focuses on the formation of institutional home through community care initiatives. As the idea of aging in place has grown in popularity, eldercare has become increasingly deinstitutionalized, with a greater emphasis on home care, community care, and care at small institutions. Scholars who study aging in place understand home care and community care as distinct but interrelated concepts. They view the home as a place with defined boundaries that differentiate, for example, between home and unhome, or a homely feeling and unhomely feeling. In this chapter, I propose the term *institutional home* to describe the expansion of home that is present in community-based eldercare,

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understanding home as not bound to the private home but instead extending into the community. Based on my fieldwork in community eldercare in Beijing and Shanghai, this chapter examines how older adults experience and define these institutional homes. The results of my work indicate that community eldercare programs form institutional homes where the practice and meaning of home go beyond one particular space or setting. This is a hybrid process and structure that is shaped by various actors, including NGOs, older adults, and caregivers, who together create a hybrid space that redefines home and community. This chapter contributes to the literature on aging, home, and community eldercare.

Chapter 6 redirects attention to caregivers at community care centers to reveal the flip side of the institutional home: while providing a homely feeling for older adults, the institutional home can be a prison of love for caregivers. Recently, feminist geographers (Lawson, 2007; Massey, 2004; Popke, 2006; Raghuram et al., 2009) have called for research that contributes to a more ethical geography of care that is responsible to society. However, after thoroughly examining the care ethics of attentiveness, responsibility, competence, and responsiveness, this chapter argues that adhering to these ethics in caring relations often exploits caregivers, instead of contributing to a more just society. This chapter examines the nature of caregivers' work and provides three significant insights: (1) care ethics embedded in job requirements demand that caregivers conduct not only bodily and "dirty" work, but also emotional work; (2) the involvement of care ethics in care work establishes different social relations between caregivers and care-recipients, which produces a different subjectivity that blurs the boundary between life and work; and (3) the new subjectivity formed when operating under care ethics

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means that caregivers tend to be put in a prison of love, in which being ethical requires them to work long hours for low wages. By theorizing the ethics of care work from the three aspects, this chapter challenges the geography of care agenda that seeks to promote a care ethics of attentiveness, responsibility, competence, and responsiveness without adequate consideration of the complexities associated with these activities.

Chapter 7 summarizes this dissertation, highlights key findings, and suggests avenues for future research on community eldercare issues.

CHAPTER II

RESEARCH CONTEXT AND METHOD

Eldercare policy in China

On May 28, 2018, Chinese president Xi Jinping made a speech on aging issues in China to the Central Politburo of the Communist Party of China. According to Xi, older age is a critical period in life, during which people can lead a meaningful, productive, and happy life. He believes that the government should deal with the aging population effectively by improving their quality of life, granting them dignity, and protecting their rights, while at the same time promoting China's economic growth. In this way, eldercare could contribute to creating a harmonious society. In this speech, he articulated China's general principles of eldercare, including government leadership, society-wide participation, and the coordination of eldercare with economic and social development. The first section of this chapter describes the broad social welfare regime in China. The next section provides a brief account of Chinese eldercare policies from 2010 through 2018, including the state's rationale for its eldercare policies and the conditions that have facilitated the development of these policies. Finally, the last section examines specific policies issued by the governments of Shanghai and Beijing in response to the central government's eldercare policies.

Social Welfare Regime and Eldercare

China's eldercare policies must be understood in a historical context. Before the establishment of the People's Republic of China, home care was the primary eldercare mode. Older adults were highly respected, because they were seen as wise and experienced (Chen & Powell, 2012). Additionally, there was a prevalent belief in *yang er*

fang lao (养儿防老)[2]. It was widely believed that when unexpected events interrupted the intergenerational exchange, such as when someone had no children or there was a natural disaster leading to loss of life, the community could be depended on for help. The majority of childless older adults and the families in poverty could get help from their community. For example, even today some regions in China have public land set aside to provide support for those in difficulty (Cao, 2011).

After the establishment of the People's Republic of China, the social welfare system, known as the "Iron Rice Bowl (铁饭碗)," was constructed around egalitarian and collective values. The Communist Party promoted the work unit (单位)[3] and the family as the leading providers of eldercare from the 1950s to the 1980s. In 1955 the State Council of the People's Republic of China issued retirement regulations for government officials' mandating that work units and government sectors should implement a retirement eldercare system that provided the same social welfare for all retired government officials. In 1958 individual retirement regulations were issued to improve the welfare of older adults. Since then, China has established retirement regulations mandating that older adults' medical care, recreation, and other eldercare services are all the responsibility of their original work unit. In the case of "three no (三无)" older adults (those who have no income, no ability to work, and no children), the local government is required to provide financial aid and support services (Carrillo & Duckett, 2011). These

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[2] raise your children to take care of you when you are old

[3] *Work unit* designated a place of employment in China that linking individuals to the Community Party. Each work unit provided its own services, such as schools, hospitals, and so on.

"three no" older adults are sent to eldercare institutions invested in, managed, and staffed by the government. Thus, at the beginning of the second half of the 20th century, Institutional care providers like nursing homes were rare and functioned only as a supplement when other means of support were unavailable or insufficient for the need (Cao, 2011).

Social welfare reform was introduced in the late 1970s. By 1978, social welfare provided by state-owned enterprises (SOEs) had slowed national economic growth due to the large budget assigned for welfare services. Competition in the globalized economy led to the reform of SOEs as well as welfare reform (Smart & Smart, 2001). Social policies were developed that favored economic growth and decreased public expenditure, which reduced state welfare provision and increased the marketization of social services. Justified by the goal of "efficiency first, equity second," these reforms aimed to give SOEs a competitive advantage and generate economic growth. Nevertheless, by the 2000s, China faced a new economic mix: economic growth was slowed by social issues such as "labor shortages and rising labor costs, population mobility, environmental deterioration, an aging population, and rising income inequality" (Leung & Xu, 2015, p. 33). In response, the government issued a new "scientific development" model that prioritized quality over quantity in economic growth and attempted to reduce urban-rural disparities.

During this period, the government began to dismantle and privatize various public services, including social welfare programs. In urban areas, a labor contract scheme was established based on permanent, contract, and temporary work categories. This scheme also regulated the new pension system and unemployment insurance

program. The health insurance program was restructured so that it offered less coverage and relied more on patient fees (Leung & Xu, 2015). From 1980 to 1990 the proportion of the population receiving state welfare benefits dropped significantly (Smart & Smart, 2001). In rural areas, the commune, which had partially provided benefits like health care, were dismantled, as was the cooperative health insurance program, leaving many peasants without health insurance. Local governments' capacity to raise funds for social services also declined (Leung & Xu, 2015).

As a consequence of these policy changes, China embarked on a period of rapid economic growth marked by social instability. Some of the migrant workers who provided the labor for that growth went on strike to try to collect overdue wages (Chan, 2010a). Migrants demanded equal access to social services, many of which required resident status in urban areas (Chan, 2010b)). There were constant questions regarding the Communist Party's legitimacy, given its underlying ideological premise that a socialist society should be based on egalitarianism (Smart & Smart, 2001).

After the reform period, especially following the 1990s, unemployment, shrinking family size, and high citizen mobility led to families being less and less able to provide care for all family members. The concept of *yang er fang lao* faded, and care began to be professionalized, provided by the market. Eldercare services became more commodified, often delegated to hired housekeepers and nannies, many of whom later become employees of community eldercare companies. With reduced state responsibility for eldercare, families found themselves increasingly responsible for eldercare. Wealthy families tended to hire a female migrant worker or a laid-off state-owned enterprise worker to perform eldercare. In families that could not afford in-home elder caregivers,

female family members, such as daughters or daughters-in-law, became the primary caregivers. However, with the high mobility of children and the changing role of gender in family responsibilities, who should take care of China's older adults became an urgent question without a clear answer.

Intensified social instability, widening social inequality, extreme poverty, and environmental degradation led to a generally recognized third turning point in China's social welfare regime, the beginning of the push by the national government to create what it called a "harmonious society" in 2006. This phase marked the development of a welfare state with universal coverage of welfare services and need-based entitlements (Leung & Xu, 2015). A new social protection system was established, comprised of social assistance and social insurance programs, including old-age security, health care, unemployment coverage, work-injury insurance, and maternity benefits (Hong & Kongshøj, 2014). Minimum income security was provided to those who could not support themselves with employment income. Initially, the health insurance program included medical insurance for urban employees, urban residents, and a new rural cooperative medical program, providing "universal coverage with minimal benefits" (Hong & Kongshøj, 2014, p. 361). In 2010, policies with hukou (户口)[4] reforms were introduced that gave rural migrant workers access to the same social welfare services as people with urban hukou (Chan, 2010b).

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[4] *Hukou* is household registration in People's Republic of China. It was initiated in 1958 to tie people to specific residential areas, such as urban or rural. It is also tied to the social welfare system in China.

Eldercare Policies under the Current Social Welfare Regime

Current eldercare policies align with the welfare regime established in 2006, which provides minimum universal coverage with increasingly socialized welfare services provided by the private sector, such as NGOs, companies, and informal organizations, as well as families and individuals. This socialization of welfare mimics the welfare pluralism of capitalist societies (Leung, 2000). Four major themes have emerged in eldercare policies since 2010, revealing the state's rationale for its policies.

Healthy Aging

The first major theme that emerged from the recent policies is the concept of healthy aging. China adopted this concept from the World Health Organization (WHO, 2018), which defines healthy aging as "the process of developing and maintaining the functional ability that enables wellbeing in older age." Functional ability is understood as people's ability to "meet their basic needs; to learn, grow and make decisions; to be mobile; to build and maintain relationships; and to contribute to society." This healthy aging agenda promotes independent and healthy older adults, individuals who do not depend on others for caregiving. By promoting health, this agenda reduces the "burden" of eldercare on the government, family, and society. See chapter 5 for more information on healthy aging policies.

The healthy aging paradigm on the one hand promotes health among older adults, while on the other hand, it reduces the care burden on other sectors, such as family members and the local government. Xi Jinping also highlights the positive influence older adults can have on society by helping solve conflicts, maintaining social stability, remaining responsible for themselves, and making contributions, even as they age.

Family Responsibility

The second major theme undergirding current eldercare policies is the notion of family responsibility, revealed when the government issues various polices promoting family members as eldercare providers. Family responsibility was written into the 2015 Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly. This law states that older adults should primarily receive care from family members. Family members should respect, care for, and care about their family's older adults, which includes financial, emotional, and physical care. The law further states that if the younger family members live separately, they should frequently visit their older family members. Additionally, the law required the state to establish support systems for home and family care that would encourage family members to live with or near their family's older adults. One such support system was designed to reduce migration constraints, which would facilitate older adults' migrating with their family members.

These policies were repeated in the 12th and 13th Five-Year plans. The 12th Five-Year Plan highlights family responsibility by providing support for older adults to migrate with their family members, promoting family-based eldercare, and extolling the value of filial piety. The importance of family responsibility is further expanded on and explained in the 13th Five-Year Plan, which requires various government sectors to issue policies to support home and family care.

In 2018, to further facilitate homecare and family responsibility, Xi Jinping stressed that China needs to respect older adults by including eldercare in its socialist core values. He suggested highlighting the importance of eldercare and respect for older adults in China's major festivals, such as the spring and mid-autumn festivals. According

to Xi, respecting older adults is one of China's traditional virtues. Thus, Xi wants the Chinese people to accept family responsibilities, build positive family culture, and strengthen the family as the foundation for eldercare.

Shared Responsibilities with NGOs and Companies

The third major theme identified is sharing eldercare responsibilities with NGOs and companies. The state actively issues policies that encourage NGOs, private companies, and informal organizations to participate in eldercare. The 12th Five-Year Plan articulates that the government should guide society in participating in the eldercare service industry as a part of the socialist market economy. In this framework, the government provides policy support, financial support, market cultivation, and oversight to other organizations in order to adapt the market's ability to redistribute resources. In 2013 the State Council issued a policy to provide guidance on the government's purchase of eldercare services from the private sector. The policy requires the government to include the private sector in the provision of public services and expand the government's purchase of these services. The policy further stipulates that the government's role in providing welfare services may include issuing financial policies, as well as providing land acquisition support, tax reductions, and subsidies to NGOs and older adults for eldercare services. However, only expenditures related to welfare services that are the government's responsibility are to be included among the purchased items.

In 2014 the Finance Ministry issued a document to guide the government's purchase of services from the private sector. This document outlines the general principles of the government's purchase of services, including governmental guidance and market cultivation. The government is to guide and manage the process of purchasing

services from the private sectors, rely on the market to redistribute resources, encourage collaboration between the public and private sectors, and encourage professionalism. The government's purchase of services is to be conducted through competitive bidding to ensure equal participation and competition among social actors.

In 2014 the Civil Affairs Ministry issued another policy that focused on accelerating health and eldercare service projects. In this document, the Civil Affairs Ministry advocates loosening regulations pertaining to the private sector's participation in the eldercare industry. For example, private sectors are encouraged to participate in the eldercare industry through sole proprietorships, joint ventures, cooperation, equity participation, leasing, and so on. To further relax the private sector's access to the eldercare market, all areas are to be open to the private sector except those prohibited by law or other regulations.

In 2015 the Civil Affairs Ministry and several other national government ministries issued the *Suggestion for Encouraging Private Capital to Participate in the Eldercare Industry*. This policy encourages the private sector to participate in home care and community care services. Through the government's purchase of services and collaborative guidance, the local government is to encourage the private sector to run eldercare NGOs or companies to deliver home care services such as feeding, bathing, cleaning, urgent care, clinical care, and so on. Second, the policy suggests that the private sector establish institutional care facilities through a cooperative shareholding system. Third, the government seeks to persuade the private sector to participate in many different types of eldercare industries, such as entertainment, education, sports, tourism, health services, counseling, and legal services.

In October of 2016 the Ministry of Civil Affairs and the Ministry of Finance issued a document titled *Pilot Project on the Reform of Home and Community Eldercare* to promote collaboration between the government and the third sector (mainly NGOs) in providing home care and community care for the elderly. Specific state-NGO collaboration modes include eldercare services purchased by the government, eldercare services that are "state built and privately run with government support," eldercare services that are privately owned but subsidized by the government, and joint stock partnerships. The policy encourages a variety of organizations to operate homes and provide community eldercare services so that they become the dominant service providers.

The 2016 13th Five-Year Plan promotes collaborations between the public and private sectors, including companies, individuals, and volunteer groups. The 13th Five-Year Plan states that by the end of the five years, there should be just as many eldercare institutions run by the private sector as run by the government. The government is to purchase eldercare services and encourage professionalization for home care organizations:

> We should completely release the eldercare market, improve eldercare service quality, and speed up the release of control of this function. For private capital and organizations that want to establish eldercare facilities, we should further relax the conditions for admission, provide support . . . encourage the adoption of franchising, allow the government to purchase services, and encourage cooperation between the public and private sector to establish eldercare facilities. We should allow eldercare facilities to establish chains so they can create a scaled up and branded operation. (13th Five-Year Plan)

This privatization trend required the government to establish a legal framework to support eldercare services. A standardized legal framework still needs to be developed to manage the service organizations' quality and infrastructure.

The privatization of eldercare services mainly occurs in collaboration with local governments and depends greatly on the local governments' attitude, budget, and context. In 2012, the Shanghai Civil Affairs Bureau issued its 12th five-year plan for the eldercare industry in Shanghai. This plan highlights the importance of cultivating chained, branded eldercare NGOs. Shanghai's 13th five-year plan promotes the growth of welfare services and the marketization of eldercare. By the end of the 13th five-year plan, Shanghai should have more than 500 newly built community eldercare institutions and 200 new comprehensive eldercare centers.

Similarly, the Beijing government issued homecare regulations mandating that the local community should establish a community eldercare station with an operating company run by micro-profits with the government's financial support. In May 2016 the Aging Committee in Beijing issued ten regulations on homecare development, which establish standards for community eldercare stations. Under the regulations, each district government must provide nonprofit services through resource management as well as through mobilizing other organizations to operate eldercare services with a low profit.

Minimum Universal Standards

The last major theme present in the examined policies is the idea of minimum universal standards. China's 12th Five-Year Plan stipulates that older adults with the lowest standard of living should be provided with a subsidy. China intends to develop an eldercare welfare system that is universally beneficial. The 13th Five-Year Plan further

articulates minimum universal standards by establishing an older adult assessment system to evaluate the status of all older adults' families, health, and finances. Local governments are to guarantee basic public services, pensions, and basic health care. In 2015 the newly issued Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly states that more effort should be made to deliver services to those in difficult circumstances to ensure that everyone receives basic services. It directed the government establish a national subsidy system for the oldest adults in financial difficulty and those with disabilities. Financial subsidies were also to be provided through local governments. Subsidies for older adults were connected to reducing poverty. In the case of older adults who are unable to work, have no income, no breadwinner in the home, and no children, local governments were directed to provide eldercare or help by following related regulations. Local governments were also to provide support for homeless people and abandoned older adults

In 2014 Shanghai's Civil Affairs Bureau issued a policy titled *Implementation of Shanghai Homecare Service Regulations*. This document defines the subsidy amount that can be provided to older adults, including service coupons. In 2016 the 13th five-year plan issued by the Shanghai government required the Shanghai government to protect itself financially by focusing primarily on disabled and diseased older adults, as well as the oldest adults living alone.

Table 1. Chinese National Eldercare Policies

Date	Policy name	Agency
2008	Recommendations for Advancing Community-based Eldercare Services	National Aging Office, Ministry of Civil Affairs
2011	12th Five-Year Plan for Elderly Social Service System Construction	State Council
2013	Notice of Accelerating the Development of Services for Older People by the State Council	State Council
2016	13th Five-Year Plan for the Civil Affairs Minister	Ministry of Civil Affairs, National Development and Reform Commission
2016	Pilot Project on the Reform of Home and Community Eldercare	Ministry of Civil Affairs Ministry of Finance

The four general themes present in these Chinese eldercare policies illustrate the

broader social welfare regime in contemporary China—reminiscent of welfare pluralism

in capitalist societies—which promotes minimum universal coverage and dispersal of the

responsibility for public welfare to society, families, and individuals. Because of these

supportive policies, more and more community eldercare programs have been

established.

<div align="center">The Chinese Eldercare Landscape</div>

Currently the eldercare landscape in China consists of three main parts: home-

based care, community-based care, and institution-based care. Home-based care refers to

family members' financial, daily living, and emotional care of their older relatives. To

rescale the caring responsibility to families, the Chinese government has recently begun

to stress Confucian values, which call for respecting and taking care of the elderly (Chen

& Powell, 2012). The Elderly Rights Protection Law states that "eldercare mainly relies on the family; a family member should care for and support the elderly." This approach to home-based care means that children provide the necessary care resources when an elderly parent remains at home. This set-up is not monodirectional: it is typically characterized by intergenerational exchanges, such as older adults providing childcare for their grandchildren and doing some housework while the adult children provide eldercare services. Even though the prevalence of home-based care is decreasing with shrinking family sizes, it remains the primary eldercare mode in China.

Institution-based care means that the eldercare is provided in some form of institutional setting, such as a social welfare institution. Historically, this kind of eldercare has been reserved for older adults who have no children, or at least no children who can take care of them. Older adults in this situation could potentially be stigmatized for being abandoned by their children. Indeed, historically, older adults receiving institutional care were stigmatized because of its association with having unfilial children. However, with the one-child policy and the high mobility of children, institutional care is becoming increasingly acceptable (Feng et al., 2011).

In some cases, being able to enter a luxury eldercare institution is becoming a symbol of social status. In 2014, the Taikang Insurance Company established several continuing care retirement communities (CCRCs) with an initial membership fee set at 2 million Chinese yuan ($300,000). The memberships sold out quicky. Since then, many insurance companies have begun to follow Taikang's example for building CCRCs targeting wealthy older adults. These luxury CCRCs erase the stigma attached to institutional care to a certain degree (Chuin-Wei, 2018).

Besides home-based and institution-based eldercare models, there is also community-based eldercare, the eldercare model at the center of this dissertation. China first initiated community-based eldercare programs on the national level with the Starlight project in 2001. It is supported by the lottery fund, government budget, and other types of investment. The Starlight project provides in-home care, urgent help, daycare, physical therapy, and recreational activities (Chen & Han, 2016). However, community eldercare has been the most controversial mode of eldercare, as people argue that the boundaries between home care, community care, and institutional care are blurred and vague in a community-based model. As a organizer stated at a workshop sponsored by Youzi Eldercare in 2017 in Beijing,

> We all know what institutional care is; we just need to improve the service. We also know that home care was previously just a housekeeping service. They just changed the name. But what is community care? If I have some beds there, isn't that institutional care? If I deliver service to a private home, then isn't that home care? What's the boundary between community care and home care?

> Even in government policies, the boundaries between community care, home care, and institutional care are unclear. Drawing on my fieldwork and participation in various community conferences, I view community care from the geographic perspective, which understands that community care is care provided in the community. It is quite varied and diverse as it is shaped by the local community.

Community eldercare can be divided into three types: small institutions, comprehensive eldercare centers, and in-home care delivery centers. Small institutions refer to those that allow overnight stays. These small institutions are called eldercare centers in Beijing and senior care homes in Shanghai. They usually contain 15 to 20 beds. According to the head of Shanghai's Civil Affairs Bureau, speaking at the ChinaAid

conference in 2017, the senior care home is designed to provide respite care for people with special needs that are beyond their family's capacity to meet, such as care after surgery. Older adults admitted to these small institutions tend to be less active and more dependent on others. Each small institution has approximately 3 to 10 professional caregivers.

Figure 1. Community eldercare institution in Shanghai. Photo by author.

The second type of community eldercare organization is the comprehensive eldercare center, which provides daycare in the form of activities and physical therapy. A typical comprehensive eldercare center usually has multiple functions, such as providing an affordable lunch, delivering lunch to older adults' homes, rehabilitation activities, continuing education courses, and sometimes health clinics and pharmacies. The comprehensive eldercare center aims to integrate eldercare resources in one location for

the convenience of older adults.

Figure 2. Dining room and activity room at a comprehensive community eldercare center in Shanghai. Photo by author.

The third type of community eldercare organization is the in-home care delivery program, where professional caregivers provide care in older adults' homes. These caregivers contract with the NGOs and are dispatched to the homes of individual older adults to perform required care services. Older adults apply for in-home care apply at the local NGO office. After a series of assessments, including a physical examination and an assessment of their family's socioeconomic status, the NGO determines the number of service hours that the older adult is qualified to receive and caregivers are dispatched for a specific number of hours each week.

These three types of community eldercare organizations have some similarities. First, they are all community-based with the goal of serving the elderly within the area, usually through a street office's[5] administrative domain. Second, they share the same goal of accommodating the elderly who live in private homes—even the small institutions aim to provide rehabilitation to help older adults return home. As such, community care does not seek to take complete responsibility for the older adults' care; instead, it aims to provide supplementary support and supplementary care to the various types of care that can be provided at home.

<center>Methodology and Data collection</center>

This section introduces the methods used in this research and the data collection process. From April to October 2017, I conducted six months of fieldwork in Beijing and Shanghai, including participatory observations in community care centers and non-participatory observations at the homes of older adults. I took field notes during these site visits. I also conducted interviews and surveys with both older adults and caregivers to investigate why older adults choose to attend community care and the experience of giving and receiving care. Last, I conducted interviews with the NGOs running the community care facilities. These interviews allowed me to better understand the dynamics between the state and NGOs in community service and community building. I include the approval from the University of Oregon's Institutional Review Board ("Human Subjects") in the appendix.

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[5] The street office is the lowest level of government in the Chinese administrative system.

Study Site: Community Eldercare Centers in Beijing and Shanghai.

The research was carried out in two cities, Shanghai and Beijing. Shanghai is the oldest city in China and has the largest rapidly aging population (Chen & Han, 2016). By the end of 2015, more than 30% of the city's population was over 60 years of age, and a majority of this group was comprised of parents of the one-child generation (Chen & Han, 2016). In part because of this, eldercare as a family function has also dramatically eroded in urban areas like Shanghai. Facing the difficulties of institutional care, particularly issues of filial piety, lack of supply, and affordability, the Shanghai government is pursuing long-term community-based care as an alternative.

In 2007, the Shanghai government issued the "90-7-3" framework: 90% of the elderly should receive care at home, 7% from the local community, and 3 % from various eldercare institutions. The 90% of the elderly who age at home will also use community-based eldercare services. Under this plan, community eldercare centers will cover 97% of the elderly, which is an efficient, affordable way of providing eldercare while not conflicting with the idea of filial piety. Shanghai's innovation in providing welfare could potentially be replicated in other Chinese cities (Chen & Han, 2016).

In 2012, the Shanghai Civil Affairs Bureau issued the 12th five-year plan for the aging industry in Shanghai. In this plan, the government summarized the current state of eldercare as the 90-7-3 framework took shape. By the end of 2017, community eldercare was to have covered 300,000 people (7% of older adults) and 100 daycare centers and 200 dining halls were to be built. Under the plan 30,000 to 40,000 older adults should have access to at least one daycare center and several dining halls. Other community eldercare services were to include assistance with dining, bathing, cleaning, mobility,

medical needs, and urgent needs. In this plan, the government also highlighted the importance of cultivating chained, branded eldercare NGOs.

In March 2016 the Shanghai Aging Commission issued a policy called *Promotion of Comprehensive Community Eldercare Services* highlighting the importance of comprehensive eldercare service centers and promoting the commission's role in integrating resources at one center. In October 2016, the Shanghai Civil Affairs Bureau issued the 13th five-year plan, outlining the ultimate goals for older adults: eldercare, medical care, learning ability, participation and engagement, and recreational ability. The plan set out several principles for eldercare: (a) The government, families, and society share the responsibility; (b) prioritize protection of older adults with disabilities or illnesses and the oldest old who live alone; (c) promote welfare services and marketization of eldercare together.

In 2017 Qinhao Zhu, head officer of the Shanghai Civil Affairs Bureau and director of the Aging Commission, delivered a speech on eldercare. According to Zhu, the traditional mode of providing eldercare at home cannot satisfy the current need, and due to the high population density and high cost of land in establishing eldercare institutions, Shanghai needs to explore a new path for taking care of the city's elderly. Community-embedded eldercare could integrate resources, provide support and protection for families. Also, community-embedded eldercare promotes aging in place, which is in line with the tradition of homecare and increases elderly peoples' willingness to participate in the program.

Table 2. Selected Shanghai community eldercare policies

Date	Policy	Agency
March 2012	12th Five-year Plan for the Aging Industry in Shanghai	Shanghai Civil Affairs Bureau
April 2014	Implementation of Shanghai homecare service Regulations	Shanghai Civil Affairs Bureau
August 2015	Community and Home Eldercare Services Regulations	Shanghai Civil Affairs bureau Shanghai Aging Commission
March 2016	Promotion of Comprehensive Community Eldercare Services	Shanghai Aging Commission
October 2016	13th five-year plan	

Beijing

I chose Beijing for my fieldwork because it was designated as the experimental site for implementing community eldercare facilities. Beijing has a relatively large aging population, with around 3.2 million adults over 60 years old (24.1% of the total population). Similar to the 90-7-3 framework in Shanghai, Beijing issued a 90-6-4 framework. From 2016 to 2017 Beijing tried to provide community eldercare centers with 0.62-mile service zone and community eldercare institutions with 1.86-mile buffer zone. At the local and township level, there are 208 newly built community eldercare institutions, 252 government sponsored newly built community eldercare institutions, and 350 community eldercare centers. In 2015 and 2016 Beijing established 763 dinning centers for older adults. However, unlike Shanghai, Beijing's eldercare services are mostly undertaken by state-owned enterprises. I will discuss this more in chapter 3.

Beijing's homecare service regulations were issued in January 2015 by the 14th Beijing Municipal People 's Congress. These rules promote comprehensive eldercare service centers that provide various services in one location. Financed by the government and privately run, services in each community eldercare center were to be established by collaborating with the street office's eldercare nursing center, bringing in a professional eldercare management team, and establishing a service platform to meet the demand and ensure supply. This document specified the essential functions and services that should be provided by community eldercare stations, include daycare, disability assistance, responding to calls, health monitors, recreational activities, and psychological counseling. These community eldercare stations are supposed to provide convenient, fast services for the elderly. This policy regulates the role of community eldercare stations, serving as a model for establishing, operating, and monitoring community eldercare services.

In November 2015 the Beijing Planning Bureau and the Civil Affairs Bureau issued the Special Plan for Old-age Service Facilities in Beijing. The primary objective of this plan is to mobilize various resources to improve community eldercare facilities, with the goal of providing medical and nursing care, rehabilitation, health management, and mental care for the elderly dwelling at home. In this document, the Beijing government envisioned that by 2016 Beijing would establish 150 community eldercare stations in six districts across the city. By 2020 Beijing is to have 1,000 community eldercare stations covering 6% of the elderly. In July 2016 the Aging Committee in Beijing issued its Suggestions for Developing Community Eldercare Centers, which specifies the function, planning, supportive management, and establishment procedures for community eldercare.

Table 3. Selected Beijing community eldercare policies

Date	Policy	Agency
January 2015	Beijing Homecare Service Regulations	14th Beijing Municipal People 's Congress
November 2015	Special Plan for Old-age Service Facilities in Beijing	Beijing Planning Bureau
May 2016	Ten Regulations on Homecare Development in Beijing	Beijing Aging Committee
July 2016	Suggestions for Developing Community Eldercare Centers	Beijing Aging Committee

Institutional Ethnography and Discourse Analysis

First developed by Dorothy Smith (1987, see also 2005) as a feminist approach,

institutional ethnography (IE) examines social relations, daily practices, and knowledge

production within specific institutional arrangements (Billo & Mountz, 2016). As a

methodology, institutional ethnography examines everyday practices on a micro level and

their relation to macro-level institutional arrangements (Smith, 1987). IE is both

epistemologically and ontologically appropriate for this research because it recognizes

that the daily life of both the older adults and their caregivers' are directly influenced by

institutions at a macro level, including national policies regarding aging issues. However,

there is more to say about these issues than what is captured using the traditional

institutional-ethnographic approach, even though it studies the micro, people's everyday

life.

Institutional ethnography aims studies how individuals relate to the broad social,

political, and economic context and how the broad context, institutions influence people's

everyday life. As a theory, IE concentrates on the one-directional flow of macro

influences on the micro level as reflected from the perspective of the individual. What is missing in this approach is individuals' agency, ability, or potential to resist or transform the macro through everyday practices—in this case, the practices of older adults and their caregivers. While highlighting the dialectic process, I recognize that it contains a certain unilaterality, where the macro has more influence on the micro (Lefebvre, 1991). Moreover, both the macro and the micro could achieve a certain stability in the process of becoming.

In this research, I study the everyday life of caregivers and older adults as they use the institutional home. While so doing, I was able to witness the introduction of the healthy aging principles in community settings where eldercare services are provided and their influence on the older adults and their caregivers' everyday practices. In turn, I was able to investigate the older adults and caregivers' performance in their usage of the community center and its potential for transforming the function of the community eldercare centers and the "healthy aging" principles. In this research, the institutional ethnographic approaches will allow me to focus on the micro level while keeping the macro level under consideration.

In the description of my application of IE, first, I interpret community eldercare programs as institutions that mediated different actors' everyday life. Here, I follow Billo and Mountz (2016) by taking institutions as constituted by everyday practices where through the everyday life, the constraint by the organization and the challenge people brought to the organization get revealed. Second, I pay attention to Texts that have generalizing effect on different actors' behavior and everyday life. According to Smith, "it is texts that coordinate people's activity across time and place within institutional

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relations (Smith, 2006, p. 21)". These texts include the government and NGO documents in advocating aging in place and healthy aging.

My attention paid to Text is also related to discourse analysis. Discourse analysis has been well-established within geography as a method to interpret ideas and speech in specific contexts (Waitt, 2010). While many scholars claim to use the methods of discourse analysis, many do not articulate which type they employ. Dittmer (2010) argues that there are three kinds of discourse analyses. The first, linguistic analysis focuses on language structure while the second, Gramscian analysis, follows Marxian cultural theory to concentrate on the way hegemonic ideology shapes a particular discourse. Finally, Foucauldian discourse analysis embraces the intersection of multiple structures of power/knowledge in shaping particular subjects rather than target one, hegemonic, ideology. Of the three kinds of analysis, Foucauldian discourse analysis is most appropriate for the objectives of this research, in that it opens more possibilities when faced with complicated empirical situations that are constituted with various kinds of discourses.

In this research, the state-NGO collaboration shapes the dominant discourse, while caregivers, individual NGO workers, and individual government officials in the eldercare program also produce certain discourses that influence the eldercare provision and the older adults and caregivers' everyday practice. Employing Foucauldian discourse analyses allows recognition of the major power dynamics, while not denying the agency of other possible discursive and non-discursive elements and processes. In its use of this approach, this research embraces the complicated web of power in the field of eldercare within Chinese community eldercare programs.

Positionality

My own experience of eldercare is limited to memories of sitting by my grandfather and grandmother's hospital beds and watching my parents pace around the room anxiously. My only role was to not to bother the adults, who were busy, exhausted, and sad. This stage went on for several months and then my parents fell into deep feelings of guilt. I constantly heard my father saying, "Your grandma wouldn't have died so early if she had received better care in a better hospital." Several years after my grandparents passed away, we moved to Beijing, the second largest city in China. This migration, according to my father, was a pursuit of better hospitals and better health care services. From my experience, eldercare was a major task that involved exhaustion and emotional work for family members. These personal experiences influence my understanding of caregivers' work, elder care, and older adults. While this research tries to capture what people said, it is interpreted through me. As such, the knowledge I produced in this dissertation is situated in and influenced by my positionality as both insider and outsider.

Doing fieldwork in Beijing and Shanghai on community eldercare issues has advantage and challenges. My native proficiency in Mandarin, and Chinese citizenship render the social and cultural contexts of my research more transparent and accessible. With family members in Beijing and four years of university in Shanghai, I was familiar with Chinese sociocultural norms. In many ways I was an insider, which helped me gain access to community eldercare centers and older adults. I easily merged with the social workers or the caregivers working at the community eldercare centers.

While identified as an insider, I found myself in the position of an outsider as well in many circumstances. My lack of connections with the community I was studying and sometimes my poor understanding of the local dialects, especially in Shanghai, often made communication difficult and meaning was lost in the conversation. This was especially true with the oldest of my interviewees, who were in their 90s. Two older adults in a Shanghai community eldercare center were eager to talk to me, but I simply could not understand them, either because they only spoke Shanghai dialects, or because I was not used to the way they talked.

The boundary between inside and outside is not fixed (Mullings, 1999). This is especially true when considering the multiple worlds that people live in. When I interacted with older adults, age was the most important factor that differentiated us. They were more willing to talk to me after seeing me help social workers organize activities. They give me gifts and invited me out for lunch. One older adult kept in contact with me after my study and messages me occasionally. I feel obligated to reply, to report on my progress, and send her greetings. In some cases, I was perceived as one of the caregivers or social workers. I was constantly asked to deal with eldercare issues. For example, one day I was asked to perform physical therapy at an eldercare center. I had to explain that I wasn't a physical therapist.

When I interacted with social workers, I was simultaneously insider and outsider. As an insider, the community NGOs included me in things such as organizing activities, helping the older adults, and preparing documents for government evaluations. I could get involved with this group easily as we shared a similar education and background and we were closer in age. To them, I was someone who provided free labor, maintain order

in the community center, and write reports to the local governments to advocate for more resources. At the same time, I was an outsider. After I left I was removed from their group WeChat. I was excluded from some types of meetings as I simply didn't fully belong to the group of social workers.

Interaction with caregivers was more complicated as we were all outsiders to the city, but they saw me as someone who could not be relied on for providing care. During my time at the community institutions, caregivers continually asked me to sit and chat with the older adults. But they wouldn't ask me to do other kinds of work as they thought it might not be appropriate or I might not be willing to do it. I found the caregivers either not willing to talk about their work as dirty work, or they were eager to talk about it in the way they had been instructed to talk about it by their supervisors. Each interaction told me something new. While organizing and analyzing the data I constantly wondered whether I was really understanding what they said. Was I interpreting their words in the right way? Was I hearing the opinions of the caregivers or the NGO managers?

This dissertation is limited by my lack of direct access to government officials. I compensated for this by participating in talks delivered by those officials, such as the leaders of National Ministry of Civil Affairs and of Shanghai Civil Affairs, the president of the National Commission on Aging, and local government officials. On the one hand, these talks revealed officials' attitudes toward aging and eldercare; on the other hand, they were limited by the context and conference setting and their intended audience of mostly eldercare companies and NGOs.

Data Collection

The main research methods used for this dissertation were document reviews, interviews, observations, and surveys. In total I interviewed 70 individuals, including 19 NGO managers, 23 older adults, and 28 NGO caregivers, to learn their views on community care. My approach to institutional ethnography (IE) mainly included (1) following NGO workers, older adults, and caregivers as they carried out their activities in the community eldercare centers and (2) and "getting at the inside" (Billo & Mountz, 2016) via interviews with those same individuals, who I perceived as insiders in the community eldercare programs.

IE involves three steps: "(a) identify an experience, (b) identify some of the institutional processes that are shaping that experience, and (c) investigate those processes in order to describe analytically how they operate as the grounds of the experience" (Smith, 2006, p. 20). By interviewing NGO workers, older adults, and caregivers I identifed their experience of community eldercare programs and how their experiences were shaped by the broader picture of State policies on eldercare, the government's healthy-aging agenda, and care work regulations. The interviews allowed me to get to know different actors' attitudes, perceptions, and experiences of community eldercare programs and helped me form new research questions. My access to NGO managers was facilitated by employees who work at the social organization association in the Jing'an District in Shanghai. This organization has the contact information of all NGOs involved in community eldercare services in the district. Ultimately I interviewed NGO leaders recommended by the organization's supervisor. The selection of NGOs thus depended on the supervisor's connections and how she ranked them. These NGOs leaders

tend to be very passionate about community eldercare programs and creating new services. For example, one NGO leader initiated the later famous "older partner plan" in Shanghai, which encourage the young old providing care for the old old.

I located other NGO leaders who participated in my study at conferences, one held at Tsinghua University and the other at the annual China Aid elder care trade show in Shanghai. These NGO leaders responded to my calls for research participants in WeChat groups (a social media app popular in China). They seemed passionate about community eldercare programs and hoped to get new information from my study. For example, one NGO leader allowed me to conduct non-participatory observation in his community eldercare center. I also helped him do research on his eldercare facilities and I submitted a report to him on caregivers' work situation.

I primary questioned the NGO managers about how they collaborated with the local government office (mainly the street office level), asking questions such as: Who finances the eldercare facilities? How are they controlled by the local government? What kinds of services do they provide at their community eldercare centers? Who are the older adults who frequent their centers? What are the expectations for the older adults, social workers, and caregivers? Do they understand the community eldercare center as public or private? What kind of spaces were they trying to create in the community for older adults? How do they deal with conflicts among older adults? By asking these questions, I aimed to understand state-NGO relationships, the ideology that the NGO adopted in operating community eldercare centers, their requirements of caregivers, and their intentions in shaping the aging processes.

Second, I interviewed 23 older adults. I gained access to them at the community eldercare centers where I volunteered. I gathered information principally from three community eldercare centers–-one in Beijing and two in Shanghai. The selection of the three community eldercare centers depended on obtaining approval for my research from the NGO managers. These three community eldercare facilities were all located in the central business district, where housing is very expensive. In these cases, most of the older adults who frequent the community eldercare centers are relatively better off socioeconomically. The Beijing center is located in Chaoyang District, near a well-known hospital. Approximately eight older adults who are severely ill or disabled live there. I interviewed only one resident there who did not have dementia. The other older adults I interviewed at this facility came to participate in activities. They were all female, active, and of relatively high socioeconomic status.

The two community eldercare centers in Shanghai are operated by three different NGOs. The first one is referred to as a comprehensive eldercare center and is located in Jing'an District. It is run by two NGOs jointly, with one being responsible for lunch and activities and the other for the daycare room. Older adults who come to the center for lunch or activities are more independent and active. Although the older adults here are a mixture of men and women, those who participated in my study were mostly women and were eager to talk to me. These older adults tend to come from working-class families that have lived in the neighborhood for 30 or 40 years or more. The other community eldercare facility in Shanghai is located in Putuo District and specialized in institutional care. Older residents here have minor disabilities or busy family members.

In my interviews with the older adults, I asked why they chose to go to a community eldercare center rather than staying home or going somewhere else. What do they do every day? Who do they interact with most frequently? Did they make any friends at the community eldercare center? Do they participate in any kind of volunteer work at the center? With these questions I wanted to learn about their participation in the activities organized at the centers, and their homemaking practices.

I also interviewed 28 caregivers, primarily at two eldercare facilities, one that provides institutional care in Shanghai and one that sends professional caregivers to older adults' private homes. I interviewed every caregiver employed at the first facility. Some were eager to talk to me, to know my background, and to relate to me by talking about their experience at the facility. Other caregivers were very shy and did not talk very much in response to my questions. At the second eldercare facility I only interviewed caregivers recommended by the manager. The recommended caregivers tended to outwardly express their passion for caregiving practices, or told me what their managers told them to say. The questions I asked the caregivers included: Do they form connections with older adults in their care? How do they perceive their work as bodily work and dirty work? Do they communicate with the older adults? What are their topics of conversation with them? How long have they been caregivers? Why did they decide to be caregivers?

In addition to the interviews, I conducted both participatory and non-participatory observations while working as a volunteer at several community eldercare centers. I mainly helped organize activities with older adults, including teaching them cell phone skills, doing craftwork, and taking part in some major festival events. Through this

participation I worked closely with older adults and other social workers, which allowed me to better understand the mechanisms and major issues at the centers. For my non-participatory observations, I accompanied caregivers to the homes of older adults who were more ill and fragile. The service content switched to bathing, physical therapy, and other services that required professional knowledge. To reduce risk to my research participants and avoid interrupting the caregivers' work, I generally sat quietly in a corner and observed. In these observations I tried to be attentive to the "emotion, subjectivity, power struggles, [and] resistance" manifested in the caregiving work (Billo & Mountz, 2016, p. 213). For example, while some caregivers tried to show me their good relationship with the older adults by acting as a host and inviting me to sit and chat at the older adults' home, the older adults sometimes politely told us to leave and showed their authority over their own homes. In these cases, I considered that the caregivers' description of their intimate connection with the older adults was not trustworthy.

Finally, I conducted surveys with 126 caregivers and 106 older adults. The purpose of the survey was to get an understanding of the demographics of older adults who frequent community care facilities and caregivers. The caregivers' survey was conducted at five major eldercare facilities in Beijing. They were distributed and collected by the manager at each of the facilities. Based on the findings from the survey, I wrote a report for the caregivers' managers on how to improve caregivers' working conditions and reduce the high turnover rate. The survey of older adults was also distributed to 106 older adults by the manager at one community care center. Hence, the survey reveals the use of and attitudes toward one particular center. I wrote a report for the manage on the usage of the care center and how to improve its services.

The interview transcriptions were imported into NVIVO for content and discourse analysis. I recorded most of the interviews and transcribed them later. Some of the interviews were recorded by taking notes; in those cases, some information was lost as I did not have enough time to take notes on everything. In other cases, the caregivers were very busy and talked to me while providing caring services. I coded the interviews into major themes and broke those down into major topics. I then connected the interview data with the broader picture it revealed, such as the social welfare regime, or the healthy aging promoted at the community center. I only translated the interviews quoted in this dissertation.

CHAPTER III

GOVERNING THROUGH THE NGO

Introduction

In 2015 Han Zheng, Communist Party chief of Shanghai, gave a speech

mandating that all local government offices should stop focusing on attracting investors

and instead focus on providing management and services. These offices are at the very

bottom of China's administrative hierarchy, but they play a significant role in bridging

the Chinese state and local residents. Thus Han Zheng indicated that local governments

should mobilize the community to take part in community service. One major community

service that street offices take responsibility for is eldercare. Shanghai is the most rapidly

aging city in China, with more than 30% of the population over age 60. Facing such a

large, rapidly aging population, the city government in Shanghai has been actively

collaborating with nonprofit and nongovernmental organizations (NGOs) to provide

eldercare services at the community level. This collaboration raises interesting questions

about the state-NGO relationship and the role that NGOs play in outsourcing welfare

services.

This chapter builds on two bodies of literature: studies on the state-NGO

relationship in China and examinations of how NGOs promote neoliberalism. The

literature on the state-NGO relationship in China mostly focus on the NGOs' lack of

autonomy, depicting a strong government that strictly controls NGO activities (Spires,

2011; Tang & Man, 2008). Recently, scholars have noticed a shift toward more

collaboration in this relationship, especially at the level of local governments. This shift

has occurred within a broader trend of the Chinese government toward more service-

oriented functions, coupled with a decentralization of welfare services. While the autonomy of NGOs is important, this body of literature has neglected the outsourcing of welfare services (accomplished in part by NGOs) as well as the potential role that NGOs play in facilitating governance.

The role played by NGOs in spreading neoliberalism has been theorized in Latin American, African, and South Asian countries. With reductions in the state's provision of welfare, NGOs have stepped in to fill the gap (Harvey, 2007; Karim, 2008; Petras, 1997; Walker, Roberts, Jones, & Frohling, 2008). In these cases, NGOs sponsored by the World Bank or the International Monetary Fund (IMF) initiate self-help projects that aim to cultivate private responsibility among people who are unemployed of in poverty. Instead of challenging the neoliberal agenda, these NGOs facilitate neoliberalism from below by cultivating neoliberal subjects, which also undermines the local community's ability to take collective action (Petras, 1997). Moreover, receiving funding from the World Bank or other government sectors depoliticizes the NGOs and leads them to develop toward professionalism (Kamat, 2004). Inspired by this body of work, this chapter argues that in China, the provision of welfare services by NGOs enables the state to gradually transfer social responsibilities to the NGOs and to require them to cultivate an eldercare market.

Besides increasing privatization, sometimes NGOs in other countries constitute a shadow state that conducts social engineering projects (Karim, 2008). Although the NGOs in mainland China facilitate certain population governance agendas, they cannot be understood as shadow states as they are controlled by the government. Paying attention to the specific social, political, and economic context in China, this chapter argues that NGOs help the local government to govern. As required by the local

government, NGOs involved in community eldercare gather information about the community's residents, including their needs, difficulties, well-being, and family relationships.

Contracting out community eldercare services to NGOs creates entrepreneurial urban governance. Harvey (1989) classically describes public-private partnerships as a type of entrepreneurial approach to urban governance. Adopting this strand of thought, Fulong Wu (2002) and other scholars (Bray, 2006; Lee & Zhu, 2006; Ye & Bjorner, 2018; Zhang, 2017; Zielke & Waibel, 2014) have discussed urban governance in China, characterized by an autonomous local government and interurban competition. However, this scholarly discussion focuses primarily on economic activities and ignores noneconomic activities, such as eldercare and the role played by nonstate actors in facilitating governance. On the one hand, the NGOs providing community eldercare services offer local governments a tool for urban governance, and on the other hand, they also cultivate a profitable market for eldercare services.

This chapter has two objectives. First, it analyzes the state-NGO collaborations involved in establishing community eldercare programs in Shanghai and Beijing, with a focus on finances, operations, and assessment. In so doing, this chapter unpacks the government's attitudes toward community eldercare NGOs. Second, it examines the NGOs' rationale for collaborating with local governments, and their effort to cultivate the eldercare market. The chapter argues that instead of forming a civil society, the NGOs providing community eldercare services constitute a tool for entrepreneurial urban governance by outsourcing welfare services and facilitating governance in the local community.

The first section of the chapter reviews two bodies of literature: scholarship on the state-NGO relationship and research on NGOs' contributions to neoliberalism. By bridging these two bodies of literature, this study examines the entrepreneurial urban governance created by state-NGO collaborations at the community level. Then, the chapter discusses community eldercare from two perspectives: the government's collaboration with and control of NGOs and the NGOs' marketization efforts. Finally, the chapter discusses the entrepreneurial urban governance that has emerged thus far from the community eldercare programs. The conclusion summarizes the findings and highlights the chapter's contributions.

Literature Review

State-society relationships in China depend greatly on the type of NGO and sector of the government involved. To capture such diverse state-NGO relationships, Kang and Heng (2008) developed a "graduated control system" to categorize the different ways that states control NGOs. This categorization system is based on the public goods that NGOs provide and their ability to challenge the state. For example, environmental and labor-focused NGOs normally receive international funds and have a specific agenda, either to protect the environment or advocate for human rights (Howell, 2015; Tang & Man, 2008). Some of these NGOs' work is political in nature (Tang & Man, 2008) and may be perceived as a threat to the state (Spires, 2011). In contrast, NGOs that focus on providing welfare services, especially for children and older adults, tend to enjoy a more positive relationship with the government (Tang, 2018). NGOs that receive funding from the government tend to form a closer, collaborative, and mutually beneficial relationship with the local government (Howell, 2015; Spires, 2011; Yang & Alpermann, 2014).

Collaborations between the state and NGOs largely rely on the decentralization of welfare and the degree to which providing for local welfare is associated with career promotions for local government officials (Teets, 2013). The current social welfare regime in China involves several sectors: the state, the market, NGOs, and the family (Wong & Leung, 2012). This new social welfare regime came into being after a call for the "socialization of social welfare" by the Ministry of Civil Affairs in 1998, which aims to include nonstate actors in welfare services. The dismantling of the work unit transferred the responsibility for urban welfare services to the community (Leung, 2000). Therefore, a combination of vertical and horizontal methods of providing for welfare emerged. Vertically, social welfare is sponsored and financed through hierarchical administrative government channels. Horizontally, it is provided through neighborhood resources, which depend on the local government and the local economy (Leung, 2000). Hence, the social welfare system in China is increasingly fragmented and highly dependent on local government (Huamin & Yeqing, 2006; Wong, 2005).

Contracting out social welfare services follows the neoliberal trend, as Harvey (2007) writes: "The rise of advocacy groups and NGOs has accompanied the neoliberal turn and increased spectacularly since 1980 or so. . . [It] "amounts to privatization by NGO" (Harvey, 2007, p. 177). In some contexts, scholars discuss NGOs' connections with the World Bank and IMF in facilitating a neoliberal agenda (Karim, 2008; Mercer, 1999; Petras, 1997). These NGOs facilitate "neoliberalism from below" by implementing self-help projects and employment training for people in poverty. These marginalized populations are transformed into neoliberal subjects, which undermines their ability to take collective actions that challenge the neoliberal regime (Pertras, 1997). Moreover,

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these self-help projects cultivate a sense of private responsibility to solve social problems, which aligns with a reduction in the state's provision of social welfare.

In China, the changing social welfare regime also gives NGOs opportunities to participate in providing welfare. However, there is a lack of theorization on NGOs' positive relationships with the government and their connection with neoliberalism. Current discussions of NGOs' participation in welfare services focuses on their autonomy or the emergence of a civil society. For example, Heberer (2009) argues that welfare provision at the community level could potentially lead to democracy or to the construction of a civil society in mainland China. Taking an opposing view, Leung (2000) argues that instead of cultivating a civil society, community service is a new tool for urban administration and social control (Leung, 2000; Rose, 2000) in addition to providing supplemental family care (Xu & Chow, 2011) and reducing the burden on the state (Yan & Gao, 2005). Other scholars take a third approach by discussing how NGOs are governed and empowered at the same time (Jing, 2015). On the one hand, these NGOs help local governments solve social problems by providing social services. On the other hand, the collaborations between NGOs and local governments are limited to welfare services (Hasmath & Hsu, 2014). Even in cases where the NGOs receive donations from abroad, they are employed and transformed into governable and manageable organizations (Spires, 2012).

The idea of NGOs as "politically inactive and professionally capable" (Jing, 2015, p. 489) resonates with the depoliticization and pluralization of NGOs in other contexts (Kamart, 2004). NGOs rooted in the local community are required to depoliticize projects that facilitate local development. NGOs that originally organized collective actions to

influence policy-making no longer have the ability to represent the majority with the pluralization of NGOs participating in world forums, especially business associations representing corporate interests. In other cases, NGOs receive funding from a government source, either a domestic or overseas government, which renders NGOs less nongovernmental. This embeddedness leads NGOs to provide services contingent on their funding. Hence, instead of providing long-term services as the welfare state did, NGOs' reliance on state funding undermines their accountability to local people (Pertras, 1997).

Inspired by studies on NGOs and neoliberalism in other contexts, this chapter aims to examine the NGO-state relationship in China and its resonance with the neoliberal trend. Instead of forming a shadow state (as scholars have found in other contexts), NGOs in China are still strictly controlled by the government and facilitate governance at the community level. Government at the community level, as theorized by Rose (1999), takes community as a government sector instituted to "encourage and harness active practices of self-management and identity construction of personal ethics and collective allegiance" (p. 176). Thus, from this perspective the state is no longer responsible for providing for the community's needs; instead, various partners have begun to replace the state by taking up these responsibilities. Additionally, the community becomes something that needs to be "investigated, mapped, classified, documented, interpreted" (Rose, 1999, p. 175). In China, as a prerequisite for government funding, NGOs must find ways to get to know their service "target" and report this information to the local government. In this way, NGOs increasingly partner with the

government to meet social needs and thereby constitute a tool for entrepreneurial urban governance.

Scholars have discussed entrepreneurial urban governance in China by drawing on David Harvey (1989), who defined public-private partnerships as one major characteristic of entrepreneurial urban governance. Instead of discussing this public-private partnership, scholars have focused on tax sharing between the central and local governments, which leads to local governments becoming economic interest groups motived to maximum revenues and support local economic growth (Zhu, 2004). Similarly, Wu (2002) has described the devolution of state power to local governments, which have the autonomy to facilitate local economic growth. The government has issued policies that promote interurban competition by liberating the private sector. However, these current discussions have neglected the role of the public-private partnership in the social welfare domain. By expanding our focus from economic to social life, it can be seen that the state and NGO collaborations in China have gradually transferred eldercare services to NGOs, which further leads to a fragmented welfare system and facilitates entrepreneurial urban governance. This shift prioritizes social stability while commodifying social welfare services.

Research context and method

Non-government organizations (NGOs) in China refers to both social organizations and private, non-enterprise entities. In this section, I first review the policies that support NGOs' participation in providing community eldercare. Then, I provide examples of the NGOs that participated in this study.

The Chinese national government has issued various policies to support the development of community eldercare by encouraging local governments' collaborations with NGOs and for profit corporations (companies). These national policies treat NGOs and companies similarly; they are both called *social forces* (社会力量 shehui liliang) and are both encouraged to participate in providing eldercare services. For example, in 2013 the State Council issued the policy, *Guidance for governmental purchase of services from social forces*, which states that both the for-profit and non-profit sectors could sell their services to the government. This policy was confirmed in 2014 by the Ministry of Finance, as well as by the 2015 policies issued by several national departments, including the Ministry of Civil Affairs. In 2016, the State Council further opened the eldercare market by encouraging investments in foreign non-profit organizations running eldercare services in China, and promised that these international non-profits will share in the same benefits that domestic NGOs enjoy. In response to these national policies, Beijing's and Shanghai's governments have issued similar policies to support the involvement of both NGOs and companies in providing community eldercare. However, they have done so through different approaches.

Beijing's government, similar to China's national government, encourages both NGOs and to participate in providing community eldercare. In 2010, only NGOs could participate in community eldercare, but more recent decisions have followed the national policy to not differentiate between NGOs and companies. For example, in 2016, Beijing's Aging Commission issued a policy on the development of community centers that encourages the government to provide free infrastructure for either NGOs or companies to run community eldercare services.

However, Shanghai's government only allowed NGOs to run community daycare centers until the policy changed in May 2017. Despite this more recent change, Shanghai's government still favors NGOs over companies in providing community eldercare services. For example, in 2015, Shanghai's government issued a policy that rewarded NGOs for running eldercare services. In 2017, Shanghai's government issued a regulation that provides insurance for NGOs running community eldercare services.

In 2017 from April to September, I have conducted fieldwork in Beijing and Shanghai to study the state-NGO relationship in the case of community eldercare services. In total, I have interview 19 NGOs, 10 in Shanghai and 9 in Beijing. I will provide a brief account of the NGOs that participate in community eldercare programs through focusing on two specific NGOs: Happy Elderly and Longevity in Shanghai.[6] Happy Elderly has two registered organizations. One registered as a non-profit non-government organization that participates in the government's purchase of public service projects. The other one registered as a for-profit corporation that runs eldercare projects. Similarly, Longevity also has two separate registered organizations: one registered as an NGO, and the other registered as a corporation that provides in-home professional care services. According to the leader of Longevity, they do not make a profit from their NGO, but they do make a profit from their corporation by providing in-home care. Although the two organizations are supposed to be separate operations, in reality, they exchange personnel, share administrative personnel, and so on. In so doing, in many cases, the operations of the NGOs' align with the goals of their counterpart for-profit corporations. For example, an employee of Love Care stated that they try to find projects

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[6] These are fake names given by the author.

in relation to eldercare. If the government welcomes the involvement of NGOs in that domain more than they welcome for-profit corporations, the corporate side of the organization will then use their NGO title to win the contract for the government project.

State-NGO collaborations

Figure 3 shows the hierarchical relationship between a local government street office and two NGOs that are responsible for various services in Pingliang District. The elderly association NGO is responsible for providing counseling and legal services, organizing volunteer teams, and offering continuing education programs for the elderly. It also conducts surveys of older adults living in the community to improve services. Based on the survey results, the association makes plans for future projects and applies for government funding. It is also responsible for managing and monitoring contracted enterprises (Yang & Xu, 2015). The other NGO, the home care service center, is responsible for running the daycare center, providing dining services, and contracting with other companies to provide eldercare services, such as assisted living equipment.
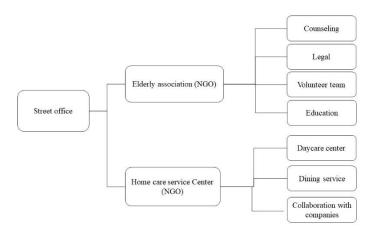

Figure 3. Hierarchy of community services in Pingliang District. Adapted from Yang and Xu, 2015.

Community eldercare programs now exist in every local government's street office that has state-society collaborations. Such collaborations may take the form of (1) programs built by the state and privately run, (2) programs privately operated with government support, (3) government subsidies and (4) services purchased by the government (Yu, 2015, p. 51). In the next section, I explain these four modes of collaboration in more detail and the problems with each mode revealed in interviews with NGO employees. These four types of collaboration between the state and NGOs show that NGOs actively collaborate with their local government for resources and potential projects. Collaboration makes it impossible for NGOs to stand in opposition to the government, prevents conflict, and fosters NGOs' dependence on the government. Local governments welcome the services provided by NGOs because they benefit local older adults and reduce the government's burden to provide welfare (Howell, 2015).

First, "built by the state and privately run" means that the local government provides infrastructure, facilities, and buildings while a private company runs the eldercare program by providing services, employees, and so on. Community service NGOs can acquire these kinds of contracts in three ways. First, the community service NGO can bid on the project, a process explained by a caregiver I interviewed:

> Publicly built and privately run" means that the government sponsors the infrastructure, and they find professional organizations to operate the services. Each street office purchases services from social organizations. It is run through competitive bidding. Social organizations like us will bid. If we win the bidding, we provide the services we promised. . . . At the end of each year, the government will hire another social organization to evaluate the program to see how well we ran it. So the current mode is that the government funds the project, or funds most of the project, and the private firm does the operation. In this way, older adults do not need to come up with that much money to receive these services. (Caregiver 18, Shanghai, May 2017)

In this case, the local government determines the community's eldercare needs and develops a handbook for bidding. Then NGOs bid on the project, and the winning bidder provides the services they promised.

The second type of collaboration is privately operated with government support in various forms. According to one NGO employee:

> We collaborate with the government in various forms. "State built and privately run" is just one form. Another form is where we establish and run the station, while the government supports and collaborates with us. For example, if we organize an event, [the residents' committee] should come. They should also introduce us to local residents [in every household]. (Interview with NGO4, May 2017, Beijing)

The residents' committee and the street offices are the two primary local government branches that have direct interactions with residents (Wu, 2002). Building on existing connections between residents and residents' committees, community eldercare NGOs develop strategies to attract potential customers. The local government also issues favorable policies for NGOs, such as tax cuts and various supportive policies. Here, the local government and NGOs enjoy a positive relationship with mutual benefit.

The third type of collaboration is a government subsidy in various forms, including subsidies for infrastructure and subsidies based on the number of older adults served. In March 2017 the Ministry of Finance issued a regulation on government subsidies for home and community eldercare services(Ministry of Finance and Ministry of Civil Affair, 2017), mandating that the first year's subsidy should be distributed according to the size of the local population of older adults, local finances, and the companies' eldercare service records. The following several years' subsidy would be distributed based on evaluations (Article 4). In practice, the standard for acquiring a government subsidy is ambiguous, as an NGO employee explained:

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The standard for receiving a subsidy isn't clear. There is no clear subsidy standard, even in Beijing. The standard is vague and broad. It is based on the size of the community center. There is an evaluation agency that evaluates the amount of the subsidy. We call them asking why they give us a certain amount of money. They don't know either. There is no clear standard for how much money they will give you. (Interview with NGO5, May 2017, Beijing)

Thus, even though the government has issued several regulations on subsidies, it is still not clear how the amount of the subsidy is determined. The subsidies are given in different amounts under different names. Such uncertainty and confusion about the amount increases the risks to NGOs of depending on collaboration with the local government, which leads them to seek other opportunities for profit making and undermines the NGOs' ability to provide long-term welfare services.(Petras, 1997).

The last type of collaboration is government purchasing of public services from NGOs. In Shanghai, most of the community eldercare centers are established through such programs. These programs are primarily managed by the district and local government offices and financed through the Shanghai Civil Affairs Bureau. The government's purchase of public services usually takes two forms. In the first form, the government distributes a service coupon that individual consumers can use for various kinds of services, such as a massage or haircut. In the second form, the government purchases services directly from the NGOs so residents can receive the service at a lower price. For example, when older adults apply for home care services and pass an initial assessment, they receive services at 10% of the market price. The remainder of the cost is paid by the local government through the government's purchase of public services. Howell (2015) described the government's purchase of services from NGOs as a direct facilitator of the positive state-NGO relationship in China. By purchasing public services, the government promotes competitive bidding among NGOs, controls their participation

in welfare service implementation, and cultivates dependent NGOs that are unlikely to challenge the local government.

These collaborations between the state and NGOs reveal a different picture than the typical depiction. Instead of forming a civil society in opposition to the state, as occurs in other countries, Chinese NGOs are instrumental to the government for the public services they provide. This finding from my research resonates with other scholars' findings on the state-NGO relationship, particularly the perspectives that through a symbiotic relationship is formed through state-NGO collaborations (Spires, 2011), that the government views NGOs through an instrumental lens (Howell, 2015), and that the collaborations are a type of consultative authoritarianism (Teets, 2013). However, these collaborations are contingent on the context. Factors affecting the collaborations include the level of government funding, the performance of the NGOs, and local government officials' perceptions of eldercare and NGOs.

<div style="text-align:center">Government control of NGOs</div>

Although NGOs enjoy some autonomy by virtue of being independent organizations, they are strictly controlled by the government. After contracting out services to NGOs, the local governments manage NGOs through midterm and annual evaluations. These evaluations help the local government to manage NGOs by documenting the quality of services they provide and to govern the community through the evaluation report, where detailed information on the aging population and how they are aging is recorded. The evaluation standards include whether services were provided, the quality of the services, the number of older adults served, and so on. These

evaluations are also contracted out to other NGOs that conduct professional organization

evaluations. The director of an NGO that conducts evaluations described his work:

> We evaluate 24 projects in 12 districts. We are all social service organizations, so
> we understand what the potential weaknesses are. . . . We ask why an NGO
> provided services to so many older adults. How do they select the older adults
> under their care? If we feel they don't have clear standards, we ask how they
> survey the needs of older adults. If they have surveys, what kinds of surveys are
> they? . . . What goals do they want to achieve? What do they want the older adults
> to get from a specific activity? If they make these things clear or think them
> through, their services will be good, realistic, and meaningful. (Interview with
> NGO 17)

This interview reveals the mid-term evaluation process. Through asking these questions,

the NGO director evaluates other NGOs' performance and examines their connections

and relationships with the residents, which enables governance through NGOs. The

director stressed the priorities of the evaluation: "Our main goals are to know the older

adults' needs, the primary focus of the bidding document, the NGOs' abilities, their final

report, and their self-evaluations. They need to at least know the older adults that they

serve."

The evaluation adheres closely to the bidding document to determine whether the

promised services have been provided and helps the NGO and the local government to

get to know the community and the local older adults' needs. Through NGOs, the local

government knows the community's illnesses, deaths, and interests (Rose, 1999). Here,

the community becomes the target to be "investigated, mapped, classified, documented,

and interpreted" (Rose, 1999, p. 176). Hence, the local community is governed through

state-NGO collaborations.

Going through the bidding and evaluation process every year costs a great deal of

unnecessary money and energy, according to the director of an NGO that operates

eldercare NGOs in Shanghai (NGO12). She viewed the bidding process as a way for NGOs to package and brand themselves using marketing principles. Even if the evaluation results are not good, community eldercare NGOs may be able to continue providing services in the community, provided they have already developed relationships with local government officials. As a result, maintaining a good relationship with the local government office is as important as providing good services. Connections built with the local community sustain NGOs' survival and continuation of their services, even when the services they provided are not good.

Maintaining this relationship is not the sole responsibility of one party. In most cases, local government officials and NGOs offer each other mutual assistance. On the one hand, the NGOs rely on government officials to get new projects with government funding. On the other hand, community building and community eldercare programs can be one of the major ways for local government officials to amass political credit (*zhengji*), which facilitates promotion within the administration. If a community eldercare program runs well or better than other programs in a certain community, the government officials sponsoring the program are more likely to be promoted. The number of beds plays a role in these promotions:

> The government has a service quota nowadays, so the residents' committee is willing to collaborate with us. We focus on communities that don't have community eldercare centers yet. Normally, one community eldercare station should have 30 beds. This is seen as an achievement in one's official career. (Interview with NGO4, April 2017)

To maintain their political credit, local government officials, especially those at the street office level, strictly monitor community eldercare centers' activities and services, even paying attention to details regarding the centers' physical arrangements:

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[The local street office leader] comes to examine our work: how many older adults visit our center, whether they are any complaints. Sometimes she messages me at night, asking me to learn from other community eldercare centers through their advertisements. She even cares how we organize things in the center. If somebody hangs up a raincoat; she will rearrange it. . . . She is very satisfied with the community eldercare program. She's proud of it. (Director of a Shanghai NGO)

The way that local government officials manage the community eldercare centers resembles an interurban competition with other communities. Instead of competing to determine which community has a better GDP, they compete to see who provides better community eldercare services. This finding differs from previous work on urban entrepreneurialism that studied interurban competition among local governments in China. Since the 1994 tax reform, the local government has more power to issue policies to maximize revenue (Su, 2015). However, in 2015, Han Zheng, then party secretary of Shanghai, argued that street offices should stop focusing on attracting investments and instead shift their agenda toward providing welfare services. As a result, welfare services have become the new site for interurban competition because providing better services increases the local government's political credit. To compete, the local government offices actively collaborate with NGOs to improve the eldercare services in the community. This collaboration commodifies eldercare services.

The community eldercare programs established by state-NGO collaborations reveal the Chinese government's strategy for providing eldercare services. Chinese Premier Keqiang Li summarizes the strategy by breaking it down into three elements: *fang* (release), *guan* (governance), and *fu* (service). Fang means a transfer of the responsibility for eldercare from the government to NGOs, which is seen as the third sector between the market and the state. Guan means that the government controls

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NGOs' activities and performance, as revealed in the evaluation programs and the government's ability to cut funding or end service contracts with NGOs. Fu summarizes the mutually beneficial relationship between NGOs and the local government, where the local government provides support and services to the NGOs to ensure quality services, which also advances government officials' careers by helping their community outperform other communities in the interurban eldercare service competition. Through fang, guan, and fu, the state reduces its burden for providing welfare services, while the NGOs transfer the risk to the local government.

Cultivating the Eldercare Market

Through various forms of collaboration and control, the local government offices now increasingly transfer their eldercare responsibility to NGOs. This social welfare regime becomes increasingly fragmented and depends heavily on the local government's financial ability and willingness to sponsor community care (Leung, 2000). Moreover, in some cases where the government purchased public services, the government gradually cut the NGOs' funding with the expectation that they could survive without support. Hence, instead of having assurance of being able to provide long-term welfare services, community eldercare services are contingent on the local government's funding, the NGOs' performance, and the NGOs' ability to survive after the government withdraws funding. An NGO director explained inequalities in funding:

> Government offices with larger budgets invest in more programs, such as those in Shanghai, Zhejiang, and Jiangsu. They have far more funding than other places in China. Also, Shanghai's government budget is far better than other places. For example, in Jiangsu province, the subsidy is one-tenth of Shanghai's. This will lead to unequal development [of community eldercare services]. (Interview with NGO1, August, 2017)

The problem with government-funded eldercare programs, according to this

director, lies in its unsustainable and fragmented funding system that varies across

communities. This NGO has several community eldercare projects in Shanghai as well as

in other cities in Jiangsu Province. According to the director, the organization's annual

budget in Shanghai is approximately 1 million yuan ($146,000). This kind of budget is

impossible for cities in Jiangsu. Additionally, even though the Shanghai government now

invests a large amount of money in community eldercare programs, the direct still had

concerns about sustainable funding in the future in Shanghai:

> I have had many conversations with the leader of the Shanghai Civil Affairs
> Bureau and the secretary of the Ministry of Civil Affairs in the central
> government. In the end, it's a problem of money. It's not a problem of eldercare
> mode. Who should fund the eldercare programs? The Beijing government offers
> only small subsidies, or they rarely fund projects. I have run one or two projects
> in Beijing as experimental sites. In Shanghai, we have an annual budget of 1
> million yuan plus a subsidy for operations and programs, which is 2 million yuan.
> . . . But overall, Beijing and Shanghai don't have big differences. Beijing has
> many state-owned enterprises that invest a lot in programs, including community
> centers and health management programs. It looks like people have invested in
> many eldercare centers, but there aren't many that are profitable. If there's no
> profit, then there won't be marketization. (Interview with NGO1, August 2017)

According to the NGO director, even though the Shanghai government provides

generous funds for community eldercare programs, he is still concerned with the question

of "who should fund the community eldercare center." Another NGO director told me

that the contract his organization signed with the government made it clear that

government funding will be reduced each year. Ultimately, the government expects

NGOs to be able to survive on their own. These funding cuts reveal the intention of the

local government for community eldercare, which is to gradually cultivate an eldercare

market.

Concerns about losing government funding and not being able to survive motivate all NGOs. They improve their services and develop creative new projects to secure funding and win the market from other community eldercare NGOs or companies.

> Now, more and more community eldercare providers come to learn from us. Once they've all learned our operation mode, we won't have any advantage. Our boss said we need to be creative, to have new projects. At next year's bidding, the street office will decide to either continue having us provide the service or else it will go to other organizations. Our program has to be approved every year. (Interview with NGO 14, May, 2017)

Community eldercare NGOs constantly find new ways to make a profit or strengthen their reputation so they can continue their contract with the local government. Through competitive bidding, the NGOs compete with each other for government projects by improving their service quality, creating new types of services, and so on.

To cultivate the eldercare market, NGOs running community eldercare centers are now frequently charging fees. For example, many community eldercare programs now charge a small fee for their services, such as 5 yuan ($.75) for a computer lesson, 10 yuan ($1.50) per Tai-Chi session, and 50 ($7.30) yuan for bathing assistance at the community center. One NGO director told me that his organization aimed to turn older adults into consumers by encouraging them to spend money on activities and services, cultivating in them the habit of spending money. Here, similar to how NGOs in other contexts initiate self-help projects for marginalized populations, community eldercare NGOs function by following the rules of the market rather than challenging neoliberalism and organizing collective actions. This situation is also partially due to NGOs' organizational structures; most of the NGOs encountered during fieldwork for this project have a for-profit

company as their headquarters, as social workers at the Jing'an NGO association[7] told

me:

> They have registered as for-profit companies and nonprofit nongovernmental
> units at the same time. Because of this, their NGOs' operations still follow the
> rule of the market. The two organizations should be separate and independent
> from each other. But in reality, NGOs normally become branch offices of the for-
> profit corporations. In most cases, they even have the same employees, just under
> two different titles.

Since the government regulations state that only NGOs can provide community

eldercare services, private for-profit corporations register as NGOs to be able to

participate in community eldercare services and collaborate with local governments.

These are technically NGOs, but they represent corporate interests. These companies do

so to occupy the market, get to know residents' needs, and prepare for the growing

demand for eldercare services, as the social workers explained.

> The private for-profit corporations who also register as NGOs have two
> motivations. First, they register as NGOs to maintain their relationships with the
> government so they can get policy benefits or relevant resources. The second
> reason is to develop and occupy the market. The government purchases services
> help them reach potential customers. For example, community NGO XX just
> wanted to provide eldercare for high-income older adults, so they got to know the
> retired, high-ranking government officials from their daycare services and long-
> term care services. It would be impossible for them to develop the market if they
> didn't collaborate with the local government.

These social workers revealed the major reasons private for-profit companies

register as NGOs and actively participate in community care. Collaborating with the

government helps them prepare for bidding on future government public service projects.

Most importantly, it helps them directly reach the population that might become their

future potential customers. The NGO mentioned by the social workers had contracted

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[7] Jing'an is an NGO that works with other NGOs. It evaluates other NGOs, organizes
trainings, and provides them with information.

several community care projects in the Central Buiness District in Shanghai, such as Jing'an and Xu'hui, where many retired government officials live. Contracting with the local government and providing services in these communities allows them to get in touch with high-income aging populations and build trust. In this way, NGOs view community eldercare programs as gateways to potential customers.

NGOs acquire government-sponsored community care projects as a platform to occupy the market. These platforms could mobilize resources by collaborating with other NGOs or companies to provide services to older adults, such as meals, housekeeping, rehabilitation, assisted living equipment, home modifications, daycare, medical care, recreational activities, and mental health counseling. For example, while doing fieldwork in one community comprehensive eldercare center in Shanghai, I noticed that they frequently bring other eldercare companies in to promote their services.

Introducing other companies and NGOs into the local community requires the NGO to know the local community. By getting to know their customers, they are able to more effectively introduce services to local residents. For example, by directly interacting with residents, the community eldercare NGO knows the needs in the local community and can connect the residents' needs with outside providers, such as eldercare institutions, hospitals, or assisted-living products., as an NGO director explained:

> Whenever older adults need a service, we try to provide it. But there are needs we can't meet. We record the need and see how many older adults need the same service. If it's only one or two people, we will just solve the issue [for those individuals]. But if the number is large, then we will provide the service on a wider scale. Of course, we provide the six major services, as well as one or two profitable ones. Other services we contract out or rely on other social resources. If we don't have the expertise, we won't step in to provide the service. (Interview with NGO 11, May 2017)

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In this case, in addition to the services that are required by the local government, the NGOs provide services that are profitable. My interviews revealed that NGOs will run one or two of the most profitable services themselves and then contract out others. Economy of scale plays a key role here: if not very many people have a particular need, the community NGO will not provide the service itself; rather, it contracts out to other agencies to run those services, such as eye care.

Conclusion

Through contracting out services to NGOs, the Chinese government aims to cultivate a third sector that could reduce the state's burden of eldercare and supplement family care. The Chinese government directly funds, collaborates with, evaluates, and manages NGOs through a bidding system for public service programs. These NGOs have become closely allied with local governments and highly dependent on the local government for funding, resources, and various other kinds of support. This reveals a different picture of the state-NGO relationship in mainland China: instead of striving for autonomy, NGOs actively collaborate with the local government.

Meanwhile, the government tightly controls these NGOs through annual evaluations. These evaluations evaluate the NGOs' performance and allow the government to become familiar with the local community through the NGOs, especially regarding how many older adults the NGO serves and what kinds of needs they have. These evaluations push the NGOs to become familiar with the local community, facilitating governance at the community level while remaining politically inactive.

Last, funding cuts, along with constantly changing and unclear subsidy policies, lead the NGOs to figure out ways to make a profit from community eldercare services. In

many cases, NGOs operate as branch offices of for-profit corporations, searching for ways to make profits. These market-oriented services may cause concerns regarding to what extent these NGOs represent the public interest, and how they can create a buffer between the market and the government (Kamat, 2004).

By bridging the literature on state-NGO relationships and neoliberalism, this chapter shows that when examining state-NGO relationships, it is not enough to only focus on issues related to autonomy and oppression. Rather, when it comes to social welfare issues, especially eldercare, state-NGO collaborations provide both parties with mutual assistance. The NGO enjoys the resources provided by the local government, while the local government appreciates the NGO's provision of community services, which also facilitates an entrepreneurial mode of urban governance.

This chapter discussed the establishment of community eldercare programs through state-NGOs collaborations. These collaborations allow the government to share the burden of eldercare facilitate urban governance, since the community eldercare NGOs provide information about the local community to the local government. The next chapter continues exploring how these collaborations support population governance: as NGOs promote and implement the government's healthy aging agenda, the state governs the aging population from a distance.

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CHAPTER IV

HEALTHY AGING IN URBAN CHINA: GOVERNING THE AGING POPULATION

Introduction

Facing an aging population, the Chinese government adopted the "healthy aging" discourse of the World Health Organization (WHO) to advocate for a healthy, active, independent, and participatory aging process. In 2017, the National Health and Family Planning Commission of the People's Republic of China (PRC) issued a health plan for the 13th Five-Year Plan (2016–2020) that featured healthy aging as the guiding principle shaping eldercare programs. Since then healthy aging has become a central goal for community eldercare in urban China. Following the principles of healthy aging, community eldercare programs designed various activities to encourage older adults to continue leading a busy life after retirement and to set health as their primary goal.

The WHO introduced the concept of healthy aging to replace other related terms, such as *active aging* and *successful aging*. Successful aging and active aging promote a participatory, independent lifestyle free from disease and disability (Rowe & Kahn, 1997; Walker, 2008). These terms are criticized for rejecting the natural aging process in order to maintain a middle-age lifestyle into elderhood (Higgs et al., 2009; Katz, 2001; Liang & Luo, 2012). Technologies of the self allow older adults to become targeted consumers for anti-aging products, pressuring them to buy an anti-aging lifestyle (Higgs et al., 2009; Katz, 2001). In addition, active aging and successful aging align with neoliberal logics, whereby responsibility for eldercare falls on individuals instead of the welfare state (Polivka, 2011; Rubinstein & de Medeiros, 2015). In this framework, a large portion of the older adult population does not meet standards of successful or active aging,

especially those who have diseases and disabilities and lower-income people who cannot afford anti-aging products and lifestyles (Higgs et al., 2009; Katz, 2001; Polivka, 2011). After these critiques, the WHO adopted the term *healthy aging* to include everyone, allowing for the presence of disease and disability and considering the diversity brought by ethnicity, family background, and education.

On the one hand, healthy aging recognizes the unavoidable bodily decay associated with aging as well as the existence of disease and disability. On the other hand, it still normalizes older adults by setting health as a primary goal for this later stage of life and promotes a lifestyle that facilitates the well-being of the elderly and maintenance of their functionality. In this way, older adults are regulated based on their will to be healthy. This form of governance is known as *governmentality*, meaning the techniques and procedures used to shape a population (Foucault, 2007). Instead of directly disciplining the individual body, governmentality regulates the environment that shapes the individual (Foucault, 2007). In response to the emphasis on healthy aging, older adults reshape their behavior patterns and lifestyles to be healthy, independent, and active. At the same time, healthy aging acknowledges the existence of disease and disability in older adults. Combining the literatures on governmentality and critical gerontology leads to fruitful analyses that can further our understanding of population governance, aging, and public policy (Powell, 2009).

In this chapter, I draw on Foucault's concept of governmentality to investigate how the Chinese government adopts the concept of healthy aging to govern the aging urban population. More specifically, I focus on how the push for healthy aging cultivates healthy, independent, participatory older adults. By examining community eldercare

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programs in Shanghai and Beijing, I first explore how healthy aging is being promoted by the Chinese government through various policies and speeches made by government officials. Second, I examine how community eldercare centers have designed recreational, social, and daily living activities to be in keeping with principles of healthy aging. Activities such as physical exercise, physical examinations rehabilitation, and volunteer work all aim to produce healthy, independent, and active older adults. In adopting these lines of analysis, the chapter draws together two bodies of literature that have developed separately: critical gerontology and governmentality. (see exceptions: Bulow & Soderqvist, 2014; Lassen & Moreira, 2014; Nosraty, Jylha, Raittila, & Lumme-Sandt, 2015; Rudman, 2015; van Dyk, 2014).

This chapter has two objectives. First, it explores the promotion and circulation of the healthy aging discourse in community eldercare programs in urban China. Second, it examines how healthy aging has informed the rationales behind the development of community eldercare activities. I argue that the middle-age ethic of being constantly busy was transferred to the eldercare setting, where older adults are disciplined and transformed into active, healthy and participatory people. In theory, healthy aging is different from successful and active aging because it recognizes the existence of disease and disease-related disability; however, in practice, healthy aging is quite similar to successful and active aging because all of these concepts discipline and regulate the elderly. Healthy aging enables the Chinese government to govern from a distance, reshaping the aging population to avoid their becoming a burden on society by being independent, and sometimes even productive, citizens.

Aging and Governmentality

In this section, I review the literature on successful, active, and healthy aging and connect it with governmentality to provide a framework for understanding governance of the aging population in urban China. Gerontology, the study of aging, began in the 1960s with a pathological approach, wherein aging was associated with disease, disability, and bodily decay (Hochschild, 1975). This view of pathological aging creates an image of older adults as decaying, fragile, and dependent. Criticizing the negative images associated with pathological aging, Rowe and Kahn (1997) proposed the concept of "successful aging" with "low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life" (p. 433). Following Rowe and Kahn, scholars have empirically examined to what extent older adults achieve successful aging(Chou & Chi, 2002; Depp & Jeste, 2006; Koh, Depp, & Jeste, 2012; McLaughlin et al., 2009). Others have tried to build on those findings by including subjective and context-based understandings of successful aging (Bulow & Soderqvist, 2014; Liang & Luo, 2012; Phelan, Anderson, Lacroix, & Larson, 2004). Beyond the academic debate, successful aging currently serves as the benchmark for policy-making as well as a tool for various anti-aging industries (Foster & Walker, 2015; Smirnova, 2012).

Similar to successful aging, active aging was introduced as a concept in the 2000s in order to encourage older adults to engage in an active lifestyle that emphasized health, participation, and a secure quality of life (WHO,2002). During the 1970s, under the welfare state, older adults were seen as dependent, fragile, and passive pension recipients (Walker, 2008). This image portrayed older adults as burdens to be borne, which to some

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extent has led to a grassroots movement promoting older adults' human rights and advocating for their social participation and inclusion (Walker, 2008). As a result, the image of older adults as dependent and fragile has shifted to viewing them as active and social. Active aging policies encourage older adults to take up new roles and activities in order to promote health and offer rehabilitation therapy when necessary to help them maintain their functionality.

Successful aging and active aging position older adults as active participants in society, instead of passive pension recipients (Foster & Walker, 2015). However, critical gerontology has criticized these terms for imposing a homogenous picture of older adults' physical abilities, which replaces natural aging with normal aging. In this perspective, natural aging refers to aging with bodily decay, while normal aging refers to the slowed aging that can occur with interventions (Higgs et al., 2009). Scholars argue that imposing desirable norms for aging on the elderly is a new form of ageism, where a generalized fear of aging is transformed into a fear of a certain type of aging, one that is disabled, diseased, and dependent (Katz, 2001). The concepts of active aging and successful aging blur the boundaries between childhood, adulthood, and elderhood, and thereby attempt to form uni-age bodies that portray older adults as active and youthful consumers (Katz, 2001). Thus, successful aging and active aging are criticized for being ageist, for refusing to acknowledge the existence of disease and disease-related disability, and for excluding those who cannot age successfully according to these standards, or those who cannot remain active (Bulow & Soderqvist, 2014; Rozanova, 2010).

Following these criticisms, the WHO reintroduced the concept of healthy aging in 2015. Healthy ageing was first proposed by the WHO as a development strategy to

address population aging as early as the World Conference on Ageing in 1990 (Hermanova, 1995). In October 2015, the release of the Global Report on Ageing and Health meant that healthy ageing was once again on the agenda. The revised healthy aging agenda recognized the fact that the elderly can become ill or disabled. Instead of talking about aging without including pathological processes, healthy aging allows for the possibility of disease and disease-related disability, as long as they are under control and have limited influence on older adults' well-being. Healthy aging combines pathological aging's recognition of bodily decay with active and successful aging's stress on well-being and participation. Thus, the WHO claims that healthy aging is designed to include those whose functional ability and well-being are not impacted by their physical condition.

To date, healthy aging has been primarily studied in three ways. First, scholars in gerontology have focused on the biomedical aspects of healthy aging, conducting studies on certain groups' health conditions, factors that affect their health, and methods for improving the health of older adults (Depp & Jeste, 2006; Franceschi et al., 2007; Price, Davis, Morris, & White, 1991). Second, public policy scholars have adopted healthy aging as a way to extend the retirement age and thereby reduce public health expenditures and the burden of eldercare (Knickman & Snell, 2002; Smith et al., 2014). Last, scholars in medical anthropology and critical gerontology have criticized the healthy aging paradigm for requiring individuals to set health as their primary goal, which aligns with neoliberal perspectives that promote the consumption of health products (Higgs et al., 2009; Lamb, 2014). In summary, on the one hand, the healthy aging agenda aims to improve the health of the population, extend their working years, and reduce the burden

of care for the state and the household. On the other hand, it promotes a certain lifestyle and image of the aging body, which further enables governance of the aging population.

Thus, the concept of healthy aging is bound up with particular forms of governmentality. Governmentality enables us to ask questions such as "Who or what is to be governed? Why should they be governed? How should they be governed? To what ends should they be governed?" (Rose, O'Malley, & Valverde, 2006, pp. 84-85). Techniques of governance include methods for disciplining individuals and regulating population indexes such as birth rate, mortality, fertility (Legg, 2005). In *Security, Territory, and Population* (2007), Foucault argues that governmentality is "the ensembles formed by institutions, procedures, analyses and reflections, calculations, and tactics that allow the exercise of this very specific, albeit very complex, power that has the population as its target, political economy as its major form of knowledge and apparatuses of security as its essentiall technical instrument" (p. 108). Through these techniques, authorities regulate important aspects of the population, such as its health, wealth, and labor capacity (Rose et al., 2006). To govern, authorities need to understand the milieu of the population.

Governing the population through its health is an important facet of governmentality, but the scholarship on governmentality rarely addresses the ways in which the healthy aging paradigm governs aging populations. Through the concept of health, older adults are governed at a distance. Their behavior is reshaped so that they must invest effort in forming a healthy body and actively participating in their community. Active and successful aging have long been criticized for their association with neoliberalism, which aims to create independent, able bodies, and thereby attempts

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to shift responsibility for eldercare from the state to individuals (Liang & Luo, 2012). Similarly, from the perspective of healthy aging, older adults are expected to manage their own risks, avoid signs of aging, and attribute others' diseases or disabilities to failure (Laliberte Rudman, 2015; Rozanova, 2010). Thus governmentality produces a model individual who is "conducting his life according to the precepts of health" and an environment designed to produce model individuals (Powell, 2009, p. 675).

The aging population is encouraged to set health as its primary goal and is governed through its will to obtain health and health-related knowledge. The environment around the aging population, such as circulating knowledge related to health, disease rates, and mortality, becomes the state's target for population governance (Neilson, 2003). The community eldercare program is one of the environments that link the individual's will to health to the state's population governance techniques. Older adults are encouraged to participate in various forms of exercise in order to have an active lifestyle and participate in the community (Katz, 2000). These programs assess older adults' bodily conditions on a daily basis to reduce their risk of contracting diseases and govern older adults' behaviors and bodies through community eldercare.

Research Context and Method

For the past two decades, the Chinese government has promoted community eldercare programs to deal with the country's rapidly aging population and the corresponding care burden. The primary approach to eldercare in the urban context has been for the government to contract community eldercare services out to nonprofit, nongovernment organizations (NGOs). These community eldercare programs mainly provide three types of care: in-home care, community daycare, and overnight institutional

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care. For in-home care, the NGOs send caregivers to older adults' private homes to provide services. For community daycare, older adults mainly come during the daytime for physical examinations and opportunities to participate in recreational and rehabilitative activities. For overnight institutional care, older adults go to overnight programs to receive respite care after surgery or to give their family members a break from delivering care. All three types of eldercare service assess older adults' bodies before admitting them for care. These community eldercare programs are also required to organize activities in the community, ranging from Tai chi, dancing, singing, and chess to volunteer work and health education lectures. These activities are the main way that eldercare NGOs are evaluated.

From April 2017 to October 2017, I conducted interviews in Beijing and Shanghai with 18 NGOs, 28 community caregivers, and 23 older adults who frequented community eldercare services. I asked the interviewees questions regarding the kinds of services the programs provided and older adults' motivations for participating in the activities and meeting the program's service goals required by the local government. The questions were designed to shed light on how the concept of healthy aging has been promoted, circulated, and implemented in urban Chinese communities. I also gathered government policies and attended national conferences on aging issues to understand the mainstream discourses around aging in contemporary China.

Discussion

Promotion of healthy aging

China adopted the concept of healthy aging from the World Health Organization, which defines it as "the process of developing and maintaining the functional ability that

enables wellbeing in older age" (WHO, 2018). According to the WHO (2018), functional ability is understood as people's ability to "meet their basic needs; to learn, grow and make decisions; to be mobile; to build and maintain relationships; and to contribute to society." This healthy aging agenda promotes independent and healthy older adults, individuals who do not depend on others for their care. By promoting health, this agenda reduces the burden of eldercare on the government, families, and society.

According to the 13th Five-Year Plan, by the end of 2020, 70% of China's older adults (individuals over 65 years old) should have a health management plan. Xi Jinping, the current chairman of the PRC, also promotes a positive attitude toward the aging population and retirement life. In 2017, the National Health and Family Planning Commission of the PRC issued a healthy aging policy for the 13th Five-Year Plan, which emphasized the importance of social participation and health for older adults. This plan serves as a guideline for healthy aging practices in urban communities. For example, it stresses the importance of educating older adults on topics such as preventing and rehabilitating from geriatric illnesses, participating in science and the arts, protecting their mental health, and acquiring new vocational skills. Aside from continuing education, this plan also encourages older adults to participate in various activities, including physical, recreational, and volunteer activities.

In response to the central government's policies, the local governments of Shanghai and Beijing local governments issued separate policies to promote healthy aging. In August 2015, Shanghai's Civil Affairs Bureau issued its Community and Home Eldercare Services Regulations. In this document, the Civil Affairs Bureau and the Aging Commission specifically regulated various eldercare service items. For example, for the

service item they titled "communication," there are five requirements: (1) find topics that interest older adults, (2) listen more and talk less to build good relationships with older adults, (3) reduce older adults' loneliness and help them maintain good relationships with their children, (4) help older adults adjust to the aging process, and (5) protect older adults' personal information.

Similarly, the Beijing city government also issued various polices to promote older adults' health. For example, in November 2015, Beijing's Planning Bureau and its Civil Affairs Bureau issued the Special Plan for Old-age Service Facilities in Beijing. The primary objective of this plan is to mobilize various resources to improve community eldercare facilities, while also providing rehabilitation, health management, and mental health care for the older adults living at home.

Overall, China's healthy aging plan advocates a positive and healthy lifestyle to improve older adults' quality of life and well-being. It requires the local community to provide workshops, health-related courses, and opportunities for participation in other activities such as reading, attending lectures, dancing, singing, and making handicrafts. According to the 13th Five-Year Plan, the community should also actively promote appropriate health care plans based on traditional Chinese medicine, improve older adults' self-help skills, and organize family activities based on older adults' interests. Thus, within these recommendations, the community is required to cultivate an environment that facilitates older adults' well-being and social participation (Figure 4).

Figure 4. Lecture on health promotion at a community eldercare center in Shanghai. Photo by author.

In addition to distributing government policies, key government officials (primarily from the National Aging Office) give talks at national conferences to promote the healthy aging paradigm. For example, Yushao Wu, vice director of the National Aging Office, presented on the importance of healthy aging at the ChinaAID conference in Shanghai in June 2017. He stressed the importance of "proper aging," referring to the United Nations' principles for older adults, such as "independence, participation, care, self-fulfillment, and dignity." Based on these principles, Wu promoted positive aging and healthy aging to the NGOs running community care facilities. He stated that healthy aging and positive aging contribute to the elderly's well-being and social participation and he listed six underlying principles:

1. Older adults should have pursuits, dreams, and plans.
2. Bodies can age, but not the spirit.
3. Physical aging is acceptable; mental aging is shameful.

4. If older adults have no goals, death is the goal.
5. Do not give up. Older adults should also grow.
6. Those in life who have self-control experience health and happiness beyond imagination.

In these six principles, Wu emphasizes the importance of the elderly maintaining a youthful mentality so that they can have the agency to pursue their dreams and participate in life. Thus, the Chinese government promotes healthy aging though governmental policies and official speeches. This healthy aging discourse is then implemented in urban community eldercare programs, serving as the guidelines for how they design their activities. These activities—education, health examinations, recreation, and social participation—are designed to improve the health conditions of the older adults and encourage their ongoing contribution to society.

Implementation of healthy aging

The community eldercare programs' efforts to implement the concept of healthy aging can be seen most clearly when they are broken down into three subsections: timetable, numerical data, and volunteer labor. In what follows, the timetable section reveals the busy activity schedule prepared for older adults. The numerical data section focuses on the statistical information recorded by the NGO, which includes the elderly's participation in activities, physical examinations, behaviors, and moods. Last, the volunteer labor section discusses older adults' work in the local community, which is performed on a volunteer basis. These three elements are the primary methods NGOs use to encourage older adults to continue leading busy lives after retirement, based on the idea that an active lifestyle is morally and ethically preferable and contributes to the elderly's well-being.

Body assessment and behavior and mood observations place older adults under surveillance, which reduces their risk of disease and further reduces the eldercare burden. Finally, the implementation of healthy aging in community eldercare reveals two modes of governance: individualization and the calculated human. The individualization mode requires caregivers and social workers to understand the older adults' individual personalities, disease histories, and family backgrounds, while the calculated human mode transforms older adults into statistical information to be used for population governance.

Timetable: An ethic of busyness

The healthy aging principles advocated in government documents and official speeches are reified in community eldercare programs. The local government (primarily the district and local level) requires NGOs to design activities to elicit older adults' participation and promote their well-being. These activities are performed according to a schedule. The timetable in Figure 5 shows that five to six activities are scheduled Monday through Friday from 7:30 am to 4:00 pm. These activities include Tai Chi, dancing, singing, crafts, and health lectures.

芒江西路街道综合为老服务中心（2017年9月18日–9月24日）

	9/18 星期一	9/19 星期二	9/20 星期三	9/21 星期四	9/22 星期五	9/23 星期六	9/24 星期日
上午 7:30– 11:00	复元坊交通舞蹈队 (7:30–9:30) 琴琴交谊舞 (9:40–11:40) 多功能健身房 健康讲座《跌倒、坠床护理》 (9:30–10:30) 长者学堂	肚皮舞学习班 (7:30–9:30) 姐妹腰鼓队 (9:40–11:40) 多功能健身房	复元坊交通舞蹈队 (7:30–9:30) 琴琴交谊舞 (9:40–11:40) 多功能健身房 老年合唱队 第五期第九节 (9:00–10:30) 影视戏曲欣赏 (13:30–15:30) 长者学堂	琴琴交谊舞 (7:30–9:30) 肚皮舞学习班 (9:40–11:40) 多功能健身房 围棋兴趣小组 (9:00–16:00) 多功能康乐区 科技助老——手机中级班 第二期第四节 (9:15–10:45) 长者学堂	复元坊交通舞蹈队 (7:30–9:30) 肚皮舞学习班 (9:40–11:40) 多功能健身房 老年摄影协会 (9:00–15:00) 长者学堂	影视戏曲欣赏 (9:30–10:30) 长者学堂	影视戏曲欣赏 (9:30–10:30) 长者学堂
下午 13:00– 16:00	吴氏太极拳初级班 (14:10–16:10) 多功能健身房 读报会 不一样的老年生活 ——《世界旅游日》 (13:30–14:30) 多功能康乐房 科技助老——手机初级班 第二期第五节 (14:00–15:30) 长者学堂	"巾帼驾到"舞蹈、舞剧培训 (13:30–15:30) 多功能健身房 影视戏曲欣赏 (13:30–15:30) 长者学堂	党建活动 (14:00–16:00) 长者学堂	吴氏太极拳高级班 (14:10–16:10) 多功能健身房 围棋兴趣小组 (9:00–16:00) 多功能康乐区 健康讲座《心梗的防治》 (14:00–14:30) 长者学堂	灵光时装队 (12:10–16:10) 多功能健身房 老年摄影协会 (9:00–15:00) 居家养老会议 (14:00–15:00) 长者学堂	影视戏曲欣赏 (13:00–15:30) 长者学堂	影视戏曲欣赏 (13:00–15:30) 长者学堂
便民服务区	9:00–11:00 小家电维修/修伞扦脚	9:00–11:00 缝纫补补	9:00–11:00 理发（每位5元）	9:00–11:00 14:00–16:00 换就医记录册 磨刀	9:00–11:00 修鞋/修手表		

多功能康乐区为老人自由活动，以按摩椅使用、动感游戏体验为主。

Figure 5. Timetable of activities at a Shanghai community eldercare center.

This timetable aims to keep seniors busy and active, fulfilling the prescribed ethic of always staying busy (Barrett & McGoldrick, 2013; Liang & Luo, 2012). Here, the ethic of busyness refers to people's preference for an active and busy lifestyle. (Ekerdt, 1986) "It is not the actual pace of activity but the preoccupation with activity and the affirmation of its desirability that matters" (Ekerdt, 1986, p. 243). Foucault expressed a similar idea in *Discipline and Punish: The Birth of the Prison* (2012):

> The timetable was to eliminate the danger of wasting it—a moral offense and economic dishonesty. Discipline, on the other hand, arranges a positive economy; it poses the principle of a theoretically ever-growing use of time: exhaustion rather than use; it is a question of extracting, from time, ever more available moments and, from each moment, ever more useful forces. This means that one must seek to intensify the use of the slightest moment, as if time, in its very fragmentation, were inexhaustible or as if, at least by an ever more detailed internal arrangement, one could move towards an ideal point at which one maintained maximum speed and maximum efficiency. (p. 154)

Time schedules, according to Foucault, are adopted to prevent time wasting—a "moral offense and economic dishonesty." Implemented in community eldercare

programs, the activity timetable keeps older adults busy and continues the active lifestyle

they had before retirement. This in turn disciplines them and cultivates within them a

desire to maintain a busy lifestyle that is supposed to lead to well-being (Foucault, 2012).

The implementation of healthy aging requires older adults to be active and busy, with the

use of bodily interventions designed to slow the aging process (Figure 6).

Figure 6. Chinese calligraphy activity at a community eldercare center. Photo by author.

The leader of an NGO that managed an eldercare center in Shanghai described

the typical daily activities at the center:

> The older adults come here in the morning for a physical examination, including
> checking their blood pressure and pulse. Then they do some exercises, like finger
> and joint exercises. After the exercises, there are a series of activities, like
> singing. One of the activities is storytelling. Each senior shares a story. In this
> way, they take in 20 to 30 new pieces of information. We lead the discussion in a

positive direction. Later they have lunch. In the afternoon, they have small-group activities based on their preferences. (Interview with NGO 16, May 2017)

Activities held at this community eldercare center are designed to improve the older adults' health and encourage social participation, which is critical to keeping older adults active and engaged. According to Katz (2000), governments use activities as a tool for encouraging an independent, active lifestyle. A social worker at a center in Shanghai described how an NGO leader became angry after learning that the older adults were watching TV instead of being required to attend activities according to the schedule:

> Our boss is angry with me for several reasons. First, I didn't follow the activity plan. Second, why did I have the elderly perform this kind of meaningless activity? After he left, all the older adults were directed to do various kinds of activities. I think he was right. Because the older adults spend money to come here, they need to get something of value. Their health is supposed to be better. (Interview with Caregiver 11, August, 2017)

According to this social worker, their leader considered reading novels a meaningless activity. Instead, the leader thought the older adults should be constantly in motion and doing physical activities that could potentially improve their physical health. The center's most important service, according to the NGO leader, was rehabilitation, which produces able bodies by keeping disease and disability under control, and restores the functional ability of older adults. Thus the rehabilitation program is designed to reduce the aging process and produce active, healthy older adults. The connection between activity and well-being allows professionals to intervene in the older adults' activities (Katz, 2000). A similar opinion was expressed by another NGO manager in Shanghai:

> Our company's mission is to help older adults get better and have dignity and be able to return to society and their family. Having dignity means the ability to do things by themselves. Interaction with the seniors requires patience and also some

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assistance. It isn't that you do everything for them. Rather, we need to keep the seniors active and energetic and maintain their fitness. Traditional [institutional] eldercare has no sense of seniors' dignity. . . . We're dedicated to giving them dignity, to improving their health through rehabilitation. When a senior becomes ill, their health drops dramatically. But if we assist them, their health will decline more slowly and will be better than in those who don't receive assistance. (Interview with NGO 28. Shanghai, August 9, 2017)

In this interview, the NGO manager targets two aging processes: natural and normal aging. Natural aging recognizes physical and mental decline, while normal aging stresses the technologies of care that can reduce the decline of older adults' health (Higgs et al., 2009). According to this NGO manager, interventions replace natural aging with normal aging. In this way, older adults are expected to maintain certain functions, which will enable them to have dignity and return to their family. This independence and involvement with society and family is closely related to the "third age identity," when older adults are free from work and child-rearing, but are not limited by disease and disability (Higgs et al., 2009). This "third age identity" is in line with the extension of adulthood and it reduces the length of the "fourth age identity," which is accompanied by disease and disability (Katz, 2001). The NGO's efforts to help older adults maintain an independent life or rely on the family for eldercare reveal the transfer of responsibility for eldercare from the state to individuals (Rozanova, 2010).

The NGO manager connects older adults' functionality to their dignity through rehabilitation, which produces independent older adults. This rehabilitation-oriented ideology is highly shaped by the principles of healthy aging and redistributes the caregiving performed in community care. For example, a caregiver emphasized the importance of engaging the older adults in their own care:

[I say], "Grandmother, you need to make your bed right. Let's do it together." I usually do things like this. "Let's do things together." In this way, you can use the

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remaining value of older adults. They can clean the floor, make the bed, or deliver food. They can do these things themselves. (Interview with caregiver 7)

By doing some basic work, older adult could use her "remaining value" to contribute to the community. In this context, older adults are "not valued unless they are active or productive" (Liang & Luo, 2012, p. 329). Using their "remaining value," according to the caregiver, helps the older adults be independent and contribute to society. Having older adults do work is a crucial component of healthy aging, as illustrated in the volunteer labor section of this chapter.

Numerical data and physical assessments

Community eldercare facilitates older adults' will to achieve good health by setting up activities for them and assessing their physical bodies and monitoring them 24 hours a day. The activities and assessments that the elderly participate in provide opportunities to monitor their behavior and record it as key statistical information. For example, a community eldercare facility in Shanghai designed activities around cultural education, recreation, hobbies, and major events.

Table 4 summarizes the activities and number of participants involved in them at a community eldercare facility in Shanghai. This table was prepared by the facility for evaluation by the local government. With tables like this, the local government gets to know older adults through their numerical data. Instead of directly disciplining the body, governments are now regulating older adults through their use of community eldercare statistical information. Through this data, the local government has a general understanding of the older adults in the local community, including their behavior

patterns, their community participation, and the community eldercare NGO's

performance.

Table 4. Activity Summary for a Comprehensive Eldercare Center, Shanghai

Activity	Number of classes (frequency)	Number of participants
Cultural Education		
Mobile phone use	40	351
Computer instruction	40	394
Tourism English	9	91
Oral history	8	204
Group singing	20	720
Watercolor painting	4	20
Lecture	20+	972
Recreational activities		
Tai Chi I	40	216
Tai Chi II	30	123
Tai Chi III	60	215
Dancing	Three times a week	1140 per year
Tai Chi	Three times a week	1087 per year
Health qigong	Twice a week	602 per year
Latin dance	Once a week	229 per year
Drumming	Once a week	435 year
Dancing for people with cancer	Once a week	118 per year
Ballroom dancing	Once a week	644 per year
Fashion model team	Once a week	227
Senior photography association	Once a week	462
Video performance	Twice a week	280
Hobby classes		
DIY crafts	10	114
Gourmet baking	6	82
Chess	Once a week	219
Chess competition		90
Reading group	2	40
Other services		
Legal consulting		29
Counseling		3
Haircut, appliance repair, sewing, sharpening knives, shoe repairs, watch repair, umbrella repair, etc.	1 or 2 items every day	3960

Table 4. (continued)

Major event		
Lantern festival		380
Dragon boat festival		124
Chung Yeung festival		120
Christmas		141
Noodles		267

Note. Data acquired by author during fieldwork.

Older adults are governed through both having their numerical data provided to the government and through physical assessments and subsequent categorization. They are required to have a physical assessment before being admitted to the community eldercare programs. The assessment determines the types and frequency of services they receive and rehabilitation plan. Thus their bodies are carefully monitored and evaluated to determine if they might be "risky" before being admitted to the community care program. A caregiver at a Shanghai center described these assessments:

> First, the seniors need to apply to their street office to indicate their willingness to receive care services. . . . Then the street office will assess them to see whether they are eligible to receive care and what kind of care they require. Older adults are assessed to determine their age, living conditions, and health. For example, they are evaluated to determine whether they can conduct daily activities by themselves or not. (Interview with Caregiver 18, Shanghai, June, 2017)

Based on an their physical condition, the assessment agency determines how many hours of service per week older adults are qualified to receive. Then the NGO will provide services accordingly. For example, after the physical assessment, one older adult was found eligible to receive three hours of service every week. Caregivers came to her home every Monday, Wednesday, and Friday to deliver services upon request, including help with grocery shopping, bathing, haircutting, nail trimming, house cleaning, and cooking. Other older adults may qualify for five hours of service per week, and some

may not qualify for any service time. Thus, they are categorized into different groups to receive different levels of care based on their health. These categorizations aim to reduce the risk of their not receiving enough care from family members or becoming dependent on more care than they really need. Through categorization, older adults are monitored through the physical assessment plan and corrected accordingly to achieve the institutional goals of healthy aging.

Older adults are also monitored in everyday life through having their vital signs and moods recorded. Some community eldercare companies require their caregivers to record the older adults' moods, ranging from sunny to stormy as well as their everyday functions, such as food intake, exercise, urination, and stool excretion. If an abnormality is observed, the caregivers adopt strategies to deal with the "abnormal condition" by either continuing to observe, calling emergency services, or contacting one of the older adult's family members. Through documenting their vital signs, moods, and everyday functions, older adults are subjected to a network of monitoring and control. This program of monitoring and control draws on observations, communication, and caregivers' understanding of the older adults' physical health, medical history, personality, and behavior patterns. The older adults and caregivers notify each other of information such as who ate less than usual, who slept more than usual, and who appears to be unhappy. Hence, the events and circumstances of older adults' everyday lives are converted into activities that are "classified as scientifically observable facts [and] these facts in turn become the bases upon which other calculations, correlations, and predictions are constituted" (Foucault, 2012).

The documentation and observation in the community eldercare center constitutes the panopticon, where many specific aspects of the older adults must be recorded and computed. In this panopticon, documentation functions as the environment through which they are watched and disciplined. However, governance in the community eldercare center goes beyond the panopticon; the individual documentation leads to the calculated human, where the older adults' basic information, such as age, gender, disease type, exercise type, and pill administration time are recorded to become statistical information. This statistical information then becomes the core persuasive power of the eldercare NGO to prove their rehabilitative effectiveness and attract future investments from the Chinese government. Hence, there is a blend of individualization and the calculated human in community eldercare. On the one hand, information about older adults' bodies is calculated in order to shape them into the ideal aging adult. On the other hand, the care they receive is highly individualized, which requires the caregivers to know the senior's personality, family condition, and history.

Volunteer labor—social contribution

In the healthy aging agenda, "to contribute to society" is a major goal driving the desire to maintain older adults' functional abilities (WHO., 2018). This goal differs from the active aging discourse, which focuses narrowly on the elderly's contributions through employment (Walker, 2009). Healthy aging recognizes various forms of contribution, including volunteer labor in the community and labor at home for the family. Chinese older adults have a long tradition of contributing to the family by taking care of grandchildren. It is beyond the scope of this chapter to examine intergenerational exchange, so here I mainly focus on the emerging trend of performing volunteer work in

the local communities. In one community eldercare center, I encountered an older adult who volunteered as a calligraphy and Chinese painting instructor:

> I was a teacher before I retired. I like dancing, but now I'm old, and my legs aren't good. . . . I took the bus to come here to teach them calligraphy and Chinese painting. I live very far away. Some older adults will come to me. If they want to learn, I will teach them. If they don't want to learn, that's okay too. For older adults, the first thing is to be happy. (Interview with Elderly 17, Shanghai, May 22, 2017)

This older adult constantly emphasized that she still wanted to be useful to society, to serve society. To her, what mattered the most was a positive experience. Serving as a volunteer allowed her to serve society, to engage with her peers, and to be happy (Figure 7).

Figure 7. Craft work organized by an elderly volunteer. Photo by author.

Older adults serving as volunteers in Shanghai are generally organized through the "old partner plan" (*laohuoban jihua* 老伙伴计划) program. This program is designed

to have the younger seniors (those in their 60s or 70s) volunteer to help the older seniors (those in their 80s or 90s). This plan embraces healthy aging principles by promoting volunteer work among the elderly. Those involved with the program claim that it helps prevent the elderly from losing their functional abilities, provides them with health education and mental health care, reduces their risk of disability and disease, promotes quality of life, and increases their social engagement (Xu Jing Ren Min Zheng Fu, 2012 July 24). The plan has been implemented in various districts, including Xuhui, Huangpu, and Zhabei. It calls for one younger volunteer for every five older participants. The volunteers' work includes making phone calls every other day to the older adults, visiting one of the participants' homes every week to relieve loneliness, performing one meaningful act every month to help a participant overcome a difficulty, and hosting one gathering every three months to build a sense of community and promote social engagement (Xuhuiqu, 2014 Sep 4).

Some of the NGOs see an instrumental value in volunteer work, where the volunteer also enjoys the process and experiences self-fulfillment. According to an article by two older adults in the local newspaper:

> "We are no longer young. We are retired. Suddenly, we are [not as] busy as we [were] before retirement. But we still have passion and remain strong. The old partner plan builds a platform for us to achieve self-realization in our second life. . . . We all follow one principle: serve others, be happy. . . . All the volunteers are no longer young, but we are still willing to contribute in our remaining years to help those who are even older than us. We take them as our relatives, our parents, and serve them with love. (Pan & Chen, 2013 Sep 11)

According to the volunteers, conducting volunteer labor often continues their busy life before retirement, which helps them use their remaining energy to build a quasi-kinship with the participants. To them, volunteer work brings not only a sense of

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fulfillment, but also hope for their own future when they become the older seniors. The

old partner plan also increases older adults' participation rates in community activities, as

an NGO director stated:

> Older adults are very lonely. Some [of the older seniors] don't want to let the
> volunteer leave. We can tell that the elderly are happy. Whenever we organize
> activities in the community, the elderly are all eager to participate. As long as they
> can walk, they will come. (Interview with NGO director 17, Shanghai, June 6,
> 2017)

Volunteer work, especially work that requires communication in the local

community, builds a sense of community and increases older adults' participation. Here,

volunteer work serves as a tool to promote healthy aging and cultivate participation

through "belonging and giving back to the community" (Lie, Baines, & Wheelock, 2009).

Thus, healthy aging has been implemented in community eldercare primarily by

creating full timetables to promote an active lifestyle, by converting the elderly into

statistical data via observation and assessment, and by encouraging older adults to engage

in volunteer labor. These three strategies motivate older adults' to fulfill the principles of

healthy aging. Moreover, participating in social activities and volunteer work continues

the ethic of busy-ness that the older adults held to before retirement, which is morally and

ethically preferred by both the government and the older adults. Volunteer labor further

engages them in the local community, which reduces the possibility of social exclusion.

Last, physical assessment and the statistical data it generates put older adults under

surveillance and regulation through both individualized care and calculation, which

reduces their risk of becoming diseased or dependent.

Conclusion

This chapter has examined the promotion and implementation of healthy aging in

urban China. Critical gerontologists have criticized successful aging and active aging for promoting one type of active aging body, which has become the new ageism (Higgs et al., 2009; Katz, 2000). Other scholars have gone further to link health, health policy, and embodied aging with Foucauldian governmentality, arguing that the discourses around aging align with the neoliberal agenda of shifting responsibility and risk management to the individual (Rozanova, 2010). Successful aging blames those with disease and disability for their failure to successfully care for and take responsibility for themselves (Bulow & Soderqvist, 2014). However, since the concept of healthy aging was introduced, it has not been fully examined and only rarely connected with its function of facilitating population governance. This chapter has examined Chinese urban community eldercare NGOs to investigate the role that healthy aging plays in population governance.

The main finding of this research is twofold. First, the concept of healthy aging has been promoted by the Chinese government and NGOs. The principles of healthy aging require older adults to set health as their primary goal and behave accordingly. Second, healthy aging has been implemented in community eldercare by NGOs through scheduling a timetable of activities, gathering numerical data from physical assessments and observations, and encouraging the elderly to provide volunteer labor to the local community. Moreover, physical assessment monitors older adults to reduce their risk of becoming ill. In theory, healthy aging differs from successful aging and active aging in that it recognizes diversity among older adults, including diversity due to inequality and inevitable bodily decay. In practice, healthy aging is largely indistinguishable from active and successful aging because it also seeks to normalize older adults' bodies, behaviors, and thoughts.

This chapter bridges two bodies of literature that have developed separately: critical gerontology and governmentality. By connecting these two bodies of literature, this chapter has argued that the healthy aging paradigm, with the related concepts of successful aging and active aging, serves as a tool for population governance. By producing healthy, independent, active, and participatory older adults, the Chinese government reduces its responsibility to provide eldercare, or shifts it to the individual. Future research should be conducted on how older adults embody the concept of healthy aging.

While this chapter has discussed the connection between healthy aging and governmentality, the next chapter in this dissertation shifts the focus to the affective aspect of population governance. To supplement home care, community eldercare centers aim to cultivate homely feelings at the center. In so doing, they facilitate the older adults' formation of fictive kinships at the community center, which provides them with social and emotional support. Being proximate in time and space to the private home also facilitates the homely feeling at the centers. However, this institutional home is not only a space of care, but also a space of control.

CHAPTER V

INSTITUTIONAL HOME—ISIGHTS FROM COMMUNITY ELDERCARE

PROGRAMS IN URBAN CHINA

Introduction

> Here, we can have lunch and attend activities. So, we come here every day, never missing a day. When it's closed during the holidays, then we also have a holiday. There are many things that we can't talk about with our children. If you were to tell them, they would be worried about you. They already a lot of pressure from their work, so we don't talk to them about our concerns. We only tell them the things they want to hear. We are all old sisters. We talk to each other about our concerns. Then we feel better. So we come here every day. (Mrs. Feng, in her 70s, from Shanghai)

Mrs. Feng is a frequent visitor to a community eldercare center in Shanghai.

There are millions of older Chinese adults like Mrs. Feng who frequent their local

community eldercare centers, established by the Chinese government to provide eldercare

for a rapidly growing aging population. There are currently 209 million people over the

age of 60 in China, and this number is projected to be 491 million by 2050 (United

Nations, 2015). Given the size of this growing demographic, the need for eldercare has

become a severe social problem. The Chinese government is actively collaborating with

nonprofit nongovernment organizations (NGOs) to provide eldercare in the community.[8]

These community eldercare centers offer various activities for older adults, who

participate in them and socialize with each other regularly, to the point that they develop

friendships, fictive kinship, and a feeling of home at the centers. Thus, community-based

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[8] For more information on specific government policies see, for example, the 12th Five-Year Plan, Suggestion for Encouraging Private Capital to Participate in the Eldercare Industry, Pilot Work on the Reform of Home and Community Eldercare, and the 13th Five-Year Plan.

long-term care becomes the institutional home that combine a mixed feeling of homely and unhomely, a mixed space of care and control.

Community eldercare programs are designed to enable older adults to "age in place," defined by the World Health Organization (WHO; 2015) as "the ability of older people to live in their own home and community safely, independently, and comfortably, regardless of age, income or level of intrinsic capacity." This approach has been favored by policymakers because it enables older adults to remain in their homes and reduces the cost of institutional care (Cutchin, 2003; Wiles, Leibing, Guberman, Reeve, & Allen, 2012). Scholars who study aging in place tend to approach home as a physical, social, and emotional space with defined boundaries, differentiating between home and unhome, or a homely and unhomely feeling (Blunt & Dowling, 2006). Rarely do scholars understand home as an extended space that goes beyond the private home, or as a place with mixed feelings of homeliness and unhomeliness (see Dorrer, McIntosh, Punch, & Emond, 2010).

In this chapter, I review the concepts of home and community and propose *institutional home* as a concept that can describe the hybrid space that is constituted of private home and community care center. The institutional home creates a mixed feeling of homeliness and unhomeliness that is constantly produced by both caregivers and the older adults who frequent these centers. The institutional home is a space of care for the older adults where they visit for social interaction and emotional support. It is also homely due to its time-space proximity to the private home where older adults maintain their connections with family and friends. However, the institutional home is also a space

of control and exclusion that regulates older adults and excludes extreme otherness, such as severely disabled and diseased older people.

By bridging the literature on aging in place and home, this chapter proposes the idea of institutional home to understand the expansion of home that takes place in urban communities as well as the legacy of institutions that render the caring space both semi-public and semi-private. This hybrid space facilitates understandings of similar caring spaces, such as community care centers for not only the aging population, but also homeless people or those in need of mental health services. This chapter first reviews the existing literature on home-based and community-based approaches to aging in place, followed by the methods adopted for this research project. The chapter then examines the expansion of home beyond private dwellings and the legacy of the institutional home. The last section summarizes the findings and describes the theoretical contributions of the notion of institutional home.

Aging in Place, Home, and Space of Care

Scholars studying aging in place stress older adults' aging experiences either at home or in the community. First, the scholarship on aging in place in the context of the home emphasizes home attachment, place integration, and meaning and identity negotiation (Andrews et al., 2007). Under this strand of thought, scholars have examined the interrelationships between home environment and older adults' well-being (Gitlin, 2003) with the goal of improving the home environment via assistance equipment (Chan, Campo, Esteve, & Fourniols, 2009; Mihailidis, Carmichael, & Boger, 2004). Second, research on aging in place in the context of the community focuses on the relationship between the neighborhood environment and older adults' well-being (Brown, Perkins, &

Brown, 2003; Glass & Balfour, 2003; Yen, Michael, & Perdue, 2009). In this community-based literature, scholars emphasize connections, familiarity, and the subjective experience of community, which includes things like the feeling of being in a home away from home (a public place that provides homely feelings), such as parks, cafes, barber shops, community centers, and churches (Gardner, 2011). These discussions on aging in place imply a narrow understanding of home as a private space with defined boundaries, and neighborhoods and communities as spaces outside the private home.

Scholars have understood home in multiple ways, examining it in terms of its physical, social, and emotional dimensions. *Physical home* refers to a physical dwelling place with defined boundaries (see also Black, 2002); *social home* emphasizes the social interactions and relations occurring within the home (Staeheli & Nagel, 2006); and *emotional home* identifies the feelings of safety, identity, and meaning associated with the home (Milligan, 2005, p. 2117). These different understandings of home tend to rely on a separation between what is inside the home and what is outside (Kaika, 2004; Staeheli & Nagel, 2006). According to Kaika (2004), the modern home is seen as being able to keep out unpleasant social processes and relations (such as "crime, socially excluded groups, homelessness, and undesired others") as well as undesirable natural processes and natural elements (such as "dust, cold or polluted air, rain, dirt, sewage, and smog";(Kaika, 2004, p. 266). By keeping these social and natural processes outside, home is seen "as a space autonomous and independent from socio-natural processes, as a distinct and autonomous 'space envelope'" (Lefebvre & Nicholson-Smith, 1991). Other scholars view the home as connecting inside and outside elements by stressing the connections that multiple homes have at various scales (Blunt & Dowling, 2006).

According to Staheli and Nagel (2006), homes are connected to the outside. We see this, for example, in immigrants, whose home-making processes are closely related to the place that they come from (Abdelhady, 2008). Thus, home is a porous concept that is both influenced by and influences the social and cultural context outside (Blunt & Dowling, 2006).

In their examinations of these multiple, interconnected aspects of home, scholars have also criticized a singular understanding of an ideal home, which is stereotypically homely, detached, and owner-occupied by a heterosexual nuclear family with intimate relationships. This idealized view of home is criticized for being "totalizing and imperialist" (Varley, 2008, p. 3), whereas the actually lived home could be different and not fixed. Instead of being seen as a fixed term for a fixed space with a fixed meaning, home should be understood as always "becoming" (Butcher, 2010), that is, changing in relation to people's "lived and imagined experiences of home" (Yantzi & Rosenberg, 2008), constituted by acts of imagining, creating, unmaking, changing, losing, and moving homes (Butcher, 2010, p. 24). Thus, home users consistently undertake home-making to feel at home. The home could be a mobile location formed through networks of people and things (Butcher, 2010), a stage of "being but not longing" (Ahmed, 1999, p. 339), or even a site of conflict (Wiles et al., 2012).

This unsettled understanding of home makes several readings of home in eldercare possible. A private home could be institutionalized, while an eldercare institution could be deinstitutionalized. Scholars studying home-based eldercare discuss the institutionalization of home for the senior adult with the intervention of professional caregivers, or the home becoming an institution for family members when they provide

care for fragile older adults (Brown, 2003; Milligan, 2000; Varley, 2008). For example, Brown (2003) has explored the institutionalization of home when hospice care is provided at private homes. In these cases, home becomes paradoxically public and private, and is a paradoxical picture of autonomy and dependency. While home can be institutionalized, eldercare institutions can be deinstitutionalized by creating homely feelings, reducing the size of the facility, providing more individualized care, or returning eldercare back to the community and private home. For example, Cooney (2012) has explored methods for allowing older adults to maintain a sense of home after relocating to a nursing home, including cultivating continuity, preserving a personal identity, establishing a sense of belonging, being active, and working.

Aging in place is closely tied to the home, because the home should be understood as more than a house: it is a concept that also includes the neighborhood and the community (see also Wiles et al., 2012). Thus, I propose the term *institutional home* to understand community-based eldercare programs as hybrid spaces that blur the boundary between home and community, and simultaneously have institutional and homely traits. This idea of an institutional home expands the concept of home so that it does not only refer to a private dwelling place, but can include the whole community. As a result, the concept of home can scale up and down to the scale of the body, household, city, and nation (Longhurst, Johnston, & Ho, 2009). The institutional home is a physical and social home that is constantly made by the older adults who use it based on their mutual care and also a sense of familiarity (Wiles et al., 2012). Thus, it is "sought, imagined, and recreated" (Abdelhady, 2008, p. 64) based on care, similarities, and familiarities. Moreover, the institutional home constitutes a caring space that provides

material resources and emotional support (Conradson, 2003b; Johnsen, Cloke, & May, 2005a; Johnsen, Cloke, & May, 2005b; Parr, 2000). The formation of homely and welcoming caring spaces also depends on harmonious relations between service users and staff members.

However, Johnsen et al. (2005) warn of the tendency to romanticize these caring spaces because in some cases, like community centers for homeless people, they can become spaces of fear, where a newly homeless person can be frightened by crime, poverty, and other issues also present in those spaces. Similarly, Parr (2000) illustrates that while community mental health centers include some types of otherness (people seeking mental health services), they also simultaneously exclude extreme otherness (those with severe mental problems). Last, while staff members in these caring spaces often desire to promote well-being, they also simultaneously discipline and regulate service users (Conradson, 2003b). Hence, while these spaces accept otherness, at the same time they exclude extreme differences, such as those who are severely ill or fail to follow established rules.

<center>Research Context and Method</center>

China is facing a large aging population whose drastic need for adequate eldercare has become a severe social problem. At the same time, the eldercare landscape is undergoing some major shifts. There are three major types of eldercare in China: institutional care, home care, and community care. The in-home eldercare option is gradually being eroded with rapid urbanization, the high mobility of the younger generation, and decreasing family size (*The Lancet*, 2016). At the same time, the Chinese government is promoting both institutional care and community care. With institutional

care being more costly, the government is now advocating for community care to facilitate aging in place. Recently, with the high demand for eldercare, the national government issued several economic development plans for promoting the eldercare industry and community eldercare centers as alternatives to institution-based care. These centers provide several major services, including food delivery to private homes, basic medical care, and community activities such as dancing, singing, and so on (Chen & Han, 2016). Currently, there are 344 community-based eldercare centers located in various districts in Shanghai and 350 in Beijing. This research focuses on one center in Beijing and two in Shanghai (Table 5). All are located in their city's central business district.

Table 5. Three Fieldwork Community Eldercare Centers and Their Services

Community eldercare center	Number of NGOs	Home care	Community care	Institutional care
A: Beijing, Chaoyang district	1	Yes	Daycare Lunch	Yes (long-term)
B: Shanghai, Jing'an district	2 (NGO-a, NGO-b)	Yes	Daycare (NGO-a) Lunch (NGO-b) Activities (NGO-b) Clinic	No
C: Shanghai, Putuo district	1	Yes	Daycare Lunch Physical therapy	Yes (< 6 months)

In total, I interviewed 23 older adults about why they visited the community eldercare center, how they spent their time there, and whether they felt that the center was a home. Also, I surveyed 106 older adults at one of the centers in Shanghai. The demographic characteristics of the survey participants are shown in Table 6. Of particular

note is that the older adults who frequent the center are primarily female and live with either a partner or their children, and nearly half are in their 60s. Gender might play a critical role in subjective feelings of home in eldercare. However, it is beyond the scope of this paper to discuss the role played by gender. In addition to interviewing and surveying the older adults at the centers, I interviewed 18 NGO employees and managers who worked for community eldercare companies. The interview questions ranged from the types of services they provided to the strategies they adopted to make older adults feel comfortable in the eldercare center. In addition, I asked them about specific regulations at the eldercare center that regulate older adults' behaviors. The interviews were conducted in Chinese and transcribed. Only the quotes included here were translated into English.

Table 6. Demographic Characteristics of Surveyed Older Adults at an Eldercare Center in Shanghai

Gender	%	Living Arrangement	%	Age	%
Male	29	Alone	25	60-70	45.45
Female	71	With partner	42	70-80	28.4
		With partner and children	33	80-90	23.9
				>90	2.3

Similar to the homeless population, the aging population is quite diverse. The older adults who go to community centers for lunch and participate in activities are normally relatively healthy and live independently. The 23 interviewees in this research project are mostly from this group, with the exception of Professor Li, quoted below. Those who have a mild disease-related disability or who want assistance during the daytime are admitted to the daycare program at community centers, where they have a separate room dedicated to them and three additional caregivers to provide them with

basic care, such as bathroom assistance, physical therapy, and daily vital-sign monitoring. Those with a more severe disease or disease-related disabilities are admitted to the respite care program, where they receive 24-hour care for up to six months. I refer to this type of caregiving space as "community institutional care."

In the following discussion, the homely and institutional elements of these centers are addressed separately. Although it may be problematic to target some elements as homely and some as institutional, this separation helps articulate the idea of an institutional home. In reality, the boundaries are blurred, flexible, and not fixed.

Homeliness

Home is a complicated concept that refers not only to the physical home, but also to the social and emotional home, where replicating social relationships and feelings of homeliness is key in the home-making process. In this section, I examine the homeliness of community eldercare programs by focusing on how they supplement the home function by providing a platform for social interaction and emotional support for older adults, facilitating fictive kinships.

Space of Care: Supplementing the Home Function

The institutional home replaces many of the functions that used to take place in private homes, such as providing food, spending time around the dinner table, and providing emotional support to family members. Community-based eldercare programs provide several vital functions that attract older adults. An eldercare center manager described the primary functions of the community center in these terms:

> I think [community eldercare] meets older adults' basic needs. For example, caregivers go to people's homes to cook. Some older adults just can't cook for

themselves. Thus, you meet their basic needs. For others, they just want company, somebody to talk to them. So our caregivers just need to be there. This is different from a housekeeping service. Housekeeping is outcome oriented. Both cooking and housekeeping services only care about providing food; they don't communicate with the older adults.. (NGO No.5)

This manager points out that the eldercare service is centered on the older adults and accommodates their various needs. He notes that older adults should be provided with not only meals, but also emotional care, which makes eldercare services different from housekeeping. By cooking for the older adults while at the same time talking to them, caregivers function as family members who provide both food and emotional support, which makes the older adults feel like they are at home.

Most of the older adults in community eldercare centers attributed their frequent visits to the center's accessibility, its low-cost lunch, and the care they received during the day. Professor Li, who was in his 80s and lived with his wife, explained this rationale in more depth:

I only have one son, who is extremely busy with work. He cannot take care of us. Hiring a housekeeper at home is too much pressure. We used to hire a nanny who never asked us what we wanted for dinner. She only bought whatever she liked, and it was expensive to employ her. It's hard to say. Here, I only spend 400 yuan (about $58) for the daycare center and 200 yuan (about $29) for lunch [each month]. That way I don't need my wife to cook for me. I'm satisfied with the service here. So is my wife. We're grateful to our communist party and our street office. This community eldercare center has great infrastructure, which was unimaginable in the past. I eat here, play chess, read books and the newspaper. I rest here after lunch and go back home in the afternoon. We're living very happily now. My wife usually comes and visits me. We live just across the street.

Professor Li indicates that he chooses to come to the community eldercare center every day for its low price, good service, and convenience. His stay at the center reduced his wife's burden, especially the task of cooking lunch for him. Here, the community eldercare center supplements the function of the home. Together, an NGO employee and the caregivers at the community eldercare center perform the functions of both

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housekeeper and wife, while at the same time offering professional care. Similar to Professor Li, many older adults visit the community eldercare center because of its ability to fulfill some of the home's functions. Mrs. Li, who was in her 70s and lived alone, stated:

> I came here because it provided lunch. I live by myself. It's hard to cook for yourself. If I make a lot, I can't finish it; if I only make a little, it's not enough. Here, they provide meat and vegetables. I mainly come here for lunch. It's too lonely to stay home.

Replacing part of the home function by providing affordable lunch and necessary care, which subsequently reduces the burden of care for family members, are the key reasons for Mrs. Li and Mr. Li to visit the community eldercare center. Thus, eating lunch every day at the community eldercare center replaces part of the function that originally belonged to the physical home, so that home includes not only the private dwelling place but also the physical building where the community eldercare center is located. By visiting the community eldercare center every day, older adults extend the boundaries of the physical home.

Space of Care: Social Interaction and Emotional Support

The second aspect of homeliness is found in the social interactions between older adults that form fictive kinships. Home, when understood as social home and emotional home, emphasizes the social relationships formed within the home and the emotional support it provides (Milligan, 2005). Extending the social relationships that originally belonged to the private home to the community requires an understanding of the formation of fictive kinships as a major part of the home-making process engaged in by older adults at the eldercare community centers. Here, *fictive kinship* means nonkin, imaginary kin, "as if" kin, or "pretend" relatives—close nonfamily members who assume

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family-like roles (Allen, Blieszner, & Roberto, 2011, p. 1159). The loneliness of older

adults can bring them to a community eldercare center; the various activities provided

there lead to greater social interactions with others, and sometimes the formation of

fictive kinships (Staeheli & Nagel, 2006). In these fictive kinships, older adults provide

each other with intimacy, emotional intensity, support, and assistance (Macrae, 1992).

For Mrs. Li, the older adult mentioned above, the community eldercare center

helps combat loneliness. As she noted:

> The second reason I come here is to solve the issue of loneliness. It's too lonely to
> stay at home. I like to do crafts because I'm lonely. . . . We all grew up in the
> same period and have similar experiences. We understand each other. Also, there
> are many activities here. You can choose which activity to do.

Mrs. Li came to the community eldercare center mainly for lunch and social

interaction. At the community eldercare center, she was able to have conversations with

other older adults and participate in activities that make her feel happy. Scholars have

verified the importance of nonfamily members' support for the elderly (Sung, 1991;

Truong, Bui, Goodkind, & Knodel, 1997). Coming to the community eldercare center to

deal with loneliness is very common. Mrs. Gong told me:

> I'm lonely at home. Nobody talks to me. My husband has been dead for almost 20
> years, and my children live somewhere else. Yesterday we held a sports activity
> outside. I participated. We older adults need to get exercise. I told my residents'
> committee that if they have an activity, they should just call me. I stay here every
> day. I'm lonely. If the residents' committee has an activity, just call me. I'm
> willing to participate regardless of my income. I'm home alone, and I'm lonely.

I encountered Mrs. Gong at the community center every day, and she was quite

talkative. She liked to talk about her life story and her children and grandchildren. To her,

loneliness was not something tangible that she could describe; she could only repeat,

"I'm lonely." She did make a group of friends at the community center. They sat together

and chatted every day. However, she was also quite selective about the friends she made.

During our fieldwork, I noticed that she had a prolonged absence. When she appeared

again, I asked her where she had been. She told me she hadn't come because she disliked

one of the other older adults in the community eldercare center. She explains her

dissatisfaction with a previous center she attended:

> I don't go there anymore. People should be able to have conversations with each other; if not, there's no meaning in sitting together. I can't compare to them. They're all better off financially. I have a grandchild who is famous in our neighborhood for being lazy and relying on me. They all know that I need to support my grandson. So I don't go there. Now we have this community center, so I come here.

Mrs. Gong made friends at the community center and it met her need for social

contact. being accepted, making friends, and having conversations were the significant

criteria underlying elderly Mrs. Gong's decision about which facility to attend.

Social interaction in the community eldercare center goes beyond making

friendships; it also involves strategies for receiving care when necessary. One of Mrs.

Gong's friends was Mrs. Feng, who also came to the center every day. Mrs. Feng, who

was in her 70s and lived alone, interacted with others to relieve her loneliness and to

make sure that she would be able to receive care based on friendship when it became

necessary:

> I have many sisters in my neighborhood. I'm very friendly to them. Whenever I need help, I just make a phone call, and they will come to help me. First of all, I need to be kind to them. If you mistreat them, why would they treat you well? I have a good sister who is younger than me. She's 60 years old. We've been good friends for 15 years. I need somebody who's younger than me. If I find a friend who's older, how can she come and help me? People in our age group should help each other. However, if I find somebody who is older than me, there is only the possibility that I help them. It is hard to ask them to help me. They can hardly walk. How can they come and help me?

Like many people in the neighborhood, Mrs. Feng had many friends at the

community center. She came to the community center every morning, had lunch, sat for a

while, and then left around 3 p.m. to visit the activity room for older adults in her

neighborhood. According to Mrs. Feng, her friends at the community center were just

"lunch friends." She also had friends that she could go out with for sight-seeing and ask

for help when she was in need. She needed these types of friendship because she lived by

herself and was afraid to contact her daughter for fear of becoming a burden.

In Mrs. Feng's case, the "many sisters" she refers to were fictive kinships, quasi-

family members with whom she could share information and stories while not being

worried about bothering them. She also expected her sisters to provide her with care

when necessary. Mrs. Feng was strategic about the friends she made and carefully

cultivated these friendships: "First I need to be nice to them," she says. "Being nice" is a

feature of care that requires emotional input and various forms of caring effort. Thus,

Mrs. Feng created social homes in the community, which produced social interactions

and relations similar to ones that occur in the private home (Staeheli & Nagel, 2006).

In most cases, fictive kinships are constructed to receive emotional support, which

plays an important role in creating the emotional home. Community eldercare centers

provide critical social support for older adults—a benefit that changes their perceptions of

the center to something similar to home. An NGO director at a center in Beijing

described an older adult who came to the center just for consolation:

> We have an older adult who came to our community eldercare station around 7
> a.m. She said she felt uncomfortable. She ate a date and swallowed the seed. She
> thought it might cause some problems, so she couldn't fall asleep the whole night.
> I asked her, "Are you in pain?
>
> She said no, she just came to ask me whether she needed to go to the hospital. I
> said, "There might not be a problem since you're not in pain, but if you're still
> worried, you can go to the hospital to check it out since it's not far away. . . . This
> older adult sees us as somebody she can rely on or trust. She came to our place for

suggestions because she trusts us and she relies on us psychologically. (NGO No. 2)

Thus a community eldercare setting is a place that older adults can rely on when they need help or when they are worried about something. Older adults consider this place an emotional home that provides a sense of safety. Their social connections and constructions of "intimacy and emotional intensive fictive kinships (Macrae, 1992) enable the community eldercare center to become an emotional home. Again, home extends outside the boundary of the private home.

Aging in Place: Time-space Proximity to the Private Home

Community eldercare centers, including both daycare and 24-hour facilities, are all located close to older adults' private homes. This allows older adults to remain in the community, and hence to maintain their sense of connection, familiarity, and security (Wiles et al., 2012). This is especially true when community eldercare provides only respite care, which aimed particularly at people whose family members are temporarily busy or on vacation, or those who are recuperating from surgery and need special recovery care (Zhengxie, 2017) Respite care consists of a series of rehabilitation programs that aim to return patients to their home; therefore efforts are made to maintain their connections with family members and their home. An example of this is the "Go Home on Friday" program at community care center C in Shanghai, which sends residential patients home every Friday to spend the weekend with their children. A caregiver described the importance of this program for maintaining familial connections:

> All the [residential] older adults here go home on Friday afternoon as long as
> they're healthy and have family members at home. Their family member will
> send them back Saturday afternoon. . . . This way, the older adults can maintain
> their connection with their family members, unlike other eldercare institutions
> where live-in older adults won't go home for ten years. The older adults living in

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our institutions maintain a strong connection with their family members, who also visit here frequently. Some family members visit every day; some visit every other day. . . . The older adults and their family members feel as if they never left home.   (NGO No.28)

Community eldercare centers are also geographically close to the residents'' homes. These institutions tend to be located within 5 to 15 minutes walking distance from the older adults' apartment or their children's apartment. My survey found that the average time for older adults to walk to Center B is around 9 minutes. At that center, the older adults still live in the same community where they have lived their whole lives. They are familiar with the surrounding neighborhood. One day, an older adult was very excited about the afternoon grocery shopping trip. She said she knew the people working in the grocery store, who could give her a lower price. Thus she was able to still maintain a strong attachment to place even in institutional care.

Being familiar with not only the environment, but also the people, is a key characteristic of aging in place. People who grow up together and grow old together are able to more easily form fictive kinships (Macrae, 1992). An elder in her 80s who frequently visited the comprehensive eldercare center talked about his long familiarity with his peers at the center:

> We used to live where the grocery shop is. We've all known each other for a long time. We lived where the grocery shop is, and she lived across the street. We're very familiar with each other. We've lived here since we were children. We grew up here, we got married here, and we lived here our whole lives. She is a Jingan girl, married in the Zhabei district—now Zhabei is combined with Jingan, so she's back to Jingan again. (Mrs. Jingyi)

The community eldercare centers' geographical proximity to private homes generates a sense of familiarity and renders the community eldercare center home. This resembles Harden's (2000) finding that children's familiarity with the people and environment in their neighborhood makes it feel safe, like home (Harden, 2000). Other

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research has found that maintaining connections with family members and friends

provides a feeling of homeliness (Milligan, 2005). Aging in place is essentially connected

to the idea of home, whether the physical home or the imagined home.

<div align="center">Institutional Home</div>

Similar to the soup kitchen, or drop-in center for the homeless population, where the care

center is simultaneously a space of care and space of fear(Conradson, 2003b; Johnsen et

al., 2005a; Parr, 2000), the institutional home also has explicit and implicit rules that

regulate older adults. This regulation and control renders community eldercare

institutional, especially when institutional care has been associated with de-

individualizing characteristics, such as the expectation that the older adults will adapt to

the institution's activity schedules and rules (Dorrer et al., 2010). This section examines

the institutional aspect of the institutional home by discussing community eldercare

centers' role as a backup choice and how the institutional home functions as a space of

control and exclusion.

<div align="center">*The backup choice for home*</div>

For most older adults, the community eldercare center differs from home, and

many retreat to a private dwelling place for rest.

> Every day, I go home to sleep. My home is just 5 minutes walking distance. I
> need to go home and rest. Regardless if I sleep or not, I need to go home and rest.
> Just 10 minutes and I will feel refreshed. It is chaotic here, not a place for resting.
> There are people who stay here after lunch. Some are lazy. Some have other
> conditions. Their home might be small, 40 to 50 square meters with four people.
> (Mrs. Li, in her 70s)

Mrs. Li said that she came to eldercare to spend the day because of loneliness, but

she also needed to go home to relax. During my time at the community care center, Mrs.

Li frequently told me that she wouldn't come the next day because she needed to travel

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with her daughter's family, pick up her granddaughter, or have dinner with her daughter's family. To her, the eldercare center was a backup place to stay when her daughter was busy and when she felt lonely.

Other older adults expressed similar feels that the community eldercare center was a backup option to their private home, as Mrs. Liu, in her 80s, explained:

> I don't have lunch here. Lunch here is not as good as at home. We're going to have visitors tonight. Another family is going to visit us. We're already well prepared at home. We need to make 15 dishes, including beef stew and salad. We also had visitors yesterday. We have visitors every day. Usually I eat at home with my daughter and son-in-law. My grandson, my nephew, and friends visit us frequently. We often have visitors.

Mrs. Liu rarely came to the eldercare center, stating that she was quite busy at home. She was not lonely at all and her children and grandchildren all treated her very well. That said, she came to the eldercare center when she had no visitors or she was not busy at home. Thus, the eldercare center is a backup space for the private home.

Based on the survey conducted with 110 senior adults in a community eldercare center in Shanghai, most of the older adults only stayed at the eldercare center for a short period, or only came when there was nothing to do at home, as Mrs. Wang, in her 70s, stated:

> When it's not open during the weekend, we stay at home and improve our diet. If we can't eat well [at the center], we cook something better at home. I take my mother outside to get some exercise and watch TV at home.

Mrs. Wang brought her whole family to the eldercare center, including her husband, her mother, and their live-in housekeeper. They came to the community eldercare center mainly for rehabilitative training services. However, they were quite dissatisfied with the lunch at the center. Thus cooking something unique and tasty was their primary activity during the weekend when the center was closed. Here, older adults

such as Mrs. Wang selectively participated in the community eldercare center, attending

for certain functions or during a certain period of the day.

The center as a backup option also provides an escape from the private home,

especially when the private home is full of tension. The director of a community

eldercare program identified one such case:

> One day we received a complaint. Somebody called the mayor's hotline complaining that we closed earlier than we were supposed to. They said that we kicked the older adults out, and they had no place to stay. . . . they could only stay in the community yard. Don't the older adults have their own home? This is ridiculous. Then I learned that there was an older adult woman whose daughter and son treat her poorly. She can only stay in the community yard. (NGO No.14).

NGO No.14 was pressured by many older adults to extend the service time so that

the center would be open for breakfast and on weekends. When older adults have poor

family relationships or an unsatisfying home environment, they tend to rely on the

community eldercare center more. Thus, the center becomes the substitute for some older

adults to escape an unhomely home. The social home at the community eldercare center

replaces the private home to certain degree.

Space of exclusion

The institutional home constitutes not only a caring space, but also a space for

control that excludes some of the elderly population. Community eldercare services

require participants to hold a locally registered hukou. Those who do not hold a locally

registered hukou, such as Ms. Li, are not qualified for government-sponsored community

eldercare services, such as access to private homecare or daycare centers. They could still

receive eldercare services at the market price, but it is dramatically higher than the price

charged those who hold a local hukou registration. In these cases, the elderly are

essentially excluded from receiving community eldercare services.

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In addition to the exclusions created by the hukou system, there are also internal exclusions for those who are extremely aged or diseased. Normally healthy older adults come to the community eldercare center for lunch and to participate in activities. Those with mild disease or disease-related disabilities are then admitted to the daycare program within the same community eldercare center for an administrative fee of 400 yuan ($58) per month. The daycare center has a separate room in the community eldercare center and typically has three social workers, caregivers, or nurses assisting the older adults. In addition to serving lunch and conducting activities, the daycare center provides other services, such as physical therapy and monitoring vital signs like blood pressure.

While the community eldercare center aims to promote older adults' well-being by providing lunch and holding activities to help the older adults be engaged with their community, these activities exclude other older adults with severe disease or disease-related disabilities. One day at a community eldercare center I was asked to serve lunch to those coming for the trial program. Approximately 15 older adults came from the same neighborhood, and they all appeared very active and healthy. The care center's original intention was to mix them with those who had been admitted to the daycare program. However, this idea of sitting together for lunch was rejected by the relatively healthy and active older adults. They were not willing to eat with those who had mild dementia or other kinds of disease. One of them took me to a corner of the room and told me, "They're too dirty. They even dribble food when they eat." Being unwilling to sit together for lunch can be construed as a form of exclusion—even though it is a space for older adults, people of advanced age or with severe disease-related disability are rejected.

This type of internal exclusion, where healthy older adults exclude less healthy older adults, confirms findings at a homeless caregiving center in the UK, where the newly homeless could be frightened by crime, poverty, and other issues (Johnsen et al., 2005a). Also, Parr (2000) found that while drop-in mental health centers are relatively open and welcoming for those with mental health issues, people with severe mental health problems are excluded. Similarly, in the community eldercare center, older adults are very diverse; in particular, those who are more advanced in age have very different characteristics from those who are younger. Again, older adults who cannot pass the body assessment are excluded from receiving community care services and may only be provided with in-home care.

Mrs. Wang attended the community center with her husband and her mother. She said they previously lived at a traditional eldercare institution. But every day people would pass away and the institution would park the dead body in the hallway, which would constantly remind the residents of death. Afraid that this would make her mother depressed, they moved out of the eldercare institution and back to their own home. They received care at the daycare center during the daytime and returned home when the center was closed. The exclusion of older adults who are severely diseased or disabled renders the community eldercare center active and full of energy. This active environment attracts older adults, such as Mrs. Wang.

Conclusion

This chapter has attempted to theorize community eldercare in urban China with the concept of institutional home. As an institutional home, the community eldercare center supplements some major functions of the private home, such as providing

affordable meals. Moreover, the community center provides a platform for social interaction among older adults to help them deal with loneliness. In many cases, the friendships developed at community eldercare centers become fictive kinships that provide mutual assistance and intensive intimacy and emotional support. In addition, these centers are close to older adults' private homes, where they are familiar with the environment and the people. The older adults are able to maintain their connections with family members and friends, which creates the feeling that they "never have left home."

While institutional home in this is portrayed as somewhat idealist here, this chapter emphasizes that both home and community institutions can be exploitative and depressing. Hence, institutional home is situated between homely and unhomely. Even though it aims to provide a homely feeling, it simultaneously regulates older adults and excludes advanced age as well as severe disease or disability. The institutional home serves as a backup to the private home, a way of either escaping abusive family members or avoiding loneliness at home. The private home is still the primary choice for a space to rest or to perform daily activities with more autonomy.

Theorizing the institutional home sheds lights on similar hybrid spaces that provide homely feelings in institutional or semi-institutional spaces, such as the drop-in center for mental health and soup kitchens for homeless people. It reconceptualizes aging in place by bridging the literature on aging in the community and aging at home with a broader understanding of home. Here, home is no longer a place with a fixed boundary and fixed meaning. Rather, home expands beyond the physical space of the private home, contains mixed feelings of homeliness and unhomeliness, and is constantly made. Hence, by unpacking the notion of home, aging in place is granted much more complex

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meanings, such as constructing a homely feeling in institutions or breaking down the fixed boundary between home and community by constructing the institutional home. Even though this research touches on the blurred boundary between public and private within the community eldercare program, more research on and articulation of the intermingling between public and private spheres should be conducted in a wide variety of homes, communities, and institutions.

CHAPTER VI

TOWARDS A MORE JUST SOCIETY? CARE ETHICS AND CAREGIVERS IN

URBAN CHINA[9]

Introduction

Taking "care" seriously, we as geographers have started to envision geography as an ethical and responsible discipline by paying attention to the questions we ask and by researching in a caring and responsible way (Lawson, 2007; Massey, 2004; Popke, 2006; Raghuram et al., 2009). In doing so, a more ethical, compassionate, and caring discipline is established, in which care ethics reshape geography and geographers' research practices epistemologically, ontologically, and methodologically (Lawson, 2007; Milligan & Wiles, 2010). Through engaging with "care ethics," geography actively observes spatial relations, which includes exploring spatial arrangements of caregiving and care-receiving, ethical place-making, and care that crosses space(Raghuram et al., 2009; Staeheli & Brown, 2003). These engagements highlight the spatiality of care(Conradson, 2003a).

The desire to shape a caring geography and a geography of care is rooted in care ethics, which challenge commodification logics and bring an alternative approach to neoliberalism (Lawson, 2007). Responding to the call for research that engages with care ethics, this chapter examines the influence of care ethics on caregivers' working experiences. The findings of this study indicate that instead of challenging neoliberalism, care ethics embedded in job requirements actually exploit caregivers and put them in a

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"prison of love." England (2005) theorized that a "prison of love" forms when caregivers are inclined to endure low wages and long working hours because of the emotional attachments they develop with their care-recipients. This prison of love arises from the dual function of emotional labor that simultaneously awards and exploits care workers (Monrad, 2017). When performing emotional labor, caregivers unavoidably form attachments with people in their care, which motivates their work and renders them willing to endure low wages. When the care ethics of attentiveness, responsibility, competence, and responsiveness (Tronto, 1993) are embedded in caregivers' job requirements, caregivers prioritize the care-recipients' needs; in many cases, this prioritization leads caregivers to accept being exploited while also blurring the boundary between life and work (Mitchell, Marston, & Katz, 2004). This is especially true when care ethics mean that care work not only includes bodily work (Clark, 1999; Dyer et al., 2008; Twigg et al., 2011; Wolkowitz, 2002) and "dirty" work (Ashforth & Kreiner, 2014; Duffy, 2007; Hansen, 2016; Jervis, 2001; Ostaszkiewicz et al., 2016; Stacey, 2005), but emotional work as well (Dyer et al., 2008; Lopez, 2006).

This chapter examines caregivers in community eldercare programs in China. Specifically, it examines the caregivers' working experience when care ethics are inscribed in the job requirements. Situated in the theoretical debate about the nature of care ethics and care work, I argue that instead of achieving a caring and responsible society by challenging commodification, care ethics have the potential to exploit caregivers and put them in a "prison of love" while blurring the boundary between life and work. Drawing on interviews with and observations of 28 caregivers, 27 eldercare company managers, as well as a survey of 126 caregivers, this chapter examines

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caregivers' working conditions and the impact that care ethics has on their work. This chapter generates three major findings. First, when care ethics are embedded in the job requirements, caregivers are expected to conduct not only bodily work and "dirty" work, but also emotional work. Second, the involvement of care ethics in care work establishes different social relations between caregivers and care-recipients, which produces a different subjectivity that blurs the boundary between life and work. Third, the new subjectivity formed under care ethics renders caregivers willing to work long hours for low pay, which puts them in a "prison of love" (England, 2005).

This chapter is structured into four sections. The first section examines the theoretical debate calling for a caring geography to challenge neoliberalism via care ethics. It also provides a conceptual framework by describing care work as bodily, "dirty," and emotional work. The second section presents the method adopted in this research and the caregivers' demographic information. The third section analyzes how care ethics influence caregivers when they are a part of the job requirements. The final section examines caregivers' work in relation to care ethics by theorizing care work as bodily, "dirty," and emotional work. The chapter then summarizes its major conclusions and contributes to future theoretical research by calling for a caring geography based on empirical research.

<center>Care ethics and Commodification</center>

According to Tronto (1993), care contains four phases: caring about, taking care of, caregiving, and care-receiving. "Caring about" refers to the ability to notice the need for care, "taking care of" refers to somebody assuming the responsibility for care, "caregiving" refers to the actual care work itself, and lastly, "care-receiving" refers to the

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response of care-receivers. "Caring about" and "taking care of" attend to needs, including the "ability and willingness to 'see' and 'hear' and to take responsibility for these needs" (Haylett, 2003, p. 806). Derived from this meaning of care, care ethics involve four elements: attentiveness, responsibility, competence and responsiveness (Tronto, 1993). Tronto (1993) explained that attentiveness refers to the ability to notice others' needs, and that, furthermore, not only is it important to be able to notice others' needs, but this noticing should be responsive to those needs, particularly in moments of vulnerability and inequality. After noticing and responding to needs, people should also be responsible and competent in providing care; essentially, they should be able to provide the necessary care. One final aspect of Tronto's (1993) description of care ethics that deserves attention is the idea that how we define responsibility is context-dependent, situated in a variety of cultural practices. Implied in this understanding of care ethics is a relational ontology that perceives humans as dependent and inter-subjective beings embedded in networks. This view comes from Emmanuel Levinas, who sees ethical responsibility as "the essential primary and fundamental structure of subjectivity" (Levinas, 1985, p. 95; see also Popke, 2006). Therefore, scholars argue that care in "loving, thinking, and doing" may indicate a new ethical, social relation that attends to others' needs and produces a particular situated standpoint through performing care work (Leira, 1992, p. 27; see also Popke, 2006).

Within this line of thinking, scholars argue that care ethics challenge the commodification of care that occurs when the market is relied on to provide and distribute care; "Those who can pay for more often receive the care, regardless of any assessment of need" (Tronto, 1993, p. 173). This is especially true under the pervading neoliberal discourses of the laissez-faire free market. Neoliberalism enshrines "economic

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rationales, competition, entrepreneurialism, individualism and independence" and other values that are contrary to state responsibilities (McDowell, 2004, p. 146) with the assumption that under the free market, individuals can act as free and rational agents with autonomy. Based on this assumption, mutual dependency and care for others are irrelevant, because the free market can solve people's needs for care (McDowell, 2004). However, this ignores the feminist care ethic that describes human beings as mutually dependent on each other to both provide and receive care (England, 2010).

Thus, scholars argue that care ethics lend us a lens to challenge the commodification of care that occurs under neoliberalism. Care implies the existence of needs. Being needy often is seen as weak and differs from the neoliberal ideal of an autonomous, individualistic human being. However, scholars argue that we are all dependent and vulnerable to some degree throughout our lifetimes (England, 2010; Lawson, 2007; Tronto, 1993). We all receive care and provide care to others, whether as "family members, colleagues, friends, or strangers"(Lawson, 2007). Therefore, care ethics challenge the neoliberal principles of "individualism, egalitarianism, universalism, and of a society organized exclusively around principles of efficiency, competition, and a 'right' price for everything" (Lawson, 2007). That is to say, care ethics start with a relational social ontology and connect individuals with "mutuality and trust" by stressing co-operation rather than competition, and interdependence rather than individuation (Popke, 2006).

Lawson (2007) and Popke (2006) attempt to envision a caring geography that begins with intersubjectivity, rather than neoliberal autonomy. However, what if care ethics are also commodified? What if being ethical in care became a part of the job

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requirements for caregivers? Scholars researching care work in the childcare industry have long explored similar issues for caregivers, which include struggles with detaching from children in their care and being professional when care requires mothering, and the depletion and burnout associated with emotional work. Similarly, Tronto (1993) points out that because care is associated with private, emotional and physical needs, care is often seen as a symbol of weakness. People who conduct care work are usually marginalized, while privileged people "pass caring work off to others" (Tronto, 1993, p. 112). In this case, "caring about" needs is the duty of the powerful (and typically associated with masculinity), while the actual care work goes to marginalized populations, mostly women of color (Tronto, 1993), whose labor is devalued because of their migration status and the care work they conduct.

Theorizing care work as bodily work, "dirty" work, and emotional work helps unpack caregivers' working conditions. Bodily work is care work that "involves work that focuses directly on the bodies of others, who thereby become the object of the workers' labor" (Twigg et al., 2011, p. 171). This work is shaped by "the attitude to the body, to different parts of the body, and to different states of the body" (Dyer et al., 2008, p. 2032). Moreover, this type of labor is conducted through the caregiver's own body. Bodily work is devalued because it is associated with "dirty" work that directly deals with those who are "rejected" and "left over" and whose bodily fluids "spill out" and "pollute" (Wolkowitz, 2002, p. 501) or with "matter out of place" (Douglas, 2003). The symbolic attachment of care work to "dirty" work also constructs the "dirty worker" (Dyer et al., 2008), who must constantly negotiate bodily boundaries. Lastly, care ethics necessarily require caregivers to conduct emotional work.

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Emotional work, a dimension of work first raised by Arile Hochschild (1983), refers to the work that imposes emotional rules on workers, whereby workers are required to display certain emotions. Care ethics, especially in requiring attentiveness and responsiveness, demands caregivers' full attention to the care-receiver, which implies that caregivers should not only care for, but also care about the people in their care. These rules commanding workers to feel certain emotions may lead to the depletion and burnout of caregivers or to workers performing the superficial display of emotions when privately felt emotions are not consistent with those demanded by care ethics workers (Cox, 2016; Kang, 2003; Karabanow, 1999; Lee & Brotheridge, 2011; Lopez, 2006; Wong & Wang, 2009). The expectation that caregivers not only care for but also care about their care-recipients indeed establishes a different social relation between caregivers and care-receivers, which may produce a different subjectivity(Diefendorff, Erickson, Grandey, & Dahling, 2011; Kang, 2003; Monrad, 2017). At the very least, these demands on caregivers' emotions blur the boundary between life and work and adds an emotional burden on caregivers when their employers stress the enabling power of care. Moreover, it might put the caregivers in a "prison of love" in which caregivers are willing to be paid less and work extended hours because of the social relations formed through caring (England, 2005).

Thus, on the one hand, care ethics challenge the neoliberal principles of "individualism, egalitarianism, and universalism"(Lawson, 2007). On the other hand, care ethics may contribute to the commodification of care work and further exploit the already marginalized populations who often comprise the majority of care workers. Care ethics accomplishes this by creating a "prison of love" (England, 2005), wherein care

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workers are made more willing to be exploited due to the social relations formed by conducting care work according to care ethics. Thus, care ethics embedded in job requirements may further exploit caregivers by continuing to blur the boundary between life and work.

Method

Fieldwork conducted in Beijing and Shanghai from April 2017 to October 2017 form the basis for this chapter's findings. I conducted interviews with 28 caregivers, 18 eldercare NGOs employee, and 9 eldercare company employees. These caregivers and employees provide eldercare services in their local communities. The caregivers' practice could be divided into two groups. One group went to elderly individuals' private homes, while others worked in local community nursing homes. Eldercare companies hired both groups of caregivers to provide community-based eldercare within local community nursing homes, daycare centers, and private homes(Chen & Han, 2016; Wu, Carter, Goins, & Cheng, 2005; Xu & Chow, 2011).

I interviewed caregivers by asking questions about how they deal with emotional attachments formed through caring; how they feel when confronted with "dirty" excrement; how they think about caring for their care-recipients' bodies, and so on. I also asked questions specifically about care ethics; for instance, I asked what the caregivers do when they notice an elderly person in need, what their reactions are to attending to the elderly's needs, etc. In addition to interviews, I went with caregivers to individual homes in order to observe their caring services and their interactions with the elderly. By doing so, I gained a thorough understanding of caregivers' working conditions. Finally, I surveyed 126 caregivers in order to gather demographic information and to gain a general

understanding of their attitudes toward their work's bodily, "dirty," and emotional

components (Table 7). Caregivers are mostly female with an agricultural hukou status.

Hukou, known in China as the household registration, attaches people to a certain place,

either urban or rural(Chan, 2010b). The agricultural hukou distinguishes caregivers from

those with urban hukou, who normally have better socioeconomic status (Chan, 2010b).

The caregivers are also mainly in their 40s and only have on average an elementary

school education. The majority did not receive any training in caregiving before starting

employment.

Table 7. Demographic and socioeconomic characteristics of questionnaire participants
(caregiver).

Gender	%	Hukou	
Male	21%	Agricultural	64%
Female	79%	Non-Agricultural	36%
Age		Income	
<20	0	1000-2000	1.6%
20-30	4.8%	2000-3000	12.8%
30-40	20.6%	3000-4000	45.6%
40-50	57.9%	4000-5000	36%
>50	16.7%	>5000	4%
Education	% (No.)	Caregiver training	
Primary school	18%	Before hiring	46.3%
Elementary school	50%	After hiring	46.3%
High school	25%	Never	7.4%
Vocational school and above	7%		

Care ethics and the prison of love

Care ethics involves four elements: attentiveness, responsibility, competence and

responsiveness (Tronto, 1993). However, being all of these things at once is extremely

demanding on caregivers. During my fieldwork, I volunteered to stay overnight at one of

the facilities from 9:30 pm to 5:30 am. During the night shift there is only one caregiver,

and that solitary caregiver is responsible for 15 elderly clients. In order to facilitate communication between the caregiver and the care-recipients, the eldercare company developed an app to be installed on the caregiver's work mobile phone. Whenever the elderly residents have needs, they can press a button, and the system immediately sends a notice to the workstation computer and to the caregiver's phone. After receiving the notice, the caregiver responds by going to see what the need is and what kind of care should be provided. In this way, the caregivers are more attentive and responsive to the elderly's needs. If the caregiver fails to respond to the notice, the elderly person may become angry and report the caregiver for being irresponsible. The level of demand placed on caregivers was illustrated when one caregiver indicated that she prefers standing when she is on duty rather than sitting. She said, "If I sat down, it would be harder for me to stand up. Moreover, I need to be prepared to stand up."

> Ms. Dong has a bone fracture. She just received surgery and is in her recovery period. She cannot move so whenever she is in need, she rings the bell, and I go to help her. Mr. Chen, his bell malfunctioned. So he walked to the door by himself and called me. He has a good personality and is very understandable. In comparison, the other grandpa that shares a room with him is not that nice. He will get angry if I do not hear his bell ring. He will talk in an angry voice. In this kind of job, even if you feel wronged, you still have to serve the residents. (Caregiver 12, August 2017, Shanghai)

Failing to hear the bell and provide responsive, responsible and competent care leads to dissatisfied elderly residents. Fearful that the bell will not work, the caregiver sometimes patrols the elderly's dwelling area to attend to their needs, a duty which the company requires for the night shift. The patrol aims to sync the caregiver's work phone with the elderly patients' smart watches. When the work phone nears the watch, the phone automatically shows the elderly patient's basic information including name, age

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and so on. Through this technology, the company can monitor whether the caregivers are being responsive and patrolling the elderly patients' rooms and needs.

In addition to this technology that reminds the caregiver to be attentive and responsive, care ethics are also required of social workers or caregivers in the community daycare center. During fieldwork in one Shanghai daycare center, I was asked to help set up the dining table and clean the table during lunchtime. Sometimes I needed to help serve the food as well. Therefore, between setting up and cleaning the dining table, I usually sat on the side and observed. However, a caregiver criticized this "sitting on the side" because to them it indicated that I was not paying attention.

> Just now an elderly man nearly passed out. I helped him walk outside. You should look and observe. Or else, why are you sitting here? You should sit here and continuously do observation, see what kind of situation is going on for them. Also, when some of the elderly stand at the entrance and don't know where to sit, you should find a seat for them. Just now, that person spat water on the floor. I told him if you do this, other people might fall. However, you need to tell them politely so they will continue coming to our eldercare center. This is what our boss told us. (Caregiver 6, May 2017, Shanghai)

As stressed by the caregiver in the above statement, even when sitting, one should always be attentive to the elderly's needs and competent in providing care. This care can include simply finding a seat for the elderly, arranging the table, or helping the elderly walk out of the room. Such care requires that caregivers pay close attention to the elderly and quickly respond to their needs. Thus, the care ethics of attentiveness, responsibility, and responsiveness may easily lead to burnout and depletion of caregivers because they are expected to be constantly alert for and responsive to the elderly's needs. Also, the caregivers' responses to the older adults' needs sometimes prevent caregivers from

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meeting their own needs. For example, in one case, a caregiver gave up her mealtime to serve an older adult who was reluctant to eat.

> He does not listen to his family members. I used to serve him at 2:00 pm. His daughter-in-law told me that he did not eat lunch. Every time I went to his home, his lunch was still there, untouched. I would then feed him. His daughter-in-law asked me to come during the lunchtime to help him eat. So I sacrifice my own lunch time to serve him. This is hard and difficult work. But I am rewarded with the older adult's satisfaction. (Caregiver 8)

In the case above, to satisfy the older adult's need, the caregiver felt that she had to sacrifice her lunchtime, which made her work difficult. Also, to be attentive to the needs of the elderly, the caregivers sometimes feel that they need to take extra time to communicate with the elderly. In many cases, this means working the caregiver works unpaid hours. Caregiver 8 stated that she always worked past the end of her shift at one elderly man's home because she had to spend the initial part of the visit trying to persuade the elderly man to accept her service.

Studies indicate that burnout syndrome is common among caregivers and nursing staff. Poncet et al.'s (2007) survey of health care professionals indicated that one-third of the people in this profession have severe burnout syndrome. As one caregiver said, "I think this is really demanding and exhausting work. So, I was thinking about quitting the job at first" (Caregiver 14). Performing care work in accordance with care ethics increases the care burden and the possibility of caregiver burnout. Thus, when a care manager or care company includes care ethics in the job requirement, it can improve care quality, but it can also easily lead to the exhaustion, burnout and depletion of caregivers.

Bodily work & "dirty" work

This section analyzes the impact of care ethics on caregivers when theorizing care work as bodily and "dirty" work, which all lead to the devaluation of care work (Duffy, 2007; Dyer et al., 2008; Wolkowitz, 2002). Bodily work is defined as "work that focuses directly on the bodies of others: assessing, diagnosing, handling, treating, manipulating and monitoring bodies, that thus become the object of the worker's labor" (Twigg et al., 2011, p. 171). Thus, care work directly conducted on a customer's body is shaped by "the attitude to the body, to different parts of the body and to different states of the body" (Dyer et al., 2008, p. 2032). Moreover, this type of labor is conducted through caregivers' own bodies. For example, in one case, the caregiver needed to take off her clothes in order to gain an elderly woman's trust to let the caregiver bathe her.

> I have been serving this old lady for three months. It includes bathing her every Monday, Wednesday, and Friday. Each time I go, she does not recognize me. She has quite a bad memory. However, she was a teacher, so she is very articulate.
> "Can you remember me?"
> "No, I do not know you."
> "Let's take a shower."
> "No, you are a male."
> "I am female."
> "You are male. You just are dressed like a female."
> She was not willing to take off her clothes because she thought I was a male. So I took off my own clothes, let her see my body.
> "See, am I female or male?"
> "Oh, we are the same [female]" Then she let me help her take a shower. (Caregiver 8, August 2017, Shanghai)

To be able to gain the elderly woman's trust, the caregiver had to take off her own clothes and show her body to the woman; the caregiver had to manipulate her own body in order to provide care. Care work as bodily work is also directly associated with feminized

work. In both the case above and below, the female caregiver was more acceptable to the senior clients because of the common perception that a female caregiver is trustworthy, gentle, and less likely to be harmful, and practices good care.

> We have 60 elderly and 15 caregivers. Every floor has a male caregiver who specifically deals with the male elderly clients. Female caregivers will take care of both male and female elderly clients. It is rarely the case that a male caregiver will practice care for a female unless the elderly female and her family members do not mind. This is because the care work relates to things such as bathing and scrubbing the body. Typically, a male caregiver practicing care on a senior woman would only occur in the case of someone who has dementia. (NGO 23, September 2017, Beijing)

As the above interview with one NGO manager suggests, female caregivers are required to practice care on all bodies with the expectation that they will be professional, whereas male caregivers can only practice care on male bodies. Care work, in its various forms (including both paid and unpaid), is primarily provided by women (Armstrong & Armstrong, 2004). This type of labor is devalued and is seen as merely the use of innate skills or housekeeping skills. This description of how care work is perceived draws from conceptualizations of work and the gendered division of labor articulated in traditional Marxism. Feminist economists criticize Marxism of viewing work as being limited to economically productive wage labor that occurs outside of the home, while domestic activities, such as housekeeping and caring for family members, are the responsibilities of wives and mothers in the private domain. As such, differentiating "work-production-public" from "care-reproduction-private" limits care work to being devalued as women's work performed in the private sphere (England, 2010). It also renders care work as a type of women's work requiring only innate skills, motivated by quasi-religious devotion, and compensated by the satisfaction gained from care work (Dyer et al., 2008; England, 2005).

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In addition to being perceived as bodily work, care work is further devalued by its association with "dirty" work, which is work that directly deals with those who are "rejected" and "left over" and whose bodily fluids "spill out" and "pollute" (Wolkowitz, 2002, p. 501). Care work as dirty work is frequently mentioned by the managers of eldercare companies when explaining the reasons for the high turnover rate of caregivers. According to one NGO leader, the most difficult things for caregivers to deal with are the elderly's excrement or urine. For example, constipation is a common problem for the elderly. Caregivers are frequently asked to help the elderly defecate.

> The elderly are dirty. If it is the shit of an infant, you do not feel that it is that dirty. However, if it is the elderly resident that needs a diaper changed or shit cleaned, some people cannot accept it. To me, in the beginning, I did not accept it. When I first came to Shanghai, I worked in another eldercare institution. The elderly there were all elderly people lying in bed. They pooped and peed on the bed. I needed to change their diapers. It was very dirty. That was my first time seeing this kind of elderly patient. I didn't want to deal with them. I thought it was too dirty. Nobody wanted to do the care work for them. They peed on the diaper. Whenever I saw the diaper, I felt it was very dirty. For somebody who has never had experience with the elderly, normally, he/she cannot accept it. When we think of infants as being dirty, people are more willing to accept it, but not of the elderly. So, in this case, if the salary is not higher than in other occupations, who will do this work? (Caregiver 12, August 2017, Shanghai)

In the above interview, the caregiver expresses how care work can be dirty work. The caregiver compared the elderly and children. In this case, the elderly patients' decaying bodies and their excrement are seen as particularly dirty. Isaksen (2002) indicates that "some bodies may be seen as particularly polluting," especially when the aging body is seen as the leftover of a lifetime of eating and drinking. This "dirty body" leads to care work being seen as "dirty work," which should be conducted professionally and competently.

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If new caregivers come, they talk about issues related to dealing with the excrement. I will tell them that first, what they are dealing with are humans, not animals. Even when people raise a pet, they need to bathe the pet, touch their body. Here, the caregivers are dealing with the elderly. If they choose the job, then they need to accept these things [having to deal with excrement]. There are good things and also bad things. Some family members will tell you that they are very sorry. Some family members think that is something you should do, which is also very typical. Since it is your job, you need to accept it. You just need to accept it. If you cannot accept it, then there's nothing to do [but leave the job]. (Caregiver 7, August 2017, Shanghai)

The caregiver above indicates that accepting dirty work is part of the job. As the care manager implies, if the caregiver cannot accept the job requirements, then the caregivers may be required to leave the job. The following interview with another caregiver manager also suggests this that idea is common.

We have one month of probation for each caregiver. Probably because of the mental barrier, some people just cannot bear the excrement, but they can do the rest of the work, such as cleaning and giving baths. These she/he can do, but they just cannot look at the excrement. We cannot do anything about this. However, if she/he can look at the excrement as being similar to taking care of children, then she/he can do it. I have one or two caregivers here who cannot bear to see the excrement. After seeing it, she/he could not eat his/her food. He/she did not fit this occupation, so she/he left. (NOG 23, September 2017, Beijing)

The caregivers must either accept this dirty work, seen by managers as a job requirement, or leave. Thus, competence, one of the care ethics, is inscribed into the job requirement. Additionally, when caregivers are asked to leave the job because they are unable to accept dirty work, they are described by the manager as having a "mental barrier," or "mental issue," or as simply not being competent enough to conduct care work. In the era of neoliberalism, individuals are encouraged to be competent in order to participate in the competition (Soss, Fording, & Schram, 2011). Workers who are unable to do the dirty work are seen as incompetent. In a similar manner to what occurs in other neoliberal projects that shape subjectivities, caregivers internalized the competence

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component of care ethics. In the following example, the caregiver actively persuaded

another caregiver to think about the elderly and consider their needs, in order to help her

competently perform dirty work:

> Other people think that dealing with the elderly's excrement is dirty, while I think it might be a mental barrier for them. Last week, I went to care for an elderly woman who is 102 years old. Every time, I asked her nanny how many days it had been since the elderly woman had last pooped. The nanny said, "Several days." Injecting Glycerin Enema did not work. It had been four days since the elderly woman last pooped. So when I cleaned her anus, I found the poop was around the anus. I said, give me a pair of gloves. I am going to pull the poop out. Do you think it is dirty? I didn't think about it when I was doing it. But afterward when I re-call it… it's disgusting. But this is an elderly woman. I need to think about her. When I think about her, I do not feel it is dirty. So I told the nanny, I didn't pull out too many. You need to inject another glycerin enema. The elderly woman does not have the energy to push the poop out. So you need to pull it again. That nanny said she could not. I told her that this is her job regardless. It's not good for the poop to stay in the belly. The elderly woman's belly is swollen, so she cannot sleep well. I tried to persuade the nanny. You can put the glove and mask on. You just pull it out, especially the dry part. The nanny said let me think about it. The next Monday, when I came, she said that she did the job how I told her to. It is hard to be a caregiver. (Caregiver 8, August 2017, Shanghai)

This caregiver believes that other caregivers have mental barriers if they think that

dealing with the elderly's excrement is dirty. However, she considers dealing with

excrement to be part of the job and believes that caregivers should do the work regardless

of any mental barriers they might have. Also, to her, being competent in this area is for

the elderly's sake. In this case, the caregiver internalized dirty work as part of the job and

believes it should be done not only because she is caring for the elderly, but also because

she cares about the elderly.

According to Milligan and Wiles (2010), "caring for" refers to the performance

and practice of caregiving. It could be formal or informal care, and it could be proximate

care or care performed from a distance by arranging for and monitoring paid professional

care. "Caring about" refers to the emotional state of caring about somebody or

something. It could also include the "generalized relational and affective elements of being caring" (Milligan & Wiles, 2010, p. 741). By complicating care and differentiating between caring about/for, Milligan and Wiles (2010) challenge common practices of care, postulating that caring for care-recipients may not necessarily involve emotionally caring about them. However, in the case of the caregiver above, "caring about" and "caring for" are intertwined. Caring about the elderly motivates the caregiver to care for the elderly, especially when the care work involves dirty work. Furthermore, this caregiver sees doing the job out of love as an index for evaluating caregivers. For example,

> All the caregivers in our company are great. They all do the job out of love. If they do the work out of love, then they can handle every situation unless they think that the elderly are dirty. If you do not think the elderly are dirty and you have love, then you can do service work. (Caregiver 8, August, 2017, Shanghai)

In this interview, the caregiver said that all of her colleagues do the job out of love. If it is out of love, they can do everything. In this case, accepting the dirty work not only reveals how caregivers have internalized the competence component of care ethics, but also suggests that for them, care work necessitates emotional competency in terms of caregivers' work attitudes and their emotional connections with care-recipients.

> Mr. Wang, our boss, trains us on how we should care for the elderly not only physically, but also emotionally. Different age groups should be treated differently. Mr. Wang has a high standard for us, and he is nice to the elderly. Once there was an elderly man who was not feeling comfortable. The elderly man vomited and our boss, Mr. Wang, used his hands to hold the vomit. He never minded that it was dirty. So, if he can do it, all of our caregivers and social workers can do it. In this way, our community eldercare center will be better and better. (Caregiver 4, May 2017 , Shanghai)

In this case, the caregivers and social workers in the comprehensive eldercare center are expected to treat the elderly nicely. Being nice includes not despising the elderly's vomit,

even to the extent of being willing to hold the "dirty" vomit in hands without gloves. This scene has become an example within the company and other NGOs in Shanghai of how caregivers should treat the elderly. Thus, care ethics implies a relational ontology that perceives human beings as dependent and inter-subjective beings embedded in networks, which may indicate a new ethical, social relationship that attends to others' needs and produces a particular situated standpoint through performing care work (Haylett, 2003; Popke, 2006). However, this relational ontology also exploits caregivers by requiring them to be attentive, responsible, competent and responsive when carrying out "dirty" work.

Thus, when care ethics are inscribed into the job requirements, care work can lead to the burnout and depletion of caregivers. This can especially be seen as true when care work is theorized as bodily, gendered and "dirty" work, which all contribute to the devaluation of care work. As dirty and bodily work, care work requires caregivers to detach themselves from the elderly by seeing the elderly as objects. However, care work is also emotional work in that being affective is also a part of the job requirement. Thus, while bodily and dirty work requires caregivers to see the elderly as objects, emotional work demands that they view the elderly as subjects who are emotional beings in need; from the perspective of care ethics, seeing the elderly as subjects necessitates that they be attentive, competent, responsive and responsible (Twigg et al., 2011). In the next section, this chapter turns to examine care work as emotional work, where sociality and connections in caring relationships are established.

Emotional Work

As mentioned above, care ethics embedded in job requirements puts caregivers in more exploitative situations. In this section, I will show how care ethics play out in caregivers' work experiences, especially by theorizing care work as emotional work. Emotional work is an essential part of care work that requires caregivers to communicate and emotionally invest themselves in personal relationships with the elderly (Atkinson, Lawson, & Wiles, 2011; Dyer et al., 2008; Haylett, 2003; Milligan & Wiles, 2010) (Figure 8).

Figure 8. Caregivers and older adults in community eldercare center in Shanghai. Photo by author

This emotional labor is implied in the care ethics of attentiveness, competence, and responsibility. When someone is paying attention to other people's needs, he or she is caring for and caring about other people. Even when providing only physical care, caregivers cannot just immediately commence giving physical care. The caregiver needs to talk to the elderly first to acquire their permission, even when the elderly person has severe dementia. For example, an elderly man was not willing to take a shower. His family member called the community eldercare station for help. A caregiver recounted the conversation required to provide this elderly man with physical care:

> I called his name, saying, "Mr. Zhu, how are you?"
> "Who are you?"
> "I came to serve you."
> "Serve what?"
> "Anything you need service for. Smell yourself? What smell
> is that?"
> "Hmmm, it does not smell good."
> "So should we take a shower?"
> "No, I don't want to take a shower."
> "If you don't take a shower, then how can we go outside for
> a walk?"
> "Let's go outside now."
> "No. You also think it smells bad. How can we go outside?"
> Ok, then he started looking for new clothes for himself. So, after the shower, it had already been over one hour's service time. But I needed to do what I had promised the elderly man I would do. So, I told the elderly man, "Let's go outside. You lead the way." Just walking around the neighborhood took a half hour, but I was fine with that. If I went over time at this elderly man's place, I would call to let the next elderly person know that I would be late for a while. They were all okay with this. (Caregiver 8, August 2018, Shanghai)

The caregiver said that she quickly figured out that the elderly man was just lonely and wanted to go out. His son went to work every day and did not have time to accompany him, and his daughter-in-law did not communicate with him. The elderly man's family would not allow him to go outside by himself out of fear that he would get lost. Thus, the

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elderly man was depressed at home. In order to have this care-recipient agree to take a shower, the caregiver told him that she would take him outside for a walk; talking and communication was the key to providing care in this case. Moreover, being natural in interacting with the elderly is also required of caregivers, as mentioned by a caregiver manger below.

> First of all, it is like communication with family members. You need to talk to them before providing physical care. People have first impressions. The first impression will determine whether you will be able to continue interacting with him/her. You need to first establish the elderly's trust with you; then you can do things. For example, one of the simplest tasks, as a caregiver, is to wash the elderly's feet. You definitely know the steps, like putting the water into the bowl. If you were to say nothing and directly bring the bowl and water, the elderly person would think that you only see this task as your job, that you don't see it as something that is part of your life. We need to make it very natural. "Grandma, let's wash your feet." You must wash them. So, you need to talk to the elderly and make it clear. Whatever problems or questions you have, you need to communicate. More and more I feel that for the elderly, it's not about how many things the caregivers have done for him/her. It's about how many times the caregivers have talked to their elderly clients. (Caregiver 7, August 2017, Shanghai)

The caregiver manager points out that communicating with the elderly while providing physical care is essential and that the communication should be casual and natural. Talking casually and naturally helps build trust between the elderly and their caregivers and smooths the process of completing the work, but it also blurs the boundary between life and work. Additionally, this natural way of talking is not picked up easily. One day, the caregiver was busy, so I was asked to perform care for one elderly woman who had just suffered a bone fracture. The elderly woman required a soft massage to help release her pain around the bone fracture. I sat by her side and did what she required by touching her skin lightly. The massage went on for half an hour, and it was awkward because we

did not talk except when she instructed me on where to put my hand and with how much

pressure. The caregiver manager responded to my "no talking" care work:

> You should ask, "How are you today? How is your eating, sleeping?" The elderly
> are living here now. Eating, sleeping and doing activities are all basic things to her.
> So our conversations are normally carried out around the elderly's basic activities
> within the institution. The elderly have mental demands; even our young people
> have mental demands. The more the caregivers get to know the elderly, the more
> they can talk. It's not about conversation for conversation's sake. Make it casual.
> Such as, "How are you? How was your meal today? I also think today's food was
> not good. But you need to eat more. It's not good to waste food." The caregivers
> need to keep talking to the elderly like this. After some time, the elderly will
> understand and start to trust the caregivers. (Caregiver 7, August 2017, Shanghai)

As the caregiver manager indicates, the conversation should be around the

elderly's everyday life within the community eldercare institution, and the caregiver

should make the conversation occur naturally, like one that would occur in everyday life

instead of one that is simply a work task. This casual interaction blurs the boundary

between life and work. Additionally, the conversation shows the "caring" part of

caregivers by asking questions such as "how are you?" As previously stated, the caring

part includes not only caring for, but also caring about the elderly (Milligan & Wiles,

2010). These conversations facilitate connections between the elderly and caregivers,

forming friendships or fictive kinship (Ceylan, 2016; Kontos, Miller, & Mitchell, 2010).

The survey of 126 caregivers from this study's fieldwork revealed that 71% of the

caregivers see the elderly as a friend or have developed something similar to friendship

after providing care. This fictive kinship further facilitates the blurred boundary between

work and life. For example, when a caregiver stops being a caregiver to an elderly

person, the caregiver still frequently returns to visit him/her after work. In one case, the

elderly person's family found him a live-in nanny, so they stopped asking the community

eldercare station to send caregivers over. Four days after the original caregiver stopped

coming to the elderly man's apartment, the elderly man called the caregiver.

> The elderly man's family said on the phone call: "Xiao Liu, please come over and visit us soon. We don't know what to do." So, I went to their apartment. Once I entered the room, the elderly man grabbed me.
> "I really miss you Xiao Liu, where have you been? Did you go abroad?"
> I said, "Yes, I went abroad, I have come to visit you."
> "I really miss you Xiaoli."
> When he said that, I could not hold back my tears. I felt very happy that an elderly person could miss me so profoundly. I bought him some fruits, telling him that I didn't bring him anything from abroad, but just some fruits. After washing the fruits, he was not willing to eat them himself, because he thought they were very precious. He asked other people to eat them. He told his daughter-in-law to cook lunch and invited me to stay for lunch. I said no, because I needed to serve another elderly client later in the afternoon.

> This family hired a nanny so they no longer needed me to provide service. However, their nanny didn't stay long. So, they came back to our company and wanted me to go back and serve the elderly man. However, I was already assigned to another elderly person, so I could not go back. Our company assigned another caregiver to him. He told me, "I really want you to come back to serve me." (Caregiver 8 August 2017, Shanghai)

The elderly man described in this interview developed a strong attachment to the

caregiver. This care constitutes a relational ontology that perceives human beings as

dependent and inter-subjective beings embedded in networks. Therefore, care combined

with "loving, thinking and doing" could potentially indicate a new ethical, social

relationship that attends to others' needs and produces a particular standpoint through

performing care (Haylett, 2003; Leira, 1992; Popke, 2006). Also, the social relationship

shaped through care goes beyond class and gender dynamics in that, although caregivers'

income and social status are normally lower than the care-receiver, the affective labor and

social relationship shape a new social relationship that goes beyond class and gender.

Although a new social relationship can be shaped, this caring relationship exploits the

caregivers, who feel obligated to visit and care for the elderly even after their

compensated service has ended. For example, in another case, a caregiver continued to

voluntarily work beyond her compensated hours:

> I think this is really demanding and exhausting work. So I was thinking about
> quitting the job at first. Then, as I continued to do care work, I started to establish
> an emotional connection with many elderly people. Gradually, it began to not feel
> like going to work. It's like continuing with everyday life. You have to do this kind
> of work. If not, you will feel bored every day. I went to their apartment every day,
> and they felt happy about it. The elderly in Shanghai are actually very warm. They
> all treat me very well. (Caregiver 14, August 2017, Shanghai)

This caregiver indicates that the connections she built with the elderly persuaded her to

stay in the caregiving position. Also, the blurred boundary between work and life

rendered her accepting of the demanding and exhausting nature of the work, because

caregiving to the elderly includes many tasks that are similar to household tasks, such as

grocery shopping.

Conclusion

In responding to the call for research that engages with care ethics, this chapter

examines caregivers' working experiences when care ethics are embedded into the job

requirements. In so doing, this chapter unpacks the meaning of attentiveness,

competence, responsiveness and responsibility as care ethics (Tronto, 1993), and what it

means to be ethical in providing care. This chapter confirms that care ethics may connect

caregivers and care-recipients by establishing friendship or fictive kinship between them

and thereby challenge the neoliberal principles of "individualism, egalitarianism,

universalism and of a society organized exclusively around principles of efficiency,

competition and a 'right' price for everything" (Lawson, 2007). However, this chapter

also argues that care ethics potentially create a "prison of love" for caregivers, wherein

they work long hours for low pay because of their connections formed with care-recipients or because of the satisfaction that they receive from the care work.

Thus, this chapter challenges the theoretical basis for advocating a caring geography that embeds care ethics into practice and research. The idea that care ethics undermine neoliberalism fails to consider the possibility that care ethics could be commodified. Through empirical research, this chapter responds to the literature on geography of care and a geography of welfare that engages care ethics. Although care ethics are based on a relational ontology that connects individuals with "mutuality and trust" and stresses cooperation rather than competition, as well as interdependence rather than individuation (Popke, 2006), care ethics fail to bring about a just society when they are commodified. Hence, this chapter advocates for a caring geography or geography of care that pays attention to the working conditions of the caregiving labor force and the power dynamics in caring relations, especially when care ethics are being imposed on marginalized caregivers. One potential direction is the "Culture of Care" developed in the United Kingdom (UK) that aims to cultivate positive working conditions for the staff while at the same time improving the quality of care. This "Culture of Care" encourages informal communication between the staff members, which provides a potential platform for caregivers to express their concerns.

The findings of this chapter shed light on other similar settings, such as NGO work or other social work settings, where workers receive less pay but are motivated by the content of the work or its perceived morality. However, this chapter does not aim to provide universal conclusions that could be applied to every setting. Rather, this argument is based in a particular context, which must be considered when applying the

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findings to any other context. It aims to contribute to the conversations surrounding care ethics by providing an empirically based perspective that can be used as an analytical tool in future research. Ultimately, this study demonstrates that when we are theorizing care ethics in order to challenge neoliberal commodification, we also need to carefully consider whether or not care ethics themselves have been commodified. One potentially valuable way to accomplish this is to build a caring geography based on empirical research.

CHAPTER VII

CONCLUSION

Respecting older adults and providing care for them are the requirements of filial

piety and the foundation of family bonds in Chinese families. With dramatic changes in

family size as well as social changes, the traditional family care for older adults is no

longer sufficient or efficient enough. Institutional care is a poor substitute for family care

because it is still, to some extent, stigmatized as a choice made by unfilial children, and it

is also considered an expensive choice. A third option, community eldercare, is

increasingly becoming the principal approach to providing care for older adults, allowing

them to age in place and maintain their connections with their family and neighborhoods.

To facilitate aging in place, the Chinese government actively collaborates with nonprofit

NGOs to establish community eldercare programs. These programs run by NGOs allow

local governments to acquire information about the community's older adults and closely

monitor their aging process under the healthy aging agenda. At the same time, by

replacing some homecare services and facilitating aging in place, these community

eldercare programs engage in emotional work that requires social workers and caregivers

to create homely feelings at the community eldercare centers, creating an institutional

home. This institutional home enables older adults to construct fictive kinships for

emotional support while also receiving physical care when necessary.

Situated between the geography of care and the geography of aging, studies of

eldercare have shifted from studying issues related to accessibility and distribution of

eldercare facilities to studying the impact of place and space on health and well-being.

Following the call to engage social theory and cultural geographies, eldercare scholars

have begun to develop the concepts of the therapeutic landscape and the landscape of care as tools to examine broader social, political, and economic contexts along with individual experiences. Although this research has contributed to the cultural turn in the geography of aging and care, it has lacked a critical lens and neglected the paradoxical nature of care provision, where care can both hurt and nurture, enable and control.

Inspired by these paradoxes, this dissertation examined the community eldercare program in urban China on multiple levels. On the macro level, first, the Chinese government views eldercare as both a responsibility and a burden. By collaborating with NGOs, the government takes on the responsibility for eldercare indirectly. At the same time, it shares the burden of eldercare with nonstate actors. Second, the government promotes its healthy aging agenda at community eldercare centers, which promotes health, independence, and an active lifestyle among older adults. This agenda governs the aging population by shaping elders' aging process and excluding those who cannot age healthily. On the micro level, community eldercare programs constitute what I call an institutional home, a space that is both home and unhome and creates mixed feelings of homeliness and unhomeliness. It is both a space of care and a space of control. Last, the affective dimension of community eldercare programs requires caregivers to conduct emotional labor and operate in accordance with care ethics. This requirement helps caregivers build connections with older adults, while it simultaneously exploits both caregivers and older adults.

In this dissertation, the first two empirical chapters discuss the paradox of care in eldercare provision. Chapter 3 focuses on the state-NGO relationships revealed in my research with community eldercare programs as well as the entrepreneurial urban

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governance implied by state-NGO collaboration. Local governments work with the NGO in four major ways, through state-built and privately run facilities, private operations with government support, government subsidies, and government purchase of public services from the NGOs. Through these four modes of collaboration, the local government invites NGOs to participate in community eldercare and is also able to control them through annual evaluations. During evaluations, the local government not only assesses the service provided by the NGOs, but also takes stock of aging in the local community, particularly who is aging, how they are aging, and the status of their financial health and family relationships. Concerned about having their funding cut by the local government, NGOs actively seek ways to earn a profit and cultivate the market for eldercare. Deeply rooted in the community, they have access to the entire local community and hope to translate these connections into economic benefits if they can persuade the local community to choose the services and products introduced by the NGO.

Chapter 3 reveals a different picture of State-NGO relations in mainland China. Instead of striving for autonomy, NGOs in China that provide community eldercare services enjoy a positive and collaborative relationship with the local government in order to have access to more eldercare projects and to occupy and build the market for future profits. Hence, the government and NGOs share mutual benefits and a relationship of mutual assistance, which ultimately privatizes eldercare services and reveals the entrepreneurial nature of urban governance.

Chapter 4 also discusses the healthy aging agenda promoted and implemented at community eldercare centers. This agenda follows the trends of active aging, productive aging, and successful aging by promoting a particular lifestyle among older adults and

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encouraging them to set health as their goal. The healthy aging agenda recognizes the inevitability of physical decay while still promoting a certain lifestyle that facilitates independence and mobility, which inevitably homogenizes the aging population. In so doing, it facilitates governance of the aging population, enabling what Foucault calls governmentality by shaping the environment, that is, the community eldercare program.

This chapter draws on two bodies of literature, Foucauldian governmentality and critical gerontology, to unpack how healthy aging, as promoted and implemented through community eldercare programs, governs the aging population from a distance. Critical gerontologists have criticized programs built around ideas of successful aging and active aging for promoting one type of active aging body, calling these programs the new ageism. Following this strand of thought, I argue that although healthy aging recognized the inevitably of physical decay, it still normalized the aging process and allowed the government to govern at a distance. Using government policies collected during my fieldwork and interviews with NGO workers and older adults, I use the Chinese context, specifically policies and officials' speeches around healthy aging, to examine this idea. I then discuss the implementation of the healthy aging agenda in promoting activities such as physical exercise, body assessment, rehabilitation, and volunteer work. Toward that end, this chapter finds, as the literature suggests, that the middle-age ethic of being constantly busy has been transferred into the eldercare setting, where older adults are disciplined and transformed into active, healthy, and participatory people by governing them from a distance.

While chapters 3 and 4 examine the paradox in eldercare services, chapters 5 and 6 turn to the paradox of eldercare experiences and practices, discussing the formation of

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the institutional home and what it requires of caregivers. Chapter 5 introduces the concept of institutional home to theorize the externalization of the home to community eldercare centers. To replace home care and facilitate aging in place, community eldercare centers aim to provide a homely feeling for older adults. Current literature on aging in place focuses on either home or community without questioning the idea of either. Reviewing the literature on home and community, I propose the term *institutional home* to describe the hybrid space that provides a feeling of homeliness while, at the same time, constituting a space of control. Theorizing community eldercare centers as institutional homes captures both the complexity of home and the nature of spaces that are simultaneously spaces of care and spaces of control.

The chapter discusses homeliness in community eldercare centers in three senses. First, the centers replace part of the home function by providing meals and emotional and social support through fictive kinship construction. Second, they help older adults maintain a connection with their private home and family members through the time-space proximity of the centers to private homes. However, the institutional home is also a space of control that regulates older adults and excludes those with an extreme disability or disease-related disability. It is also considered a backup choice by older adults when they can no longer remain at home. This chapter contributes to the literature on aging in place by developing the notion of institutional home to describe spaces that are simultaneously spaces of care and control.

Chapter 6 continues discussing caregivers' work. Providing a homely feeling for older adults requires caregivers to work ethically by being attentive, competent, responsive, and responsible. Being ethical in care, or caring ethically, according to the

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literature on the geography of care, could help achieve social justice as people are connected through care ethics and no longer individualized (relegated to a state of self-care) under neoliberalism. However, a close examination of caregivers' work reveals that it may lead to a unwanted outcome when care ethics become commodified. Performing emotional labor leads caregivers to form an attachment with the care-receiver and requires them to work long hours for low pay. Viewing care work as emotional work, body work, and dirty work shows how being ethical in care work can hold caregivers in a "prison of love" in which they are willing to be exploited because of their shared connection with older adults. This prison of love is related to the paradox of emotional labor: simultaneously rewarding and exploiting care workers (Monrad, 2017).

Drawing on my interviews with caregivers, in describing their working experience, and how being ethical while conducting body work, emotional work, and dirty work exploits them, I confirm that performing care work indeed reshapes caregivers' subjectivity because of the connection they build with older adults. Also, care work usually blurs the boundary between life and work, and leads caregivers to work long hours for low wages. These findings challenge the existing popular understanding of care ethics in the literature on the geography of care.

In conclusion, while I discuss the enabling and controlling feature of care separately, in practice, they are not mutually exclusive; rather, they are intertwined. For NGOs, getting to know their "target" and building trust for future profits inevitably leads to building close, intimate connections with people who frequent community eldercare centers. For example, caregivers who provide responsive, competent care are asked to be aware of older adults' needs and address them promptly. Moreover, the very concept of

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institutional home combines intimacy and governance when older adults are under each other's gaze, with their behavior watched and regulated.

By unpacking the paradoxical nature of care at multiple levels, this dissertation contributes to a deeper understanding of the affective dimensions of population governance, which govern the population's collective thoughts, feelings, and beliefs (Anderson, 2011). By situating caregiving in its broader social, political, and economic context, this dissertation reveals how the government uses community eldercare centers to govern the aging population, provide for their needs, and create homely feelings. These aspects of community eldercare centers in urban China reveal some of the affective dimensions of state governance. In so doing, this dissertation bridges the literature on affective care and state governance.

Moving Forward

This dissertation studies community eldercare in China, which exists widely in Beijing and Shanghai. These two cities were chosen by the Chinese government as experimental sites for community eldercare; if their programs are successful, community eldercare will be promoted in other cities. The expansion of community eldercare to other cities requires further research and analysis. As one NGO leader commented, he could receive up to 2 million yuan in subsidies in Shanghai, while he could barely receive one-tenth of that in a city in Jiangsu Province. With such a limited budget, he lost interest in running community eldercare services in Jiangsu Province. Even when he did run community eldercare services in Jiangsu, he did not provide the same quality of eldercare services there as he did in Shanghai. He cut the types of services provided and reduced the number of social workers at the community eldercare center. According to this NGO

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leader, the promotion of community eldercare in China will be a problem in cities that do not have as large a budget as Shanghai, such as small cities and cities in western China.

The varied local conditions and diversity of NGOs providing community eldercare services will further lead to a fragmented eldercare system in mainland China. Moreover, NGOs are now gradually charging fees for eldercare services, which produces a spatial disparity at community eldercare centers, where one or two rooms require payment while the other rooms are free to the public. Rooms requiring payment usually accommodate fewer older adults and provide more caregivers, as well as some special services like snacks. The free rooms are more crowded and have fewer assigned caregivers. Hence, even though the Chinese government intends for community eldercare programs to facilitate aging in place and to cultivate caring spaces in cities, the actual practices of NGOs play a critical role in how these care services are provided. Privatization through NGOs will further lead to a fragmented and variegated social welfare system for older adults.

The study of community eldercare programs as institutional homes could be expanded to other settings. This dissertation studies geographically based community eldercare; however, there is an increasing interest in identity-based care. For example, my parents picture themselves living on a farm near a mountain with several close friends in their retirement. They want to raise chickens, walk around the farm, and sit with their friends by a mountain. The picture that my parents paint is a type of community eldercare, but instead of a geographically based community like those that this dissertation studies, it is an identity-based community. These communities are now emerging in European countries as mutual assistance eldercare, for example, as well as

elsewhere in China, such as the Taikang CCRC, a community based on socioeconomic status. In these settings, fictive kinships and the concept of home will be more salient, while the institutional elements will be less apparent. Thus, the concept of institutional home applies to these settings, but with different compositions of the institutional and the homely aspects. The boundary that differentiates institution and home may be even more blurred and fluid, depending on the specific community eldercare program and the composition of its older adults, caregivers, and social workers.

Finally, community eldercare relies heavily on caregivers. The high turnover rate of caregivers and lack of social workers at community eldercare centers is widely recognized. Meanwhile, the black market for Filipino domestic workers has grown. To ensure that community eldercare centers have the necessary workforce and to regulate the black market, the Chinese government began issuing work visas to Filipino domestic workers in 2017. Although the demand for Filipinos is mostly due to their competence in English and their professionalism, the projected exponential growth of the aging population raises concerns about shortages in the caregiving workforce. Regardless of whether caregivers come from rural China, western China, or the Philippines, they mostly migrate from less developed areas to more developed areas where they will encounter high mobility, devalued work, and paradoxes in providing care services.

关于社区养老中心满意度调查问卷

您好。本次问卷是为了解本社区养老中心的使用情况，需要获取您的基本资料，本问卷不署名，会保密。请如实填写。感谢您的配合

1，性别
男，　　　　　女
2，年龄
60-70　　　　　70-80　　　　80-90　　　　　90 以上
3，家庭成员构成
独居　　　　伴侣同住　　　伴侣子女同住　　保姆同住
4，所在居委会
5，老中心花费时间
　5 分钟左右　　　　5-10 分钟　　　　15-30 分钟　　　　30-60 分钟
6，来中心次数
每天都来　　每周 2-4 次　　每周一次　　　　偶尔
7，来中心的意愿
无子女在身　　　喜欢和其他老人在一起　　　活动课程丰富
饭菜可口　　　医疗方便　　　陪家里老人来

8，对中心各类设施的满意度

	满意度	当前使用频率	预期使用频率	强烈推荐	不强烈推荐
总体服务项目满意度					
整体服务及人员					
中心环境					
老年餐					
围棋兴趣班					
科技助老手机班					

科技助老电脑班					
老年合唱团					
讲座					
读报会					
手工 DIY					
美食 DIY					
影视服务					
便民服务					
心理咨询，法律咨询					
大型主题活动					

9，老年餐满意度调查

荤素搭配	厨师炒菜用油	口味	品种多样化	卫生	就餐秩序

10，

望增加的服务项目

助医	助学	助浴	添加早晚餐	助洁	陪伴
延长营业时间	代办	助急			

11，您的咨询和抱怨会得到及时的回复么
是　　　　　不是

12，是否在养老中心结交到好朋友
是　　　　　　　不是

13， 在中心是否让您感到'家'的舒适

是，这就是我家　　　　　是，这是老年人的场所　　　　　不是，这是个公共场所

关于养老机构护工人员工作状况的调查问卷

您好。本次问卷是为了解养老行业护工的工作状况 需要获取您的基本资料，本问卷不署名，会保密。请如实填写。感谢您的配合

A．基本情况

A1. 您的年龄

1. 小于 20　　　2. 20--30　　　　　3. 30-40.　　　4. 40-50　　　5. 大于 50

A2. 您的性别

1. 男　　　　　2. 女

A4. 您的文化水品

1.初中　　　　2.高中　　　　　3.专科　　　　　4.本科及以上

A5. 是户口类型　1 农　　2 非农

A6 户口类型　1 农　　2 非农

A6. 您从事护工行业工作年限

1. <1 年　　　2. 1~3 年　　　3. 3~5 年　　4. 5 年以上

A7 在目前的养老院工作年限

1. <1 年　　　2. 1~3 年　　　3. 3~5 年　　　4. 5 年以上

A8. 今后的打算

1.长期工作于此　　2 准备换到其他养老机构　　　3. 准备换到其他行业　4 看情况

A8.个人月收入

1.<1000　　2. 1000~2000　　3.2000~3000　　4.3000~4000　　5.>4000

B．工作状况

B1. 从事养老行业的原因是

1，谋生　2 机缘巧合 3 善于护理 4 热爱养老事业

B2 怎样看待当前从事的工作

1 有意义 的工作   2 脏累的工作   3 只是单纯的谋生工作而已

B3，如果有一天离开养老行业，会是因为

1，工资低 2 待遇差 3 休假少 4 不受人尊重 5 工作累

B4 工作过程中，是否有不被老年人及其家人理解的情况

1， 从来没有 2 偶尔 3 经常 4 每天都有

B5.如果自己的工作不被老年人理解，会

1，非常委屈 2 自我开导   3 同事间交流   4 习惯了，无所谓

B6，您认为当前的工作需要有哪些提升

    1   得到领导的认可
    2   得到自己家人朋友的认可
    3   得到被照顾的老年人的认可
    4   提升工资待遇
    5   增加假期
    6   职业规划培训

B7. 您是否满意当前的工作

1．非常满意 2.满意   3.一般   4.不满意   5.非常不满意   6. 无所谓

B8.工作完一天，会不会觉得非常的累

1. 非常累   2 比较累   3. 累   4 比较不累 5 完全不累

B9. 工作中，会不会跟老年人说话交流

1. 经常   2 一般   3 偶尔   4.很少

B10. 您是否参加过护工培训

1，入职前培训   2.入职后培训   3.没有，边学边做 4. 没有，并不需要特殊的培训

B11 在工作场所是否感到放松

1，非常 2 比较 3 一般 4 比较没有 5 完全没有

D.开放性问题

1 假如有一天离开养老院，会从事什么行业，会考虑返回养老行业么？有哪些改善您会愿意回来

2，您认为城市人口为什么不愿意从事养老护工行业

2，您认为城市人口为什么不愿意从事养老护工行业

APPENDIX C PROJECT APPROVAL FROM HUMAN SUBJECTS

PROTECTION PROGRAM, UNIVERSITY OF OREGON, 2017-2019

UNIVERSITY OF OREGON

DATE: June 06, 2017   **IRB Protocol Number: 03142017.017**

TO: Yi Yu, Principal Investigator
          Department of Geography

RE: Protocol entitled, "Seeing like a state/feeling like a family--institutional home and the
          biopolitics of eldercare in Shanghai, China"

Notice of IRB Review and Exempt Determination
as per Title 45 CFR Part 46.101 (b)(2)

The above protocol has been reviewed by the University of Oregon Institutional Review Board and
Research Compliance Services. This is a minimal risk research protocol that qualifies for an
exemption from IRB review under 45 CFR 46.101(b)(2) for research involving the use of educational
tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or
observation of public behavior.

Please note that you will not be required to submit continuing reviews for this protocol, however, you
must submit any changes to the protocol to Research Compliance Services for assessment to verify
that the protocol continues to qualify for exemption. **This exempt determination will expire June 05,
2022.** Should your research continue beyond expiration date, you will need to submit a new protocol
application.

Your responsibility as a Principal Investigator also includes:
- Obtaining written documentation of the appropriate permissions from public school districts,
  institutions, agencies, or other organizations, etc., prior to conducting your research
- Notifying Research Compliance Services of any change in Principal Investigator
- Notifying Research Compliance Services of any changes to or supplemental funding
- Retaining copies of this determination, any signed consent forms, and related research materials
  for five years after conclusion of your study or the closure of your sponsored research, whichever
  comes last.

As with all Human Subject Research, exempt research is subject to periodic Post Approval
Monitoring review.

If you have any questions regarding your protocol or the review process, please contact Research
Compliance Services at ResearchCompliance@uoregon.edu or (541)346-2510.

Sincerely,

Lizzy Utterback
Research Compliance Administrator

CC: Xiaobo Su, Faculty Advisor

DATE: August 14, 2018   **IRB Protocol Number: 03142017.017**

TO: Yi Yu, Principal Investigator
          Department of Geography

RE: Protocol entitled, "Seeing like a state/feeling like a family--institutional home and the
biopolitics of eldercare in Shanghai, China"

Notice of Amendment Review and Exempt Determination

The amendment submitted on August 7, 2018 to the above protocol has been reviewed and determined to continue to qualify for exemption as per the Common Rule regulations found at Title 45 CFR 46.101(b)(2). Any other change to this research will need to be assessed via a separate amendment to ensure the study continues to qualify for exemption. The research is approved to be conducted as described in the attached materials.

The purpose of this Amendment is to:
- Associate funding from the Society of Woman Geographers (EPCS #26607) to the protocol.

Approval period: August 14, 2018 - June 05, 2022

If you anticipate the research will continue beyond the approval period, you must submit a Progress Report at least 45-days in advance of the study expiration. **Without continued approval, the protocol will expire on June 05, 2022 and human subject research activities must cease.** A closure report must be submitted once human subject research activities are complete. Failure to maintain current approval or properly close the protocol constitutes non-compliance.

You are responsible for the conduct of this research and adhering to the *Investigator Agreement* as reiterated below. You must maintain oversight of all research personnel to ensure compliance with the approved protocol.

The University of Oregon and Research Compliance Services appreciate your commitment to the ethical and responsible conduct of research with human subjects.

Sincerely,

Chris Duy
Research Compliance Administrator
Research Compliance Services

CC: Xiaobo Su

COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS ● RESEARCH COMPLIANCE SERVICES
677 E. 12th Ave., Suite 500, 5237 University of Oregon, Eugene OR 97401-5237
T 541-346-2510 F 541-346-5138 http://rcs.uoregon.edu

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