Aging, health and place in residential care facilities in Beijing, China

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\textbf{A B S T R A C T}

In recent years, residential care has become an alternative option for elder care in Beijing, China. Little is known, however, about the well-being of elderly residents and the relationship between their health and living in residential care facilities (RCFs). Hence this research aims to understand the well-being of elderly residents in RCFs and how the environment of RCFs affects elderly people’s everyday activities and health. The concepts of therapeutic landscapes, active aging, and well-being contribute to understanding the relationships among aging, health, and environment within RCF settings. Qualitative data from 46 in-depth semi-structured interviews with RCF managers, elderly residents, and family members in Beijing were transcribed and analysed using the constant comparative method. The results show that most of the elderly residents are satisfied with their lives in RCFs, but a few of them feel isolated and depressed after their relocation. Each RCF, as a place with its unique physical and social environment, has a significant influence on the elderly residents’ physical and psychological well-being. Individual factors such as characteristics of elderly residents, their attitudes on aging and residential care, and family support also play important roles in their adaptation and well-being after relocation from home to RCFs.

\section{Introduction}

The population is aging rapidly in China as a result of the decrease in fertility and mortality in recent decades. Beijing, the capital of China, has 2.2 million elderly people aged 60 and over, which was 17.7 percent of its total population in 2008. The population aged 60 and over is expected to be 4.2 million by 2025, which will be 30 percent of its total population (Beijing Municipal Bureau of Statistics, 2000; Committee on Aging of Beijing, 2009). The decreased availability of family caregivers providing day-to-day care for their elderly family members, the absence or shortage of community care services, and the development of residential care services facilitate the utilization of a variety of forms of residential care in recent years (Gu, Dupre, & Liu, 2007; Zhan, 2008). By the end of 2008, there were 336 residential care facilities (RCFs) with 39,994 beds in total, available for 1.8 percent of the elderly population, and 62.9 percent of the beds were occupied (Beijing Municipal Bureau of Civil Affairs, 2009).

Since the late 1970s, a group of geographers have focused on the elderly population, where they live, and their health within theoretical frameworks that link the mind, body, environment, and society (Golant, 1984; Kearns & Andrews, 2005; Kearns & Gesler, 1998; Laws, 1993; Rowles, 1978). The existing theoretical and empirical research emphasizes the importance of understanding how embodied and emplaced experiences shape individuals’ identities and sense of place for the study of one’s well-being (Kearns & Gesler, 1998). Much of the research focuses on elderly people in the community and formal and informal home care (Andrews & Phillips, 2005). Far less of the research is on residential care. What research exists in English-speaking countries focuses on not only the physical environment of RCFs including the natural landscapes, building design, and amenities, but also on the social relations, attitudes, behaviours, and sense of security and belonging within the RCFs and their importance for the well-being of elderly residents (Andrews & Phillips, 2005; Bernard, Bartlam, Sim, & Biggs, 2007; Gatrell, 2002; Hodge, 2008; Reed, Cook, Sullivan, & Buddidge, 2003; Reed, Payton, & Bond, 1998).

The studies in China are relatively limited compared to those in English-speaking countries. Before the 1980s, RCFs in China only provided services for elderly people without children, the disabled, and orphans, and always put the three vulnerable groups under one
The concepts of therapeutic landscapes and active aging

The geography of health emphasizes the importance of place, the use of social theory (e.g., feminism and postmodernism) and qualitative methods (e.g., in-depth interviews) (Cutchin, 1999, 2007; Dyck, 1999; Kearns & Andrews, 2005; Kearns & Moon, 2002; Laws, 1993, 1995, 1996; Rosenberg, 1998). The cultural turn in health geography also calls for more theoretical development in the study of elder care (Andrews & Phillips, 2005). Concepts such as therapeutic landscapes (Gesler, 1992) and active aging (WHO, 2002) are suggested as ways of framing the study of elderly people’s well-being in various settings.

The concept of “therapeutic landscapes” was first developed by Gesler (1992) and increasingly used by health geographers. Originally, therapeutic landscapes referred to “places that have achieved lasting reputations for providing physical, mental and spiritual healing” (Kearys & Gesler, 1998, p. 8). The concept emphasizes the power of place, and specifically how place interacts with a combination of physical, social, and individual factors to shape the outcomes of health beliefs and the experiences of well-being. The formation of therapeutic landscapes is a dynamic process shaped by both social structures and human subjectivities (Gesler, 1992, 2003; Kearys & Gesler, 1998).

Already some studies have used the concept of therapeutic landscapes to understand the role of physical, psychological, and social meanings of place in elder care provision in various settings such as hospitals, institutions, and homes in the U.K., New Zealand, and Canada (Martin, Nancarrow, Parker, Phelps, & Regen, 2005; Moon, Kearys, & Joseph, 2006; Williams, 1986). Kearys and Andrews (2005) have argued how a residential care setting is a place shaped by its physical and social environment for the care and healing of its elderly residents. The environments of RCFs and social relations within them have profound subjective meanings to individuals and affect their health. The concept of therapeutic landscapes has great potential to contribute to studies of elder care in RCFs (Kearys & Andrews, 2005).

Ideas of active aging (World Health Organization [WHO], 2002) and some similar concepts, such as successful aging (Rowe & Kahn, 1997), healthy aging (Bartlett & Peel, 2005), and positive aging (Bowlings, 1993), have been developed in response to rapid population aging and elderly people’s quality of life. The WHO (2002, p. 12) defines active aging as “the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age”. The models of active aging posit that the quality of life of elderly people does not only depend on their physical and psychological health but also on their morale, life satisfaction, and engagement with life (Fisher, 1995; Guse & Masesar, 1999). Existing research has studied the meaning of active aging for elderly people at various stages, the crucial factors to enable active aging, and empirical evidence on the role of leisure activities in promoting health (Chong, Ng, Woo, & Kwan, 2006; Clarke & Warren, 2007; Hutchinson, Yarnal, Staffordson, & Kerstetter, 2008). The term “active” donates continual participation in physical, social, and spiritual activities taking into account people’s capability as they age (Andrews & Phillips, 2005). Active aging is not only a way of understanding how elderly residents build up their feelings of self-esteem and self-worth and their engagement in the social environment of RCFs, but it is also a guide for the management of RCFs to provide elderly residents with a healthy living environment.

The well-being of elderly residents is shaped by individuals’ perceptions and their sense of place. The determinants of well-being include the physical and social environments of RCFs, capacity for self-care, satisfaction in services, sense of security, social connections, and opportunities for leisure activities (Andrews & Phillips, 2005; Center for Health Promotion, 2000; Gatrell, 2002). The concepts of therapeutic landscapes and active aging help us to understand the interaction between environment and individual well-being in residential care settings.

Methods

To gain a multiple perspective from key actors in the process of residential care of older people, in-depth semi-structured interviews were conducted among three groups of participants: elderly...
Residents, family members, and RCF managers. Elderly residents were asked how they evaluate their health status and quality of life selecting from excellent, very good, good, fair, or poor before and after relocation, what their daily activities are, and what the changes are after their relocation. Family members were asked similar questions, while RCF managers were asked which types of services they provide for elderly residents and what factors they think are important for the well-being of elderly residents in RCFs (for a complete list of questions for each group, please contact the first author).

Interviews were carried out in six RCFs taking into account their types of ownership and location. An experienced research group in the Institute of Geographic Sciences and Natural Resources Research at Chinese Academy of Sciences in Beijing recommended one RCF as a study site, and the other five RCFs were recommended by the manager from the first RCF. The six RCFs are typical in Beijing in terms of their location and ownership. Three of the RCFs are located in the central districts of Beijing, and the other three are located in suburban areas. The types of ownership were private, community, and publicly-owned privately-run RCFs. All the six RCFs provide assistance to Activities of Daily Living (ADLs) (e.g., bathing, dressing, eating, indoor transferring, toileting, and continence), Instrumental Activities of Daily Living (IADLs) (e.g., shopping, household chores, obtaining healthcare, and traveling to these activities), and basic health care for their residents. Four of the RCFs only accept residents with self-care abilities and their residents are generally physically and mentally healthy, while one community RCF and one publicly-owned privately-run RCF also accept residents with only some self-care abilities who needs more assistance to their activities (see more detailed information in Table 1). All six RCF managers were contacted by phone first. After permission was given, time to visit the RCFs was arranged. RCF managers helped recruit elderly residents who were willing to participate. Based on the manager’s knowledge of the residents, only those without cognitive impairments were selected. Both managers and residents helped recruit family members as participants. In total, 27 elderly residents, 16 family members, and five RCF managers were interviewed in the six RCFs. The length that the elderly participants stay in RCFs varies from six months to three years which enables them to provide reliable information on their experiences in RCFs (see more detailed information in Table 2). The interviews were carried out in private and quiet rooms or outdoors in the six RCFs. The interviewer took notes and the interviews were audio recorded at the same time. The interviews varied from 30 to 90 min. Mandarin was the language used during the interviews because it is the official and everyday language in Beijing. Ethics approval for the research project was obtained from the General Research Ethics Board of Queen's University in Canada.

The analysis of the data is based on the constant comparative method (Glaser & Strauss, 1967). The content of the audio-recordings was fully transcribed. The transcripts were read line-by-line several times in order to mark the key points with a series of codes, and similar codes were grouped into a concept. As concepts accumulated and their descriptions became more detailed, similar concepts were rearranged by common themes and thematic categories were developed. Finally, the thematic categories were used to define concepts and find associations between themes. Together the thematic categories, concepts, and resulting associations were used to provide explanations for the findings (Strauss & Corbin, 1990, 1998).

Results

The results show the general well-being of elderly residents in RCFs in Beijing and identified the factors which affect residents’ well-being. The natural, built, and social environments of RCFs and individual factors shaped by one’s attitudes, behaviours, and experiences in RCFs are important to well-being. The results contribute to understanding how therapeutic landscapes and the active aging model of RCFs provide a healing function for elderly residents and shape their personal and collective self-perceptions and sense of place. The interaction between health and place in RCFs helps to create a healthy living environment for elderly residents in RCFs.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Basic characteristics of RCF research sites.</th>
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<tr>
<td>RCF</td>
<td>Location</td>
</tr>
<tr>
<td>A</td>
<td>Suburban district</td>
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<tr>
<td>B</td>
<td>Central district</td>
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<td>D</td>
<td>Central district</td>
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<tr>
<td>E</td>
<td>Suburban district</td>
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<td>F</td>
<td>Suburban district</td>
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*Note: currently, ownership of RCFs in Beijing is divided among government operated facilities, community facilities, private facilities, and publicly-owned and privately-run facilities. Government operated facilities include those operated and funded by local governments. Community facilities include those operated by city neighborhood committees and village committees, and they are usually funded by local government and communities. Facilities operated by persons, companies, enterprises, and organizations are categorized as private facilities. The publicly-owned and privately-run facilities are a new type of ownership developed in recent years, which are set up and funded by government, but managed by the private sector. The private sector does not own the properties nor need to pay rent, but assumes sole responsibility for the profits or losses (Beijing Municipal Bureau of Civil Affairs, Beijing Municipal Commission of Development and Reform, Beijing Municipal Commission of Urban Planning, Beijing Municipal Bureau of Finance, & Beijing Municipal Bureau of Land and Resources, 2008).

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Basic characteristics of elderly residents and family members interviewed.</th>
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<tbody>
<tr>
<td>Participants</td>
<td>Gender</td>
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<tr>
<td>Elderly residents</td>
<td>Female (17)</td>
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<td></td>
<td>Male (10)</td>
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<td></td>
<td>Gender</td>
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<tr>
<td>Family members</td>
<td>Female (14)</td>
</tr>
<tr>
<td></td>
<td>Male (2)</td>
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Well-being of elderly residents in RCFs

Most of the elderly residents and family members interviewed were satisfied with the residents’ lives in the RCFs. Some of the elderly residents and family members reported significant improvements in physical and mental health status and social skills of the residents after relocation. Collective life in RCFs provides elderly residents with more social opportunities and interaction with their cohorts than living alone at home, which in turn enables them to cope with the changes and challenges experienced as they age. In many ways, elderly residents involve themselves in various social activities and maintain their social connections within and out of the RCF.

He (the interviewee’s father) gained some weight (he was too thin when he was at home). The most important thing is that his spiritual well-being has improved a lot. He used to avoid socializing with others because of his poor hearing and sight. Now he starts to gain back the willingness to socialize with others after the relocation. (A family member)

The results, however, also show that a small proportion of residents felt isolated and depressed after their relocation. They had low levels of interest in participating in social activities, had grown pessimistic about their futures, and worried about death. They reported their mobility had become restricted because of either the physical environment or social management mechanisms of the RCFs (see the next section). They felt that they had gradually lost their social connections with the outside world and with their former lives. They also reported a lack of emotional support from the staff, their families, and friends had increased their feeling of loneliness living in the RCFs. No matter whether elderly residents reported good or poor health status, their well-being was highly related to the physical and social attributes of the RCF in which they lived.

Health and place in RCFs

Sense of place involves physical, social, and psychological components (Rowles, 1983). In terms of residential care settings, Andrews and Phillips (2005, p. 192) describe RCFs as places with “objective place characteristics and subjective place experiences”, which have significant influence on elderly residents’ well-being. The results from this research confirmed the importance of the physical and social environments of RCFs to elderly residents’ experience of place and their well-being. Apart from the above, individual factors such as the socio-economic status of elderly residents, their attitudes about aging and residential care, behaviours, and family support also play important roles in their level of adaptation and well-being after the relocation from homes to RCFs.

Physical environment

The combination of natural and built landscapes within and around the RCF, building design, and housing styles, as well as the micro-environment of individual rooms have significant influence on the well-being of elderly residents.

First, certain landscapes such as mountain areas, gardens, water, and parks are reported as healthy landscapes with healing functions for elderly residents’ well-being, whereas the noisy city environment, limited open space, and busy streets outside of the RCFs were reported as unhealthy landscapes where elderly residents were more likely to have negative experiences.

I am tired of the noisy environment in the city. I felt depressed and hopeless…. I decided to move to a pleasant environment....
these activities, either through the crafts they make or the role they play in educating the young generation, provided them with a therapeutic function improving their physical, social, and psychological well-being.

We have the monthly birthday party at the first weekend of each month. We invite family members to get together, share a birthday cake, make birthday wishes, and sing songs. We also publish a monthly newspaper. All the manuscripts are submitted by the elderly residents. They write comments about news, about their lives in the RCFs, all kinds of stuff. They are really happy to see their words being published. (An RCF manager)

Secondly, the management and staff members constitute an important part of the social environment of RCFs and have significant impacts on elderly residents' well-being. Most of the elderly residents who were interviewed evaluated their lives in current RCFs as being well organized with the freedom to participate in activities that they prefer. There are, however, reports about some RCFs where management and staff resorted to taking precautionary actions to minimize elderly residents' risks of the negative experiences, which restrict their level of independence and had negative effects on their well-being (Li, Huang, & Dong, 2007). In this research, some participants reported that they had negative experiences in other RCFs before, which caused them to relocate from one RCF to another. Regarding the management and staff members, the lack of professional training of staff members, their lack of motivation and job satisfaction, and high frequency of labour turnover in the industry affect the quality of service provided.

The chefs are paid very low. That’s why they don’t want to stay long and we cannot have good meals.... There is not much professional training of the staff members.... Two staff members were sent to workshops for training last year, but they left for a better pay in another RCF soon after they finished the training. (An elderly resident)

Thirdly, access to services and service quality exert an important influence on elderly people’s quality of life in RCFs. Taking the food service as an example, it is one of the services mentioned most frequently by elderly residents. The food service carries with its social meanings that extend beyond the daily routine for many residents. Some elderly people reported that they had difficulties getting groceries and cooking and sometimes they skipped meals at home before they moved to RCFs. The RCFs provide various kinds of food for them to choose and change menus everyday taking into account nutritional balance. They ate better in RCFs than at home and gave highly positive evaluations of the quality of food they were served. Other elderly participants were dissatisfied with the food service provided. They complained about the poor quality of food and the lack of choices. The satisfaction over the quality of services affects elderly residents’ experiences and well-being in RCFs.

To create a healthy living environment for elderly residents in RCFs, it is important to provide a healing function through the social relations and social practices within RCFs, which is a significant component of therapeutic landscapes in RCFs. Healthy physical and social environments of RCFs are also crucial for providing elderly residents with opportunities for active aging.

Individual factors — elderly residents

The inequality of experiences of elderly residents is affected by institutional factors such as the physical and social environment of RCFs, and also by individual factors such as elderly residents' personal characteristics, health status, attitudes on aging and residential care. The findings imply the importance of understanding that elderly people are not a homogenous group and individual factors play significant roles in affecting their health outcomes when improving equity of elder care. Efforts should be made to provide the elderly with attractive options and give them the opportunities to make their own choices.

First, individual characteristics including the personalities and social skills of elderly residents have direct effects on their social network within the RCF. Most elderly residents interviewed reported that it was easier for them to live with those with similar characteristics, life experiences, and socio-economic status. Once elderly residents move to one RCF, many of them tend to stay there for years unless the services provided cannot match their needs.

Secondly, the decline in elderly residents' health status (e.g., the decline of eye sight, hearing, and walking ability) limits their mobility and reduces their opportunities to interact with other residents. The social activities organized by RCFs have changed over time with changes in elderly residents' number, age structure, and health status. At the time of the interviews, activities which had previously been organized by the RCFs were no longer offered because of declines in health status of some of the elderly residents or the increasing costs of the activities. Elderly residents' intensity of engagement in activities is also affected by the changes in their health status. Decreasing levels of strength and agility pose significant constraints upon their movement, and occasional fainting spells and decreased hearing ability affect their communication with others.

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

Thirdly, attitudes on aging and residential care, awareness of self, and sense of control affect the self-evaluation of elderly residents' well-being. Cultural values of filial piety and Confucianism have played an influential role in shaping the long-standing negative perceptions of residential care in Chinese society. Traditionally, elderly parents are cared for by their adult children. Society used to disapprove of family members who relocated their elderly parents to RCFs, casting it as a way of shrugging off their filial obligations. With the socio-cultural changes in recent decades in China, the stigma of residential care is gradually breaking down. Notwithstanding these changes, certain members of the public, including some elderly residents and their family members, still have ambivalent attitudes towards residential care.

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

For some older people, residential care was a preferred choice to enhance the quality of their elderly life, which they consider as a way to relieve themselves from the heavy demands of housework and spend more time on personal interests. Some elderly residents chose residential care as a strategy to relieve the care-giving burden on their family members, but some were reluctant to move and resented being abandoned by their families.
The willingness to relocate and attitudes on collective life affect the adjustment to the transition (Andrews, 2005). Active participation in various activities helps adaptation to relocation and maintains or improves physical and psychological well-being. Elderly residents also developed various strategies to manage their lives in RCFs, such as searching for better RCFs if they were not satisfied with the current one, hiring hourly caregivers to offer additional services, and taking housekeeping chores as a form of exercise to maintain their independence. Additionally, some elderly residents participated in community services where the RCFs are located and continued to contribute to society with their expertise after the relocation.

I encourage other elderly residents to sing with me. I have taught them more than 10 songs, including a song I wrote for our RCF, and we perform some of them when people come to visit or on festivals…. I also wrote a song for the school next to our RCF and taught the music class there for a year. (An elderly resident)

Rather than being passively “placed” in an RCF, some elderly residents actually “live” in the RCF, where they make active choices, decisions, and judgments about their living environment (Andrews & Phillips, 2005).

**Individual factors — family members**

Both elderly residents and their family members’ attitudes towards aging and residential care directly and indirectly affected elderly residents’ well-being after relocation. In Asian societies, the obligations to filial piety continue to persist even with the recent dramatic socio-economic changes, albeit in an apparently modified form (Ng, Phillips, & Lee, 2002). The attitude toward residential care also varies among family members. Some of them have positive attitudes toward residential care and continue to provide all kinds of supports for their elderly parents after the relocation, whereas some of them are negative about residential care or choose to reduce their supports after the relocation.

This research shows that most adult children continued to support their elderly relatives in various ways after their relocation, and the continued involvement influenced the quality of care received by elderly residents. Family members engaged in a range of physical care tasks such as bathing, laundering, and shopping. They also undertook social care tasks, such as financial support, visiting, and taking the elderly residents out for social activities or to family events. Emotional support from family members was valued as the most important form of support for elderly residents. In addition, family members undertook an important monitoring role checking on the quality of care given to the residents. Sometimes, family members also helped other residents they got to know, which is especially significant for those who have few visitors. This phenomenon is similar to what others have found in other cultural settings (see Gladstone, Dupuis, & Wexler, 2006; Milligan, 2006). With the cooperation of staff members, family members contributed their knowledge and experience about the care needs of elderly residents to improve their overall quality of care that elderly residents received.

Every week, I bring her some magazines and newspapers when I come to visit. Sometimes, I take her out for lunch or take her home for a few days during the holidays. She likes me to come and talk to her…. I help her do some laundry and wash her hair…. I usually bring some extra food to share with other elderly residents and staff when I come to visit. (A family member)

All the family members interviewed reported that residential care reduced their care-giving burden. Most family members, however, were unable to visit their elderly relatives and care for them everyday because of other social and family obligations. Some of them developed strategies to maximise their support. For example, adult children took turns to visit their elderly parents. Some of them contributed more financial support, while others provided more social and emotional support, depending on their capabilities.

The active aging model emphasizes the role of individuals in continuing to participate in social activities and engaging in their lives. The examples of how changes in one’s health status affect the ability to participate in social activities and how elderly residents and family members develop strategies to meet the challenges they face illustrate the dynamic attributes of sense of place and the initiative of making place for adaptation. The individual experiences of social relations and social practices within the RCFs are important when considering well-being and linking health to place.

**Discussions and conclusion**

This study is among the first studies on residential care in Beijing from the perspective of health geography. It uses a multi-perspective analysis of the relationship between health and place in RCFs. The results show that the majority of elderly residents are satisfied with their lives in RCFs. It provides unique insights into the physical and social environment of RCF life in Beijing as well as how individual characteristics and attitudes are of vital importance to elderly residents’ well-being. The meanings of therapeutic landscapes to individuals are shaped by the physical and built environment of RCFs, as well as the social environment which is composed of social activities, social interactions, and management mechanism within RCFs. The concepts of therapeutic landscapes and active aging provide explanation on how the environment affects the individual’s well-being and how individuals adapt to the environment and aging process.

The rapid aging of the population in Beijing is creating many challenges in terms of financial security, health care, and elder care for elderly people. Residential care as an option for providing elder care and creating a healthy living environment for elderly people is attracting more and more elderly residents. Studies in this area are urgently needed to contribute knowledge for both researchers and policy makers. The analysis of how RCFs create healthy living environments for elderly residents and how elderly residents actively engage in the social life in RCFs is helpful to improve the future planning and service quality of residential care.

The active aging model emphasizes individual responsibility in terms of maintaining a healthy lifestyle and engaging in a life-long preparation for old age and active participation. However, the role of RCFs and government are also important for providing necessary facilities, services, and management mechanisms to facilitate the participation and increase the opportunities for elderly residents. In the current context of China, the active aging model encourages the people in the early stages of aging (60–79 years) to be important care-giving resources both for the oldest—old and for young children not only in families, but also in RCFs, the community, and society in general. Building up elderly residents’ self-esteem, feelings of self-worth, and valuing their expertise is helpful in improving their quality of life. The active aging model has a cumulative effect that can provide mutual benefits to individuals and society. Additionally, to engage family members in care-giving, especially emotional and social support is necessary for improving the well-being of elderly residents (Milligan, 2006).

There are some limitations to this research: the elderly residents and family members interviewed are not matched within families.
because of the difficulty in recruitment; all the elderly participants have self-care abilities; and this paper does not address the variable outcomes among RCFS in terms of their size and type of ownership. For future research, more studies need to focus on the relationship between place and health of elderly people with some or no self-care abilities, and whether findings from this study would match findings from other studies of the elderly population living in RCFS in other parts of China.

Many of the findings parallel research on residential care for the elderly in English-speaking countries in examining the impacts of housing styles, building designs, access to services, and the quality of care (Calkins, 2001; Hubbard, Tester, & Downs, 2003; Keen, 1989; Netten, 1993; Traupmann, Eckels, & Hatfield, 1992); preference of using on-site common areas to separated facilities (Bernard et al., 2007); and impacts of on service quality due to low salaries, long working hours, and poor working conditions for caregivers in RCFS (Bartlett & Phillips, 1995; Matosevic, Knapp, Kendall, Henderson, & Fernandez, 2007). There are, however, many aspects to residential care in life in China that are a unique blend of Chinese tradition (e.g., room orientation) with the practical necessities of providing care. There is also the particular tension created between elderly people, their family members, and the community over whether residential care includes disease. A break with tradition and the failure of children to honour their responsibilities to their parents. Finally, there are the specific issues of creating a residential care system quickly to meet the rapid growth of an elderly population at an unprecedented scale in the complex environment of provision by services representing a mix between public and private ownership.

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