Possibilities and Challenges of Care Management for Elderly in Urban China: Based on the Experience of Care Management Models in Developed Countries

Xinyue Sun

Graduate School of Social Studies, Doshisha University

Abstract

This study examines the necessity of care management in the supply system of community-based elderly care services and investigates the current state and trends in care management in China, thereby identifying its challenges. Based on these findings, the development and models of care management in different countries are reviewed to provide insights into their potential implementation in China.

To effectively implement care management in China, three key points are emphasized. First, defining clear objectives for care management and conducting assessments and care plan development based on the needs of the elderly and their families. Second, ensuring reliable access to services aligned with care plans, through the coordination and maintenance of care service continuity and consistency. Finally, establishing a sustainable care management system by involving all relevant services and agencies, and developing strategic plans within the broader community service system.

Based on international experience and theory, this study proposes the involvement of all services and relevant organizations in formulating a strategic plan based on the overall service system in the community. The suggestion is to establish the service center as the base and form a team consisting of professionals, administrative agencies, residents' committees, and other representatives. This team would implement care management through regular joint meetings, ensuring collaboration among various organizations for comprehensive assessment and individualized care plan development.

The successful implementation of these points would enable the development of an effective care management model catering to the needs of elderly individuals and caregivers in China. Additionally, the establishment of a care management system would foster connections among service providers, forming a network centered around community-based elderly care services.

Keywords: Care Management Model, Elderly Care, Fragmentation, Integrated care, Network

I. Introduction

A. Problem Statement

Since 2000, the socialization of elderly care has been promoted in China, leading to the diversification of care providers. As a result, home-based care for the elderly has been shared among family members and professionals based on their individual needs. However, there has been a lack of continuity and consistency in care, resulting in fragmented care for the elderly. Therefore, it is necessary to focus on resolving the issue of fragmented care experienced by the elderly and set up a user-friendly approach to service delivery. To achieve this, it is essential to address the challenges in the service delivery system from a practical perspective.

Currently, in China, the concept of "integrated care" has been proposed as a response to fragmentation, and the establishment of networks for community-based elderly care services is expected based on this concept. However, Sun (2022) has examined the trends and challenges of previous studies on integrated care in China and found the following challenges when introducing integrated care in China. The challenge is to not solely emphasizing governance by the government to coordinate and integrate various stakeholders in the community, such as residents, service providers, and social organizations, but rather exploring a method that can complement government governance by coordinating various practical social resources. To find ways to coordinate these social resources, it is necessary to consider how to connect appropriate social resources to users within the community. That means "care management" from a user-oriented perspective should be discussed when considering the solution to the fragmentation problem.

B. Research Objectives

This paper discusses the reasons why care management is necessary in the supply system of community-based elderly care services and examines the current state and trends of care management in China to find the challenges. Based on that, the development and models of care management in various countries are organized to provide insights into the framework for implementing care management in China.

C. Methodology

This is a literature study. Section II discusses the reasons why care management is necessary in the supply system of community-based elderly care services. Section III examines the current state and trends of care management in China to find the challenges. To facilitate the trends and find the challenges in research on care management in China, this study conducted searches (details are in Section III. B) for literature on care management using the "China National Knowledge Infrastructure (CNKI)[1] " database.

Next, it is valuable to refer to the practices and previous studies on care management in various countries outside of China. Therefore, in section IV, the models and developments of care management in other countries will be analyzed to examine the framework for the future introduction of care management in China.

II. Why Care Management

A. Background of care management

In 2021, China introduced the 14th Five-Year Plan, which determined the direction of development for various sectors across the country. Within this plan, the establishment of a network for community-based elderly care services to enhance the elderly service system was explicitly stated. This initiative was prompted

[1] An electronic platform created to integrate significant Chinese knowledge-based information resources. CNKI is the most authoritative, comprehensive, and largest source of China-based information resources in the world, reflecting the latest developments in Chinese politics, economics, humanity and social science, science and technology (www.cnki.net/index/).

by the challenge of fragmentation in the current supply system of community-based elderly care services in China.

Fragmentation refers to a situation in which diverse providers, such as the government, private companies, and non-governmental organizations, offer services with different objectives, pursuing their own interests and convenience. As a result, services become disjointed, lacking information exchange, collaboration, and cooperation.

This lack of coordination leads to a decline in the quality and efficiency of services, resulting in the fragmentation of principles and practices concerning user-centric care (Sun, 2022). Therefore, existing community-based elderly care services in China have been unable to provide comprehensive and integrated care, and do not effectively meet the needs of elderly individuals.

Care management is being utilized in various countries as a means to address the fragmentation of care and to provide the most appropriate services to individual care recipients, thereby reintegrating care. The practical aspect of care management aims to coordinate and collaborate services and resource support systems with a focus on user-centeredness (Kono 2021, 36). Therefore, it is believed that care management, with such characteristics, can lead to resolving the current state of fragmentation in community-based elderly care service supply system.

In order to address the state of fragmentation, it is necessary for care recipients to coordinate the available services and social resources from a user-centered perspective. As demonstrated by Challis et al. (2002, 142), comprehensive and coordinated service planning significantly impacts the well-being of the elderly. Service coordination enhances the quality of life for the elderly and contributes to the provision of accessible services.

On the other hand, providing services to the elderly without any limitations can impose a financial burden, making it difficult to achieve in both China and other advanced countries. Especially in China, where the phenomenon of "aging before affluence" is observed. Therefore, from a policy perspective, when support beyond the scope of services is needed for the elderly, it is necessary to consider cost-effective methods of service coordination.

Care management is considered an effective means to strike a balance between the necessary services or resources for the elderly and limited funding. Therefore, considering the two aspects of service coordination to provide user-friendly services and cost management for cost-effectiveness, it has been deemed necessary to establish a care management system. This study focuses on examining the establishment of a care management system within the supply system of community-based elderly care services in urban areas of China, addressing the challenges of network development.

B. What is Care Management

"Care management" originated from the United States in the late 1970s. In the United States, the term "case management" was initially used as a systematic approach to promote community care for individuals with mental disorders. It later expanded as a method of community living support for the elderly, individuals with disabilities, and abused children. Subsequently, the concept and practices of "case management" were introduced from the United States to the United Kingdom, where it was institutionalized within the National Health Service and Community Care Act (NHS), and the term "care management" was adopted. Currently, care management has been introduced in countries such as Canada, Australia, Germany, and Japan.

The reasons for changing the term from "case management" to "care management" include: (1) the term "case" had a derogatory connotation, while "care" carries a warmer nuance, (2) "care" is seen as managing the care itself rather than the "case" (Individual user) (Shirasawa 2018, 3). In China, the term "个案管理" (individual case management) has been adopted as a translation of "case management." However, in this study, relying on the reasons for the change in terminology and maintaining consistency in the text, the term "care management" is used.

Regarding the definition of care management, it has been redefined over the years as a method to achieve more integrated and coordinated services. Since each country adopts different practical approaches

and perspectives, there is no universally accepted definition. Kono (2021) organized the concept of care management in research conducted in Japan and other countries and associates care management as one method of social work and examines its uniqueness by comparing it with case work, group work, community organization, and other methods. Care management is defined as follows:

"Care management is a social work repertoire that involves the effective and efficient coordination and provision of services and resources tailored to the user's needs. It utilizes groups and teams to achieve effective institutional management, coordination of services and resources, and efficient operation of institutional programs that align with the user's needs. Furthermore, it aims to solve community problems related to user needs and improve systems and policies by providing feedback from micro to macro levels. It forms a user-centered support system." (Kono 2021, 51)

While there is no universally accepted definition of care management, there is a certain consensus on the process it entails. As shown in Figure 1, the care management process consists of seven stages (Department of Health, 1991): (1) Publishing information, (2) Screening or case finding, (3) Accessing need, (4) Care planning, (5) Implementation of the care plan, (6) Monitoring, and (7) Reviewing. Some studies combine the first two stages into one.

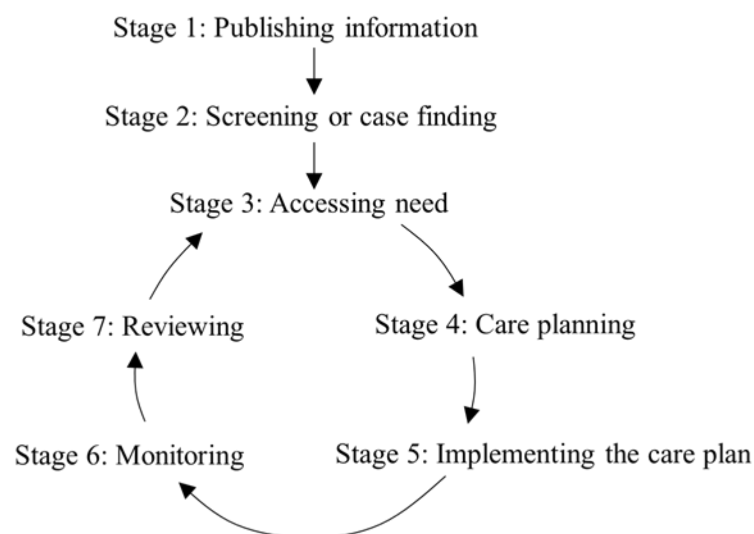

Figure 1 Process of care management (Source: Department of Health, 1991)

However, although the purpose of this paper is to explore care management in the field of the elderly, it should be emphasized that case management originated in the United States and is often applied to the mentally disabled.

Therefore, adapting care management theory to the elderly field involves recognizing the unique characteristics and needs of elderly individuals. Unlike the application of care management to the mentally disabled, caring for the elderly requires a tailored approach that considers various factors such as physical health, cognitive function, social support, and lifestyle.

For example, elderly individuals need to consider issues related to mobility and safety. Therefore, during the assessment stage, it is necessary to assess the home environment for potential hazards and provide recommendations for modifications to ensure a safe living space. Then, like Germany and Japan, there are long-term care insurance systems for the elderly, so it is necessary to consider the national system when formulating care plans and explore how to integrate and adjust the resources of formal and informal care.

III. Current State, Trends and Challenges in Care Management Research in China

In the previous section, this study discussed the need for care management in building networks for community-based elderly care services and clarified the definition and process of care management. Building

upon that, this section will examine the current state and trends of care management in China and identify the challenges.

A. Current State of Care Management in China

Regarding the current state of care management practice in China, Shirasawa (2018, 7) points out that "in China, home care services for the elderly are implemented in community centers on an individual basis, but the concept of providing packaged services through care management have not been realized." As Shirasawa notes, there is still a lack of practical initiatives and efforts related to care management in China.

At present, care management has not officially started to be implemented in China, and there is no national government document mentioning the implementation of care management systems. However, care management, as a method of social work, has been experimentally explored in folk practice in the medical field.

In 2013, the State Council of China released a document called "Seven Opinions of the State Council on Accelerating the Development of Elderly Care Service" and proposed the concept of combining medical resources with elderly care resources. To explore the mechanism of combining medical care and elderly care resources, care management is often experimented on in the medical field.

For example, according to Liu et al. (2022), in September 2017, Shenzhen People's Hospital began to introduce two professional social workers through purchasing positions to provide continuing services to hospitalized and discharged patients together with other medical staff in the Continuing Services Department. The social workers of the Continuing Services Department have played a more professional role as resource integrators and communication coordinators, providing patients with more humane medical services by coordinating internal and external resources.

However, in the field of elderly care, although there are studies suggesting the introduction of a care management system in the elderly care field, care management still remains at the suggestion stage and has not been extensively experimented on in communities or elderly care facilities.

Therefore, to address the state of fragmentation and integrate care resources, Shanghai is promoting the establishment of an integrated care service center (integrated service center for the elderly, hereafter "service centers") concentrating on each service that can meet the needs of the elderly in the living area within 15 minutes' walk from home. This service center includes an on-site service center, day care center, short-term custody and so on. In addition, in order to connect various services with users, the elderly care consultant system was launched in 2018. The role of the elderly care consultant is to provide service information to the elderly and users and so-called "private customization" for the elderly (Qian, 2018). That is to say, in terms of linking users and services, elderly care consultants may be expected to undertake some of the care management functions.

On the other hand, about the policies related to elderly services, in 2016, the General Office of the Ministry of Human Resources and Social Security issued the "Guiding Opinions on Pilot Implementation of Long-Term Care Insurance System" and released the first batch of 15 pilot cities for Long Term Care Insurance. In 2020, 14 additional pilot cities were added. In Japan, care managers who are responsible for care management were positioned in the Long-Term Care Insurance Law.

However, China's long-term care insurance does not include a care management system. Regarding the implementation of Long-Term Care Insurance, Sun (2023a) clarified the user's utilization process of the Long-Term Care Insurance system in Shanghai, China. As a result, the process until the elderly received the service was divided into four stages: "service use", "application and use of the Long-Term Care Insurance system" and "service selection and application". In those four processes, although there is an assessment investigation on the physical condition of the elderly, this is only as a basis for judging the payment of long-term care insurance, not the comprehensive assessment of customers' lives as emphasized in care management (Sun, 2023a). In addition, the Long-Term Care Insurance service is currently limited to home visit care. The home visit service content table (for users' choice) is understood as a care plan, and therefore some administrative agencies claim that care management has been introduced (Sun, 2023b).

To sum up, there is still a lack of discussion on care management in China at this stage, both in policy and practice. Therefore, the following will explore the trends in research on care management in China.

B. Trends in Research on Care Management in China

Research on the concept of care management was introduced in China in the 1990s. However, due to the delayed development of specialized social work, related papers discussing care management as a technique in social work were first published in the CNKI in 2003 (Ma & Liu 2019, 111). Ma & Liu (2019, 106-112) conducted a content analysis of literature on care management published in CNKI between 2003 and 2018, excluding care management in the medical clinical field. The results showed that there were only 61 papers discussing care management as a technique in social work. That indicates that research on care management in the field of social work is insufficient. Furthermore, regarding the content of those studies, they pointed out that “due to inadequate communication and collaboration between practical fields and academic domains, research on care management is scattered, and research in practical settings is lagging” (Ma & Liu 2019, 111).

Based on Ma's research, it is evident that there is a lack of research on both the theoretical and practical aspects of care management in China. Furthermore, the specific types of research conducted have not been clearly addressed. Therefore, this chapter aims to reexamine the research trends of care management in China, specifically focusing on its application in the supply of community-based elderly care services.

To elucidate the trends in research on care management in China, the next searches were conducted for literature on care management using the CNKI database.

First, as of March 7, 2023, a search was conducted on the CNKI database using the theme of care management, resulting in a total of 3,223 published papers. When examining the distribution of these papers by academic disciplines, the top discipline was “Clinical Medicine,” with 1,407 papers, accounting for 42.1% of the total. The next most common discipline was “Sociology and Statistics,” with 379 papers, accounting for 11.34%. Other fields, such as Political Science, Education, and Economics, also conducted research, but their proportions were each below 5%. From these results, it can be inferred that care management is predominantly studied in the field of medicine.

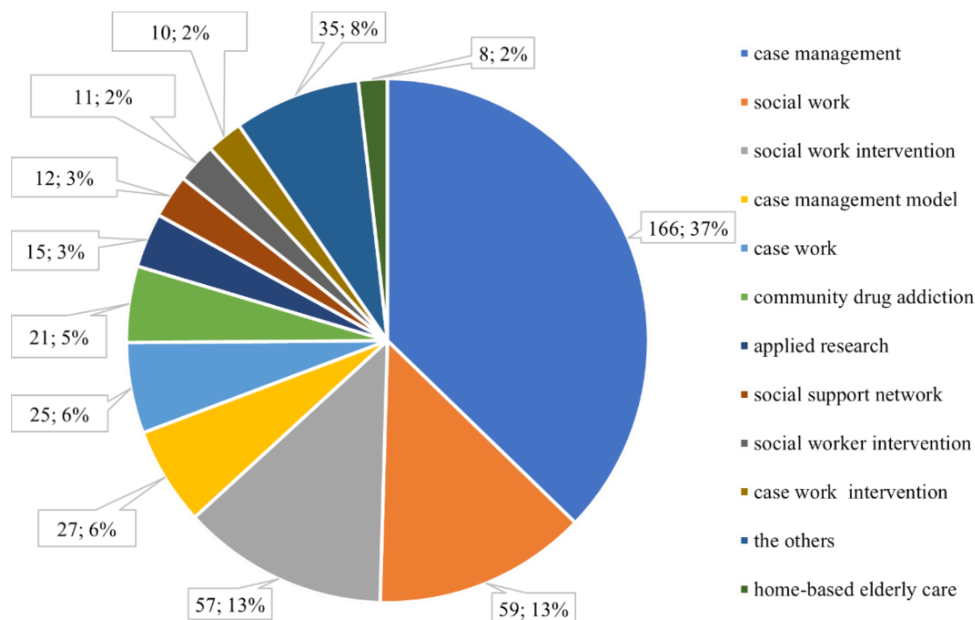

Figure 2 Distribution of the main themes in the literature search on ‘case management’ and ‘social work’ (Number of literatures; Ratio)

Next, to analyze the previous studies that have discussed care management in the field of social work, a search was conducted using the CNKI database with the keywords “case management” and “social work”, resulting in a total of 437 relevant articles. The distribution of the main themes in these articles is shown in Figure 2. The previous studies suggest the utilization of care management methods such as assessment, service planning, monitoring, and evaluation to address the challenges faced by individuals in various contexts, including drug addiction, mental disorders, domestic violence (DV), and child abuse. These studies primarily focus on the techniques of social work, often overlapping with case work.

Regarding the application of care management, the previous studies primarily focused on the field of drug addiction, with a significant number of studies. Research related to mental disorders, children, DV, and other fields is also observed, but there were only eight articles specifically addressing “home-based elderly care”.

So, in order to clarify the relevant research on care management in home-based elderly care, a search was conducted using the keywords “care management” and “elderly care” in the CNKI database, and a total of 117 articles were found. After excluding conference records and newspapers, 73 articles from academic journals and research papers were extracted. Among these 73 articles, 12 were deemed irrelevant to the purpose of this study, and eight focused on rural areas. As a result, 53 articles were extracted for further analysis.

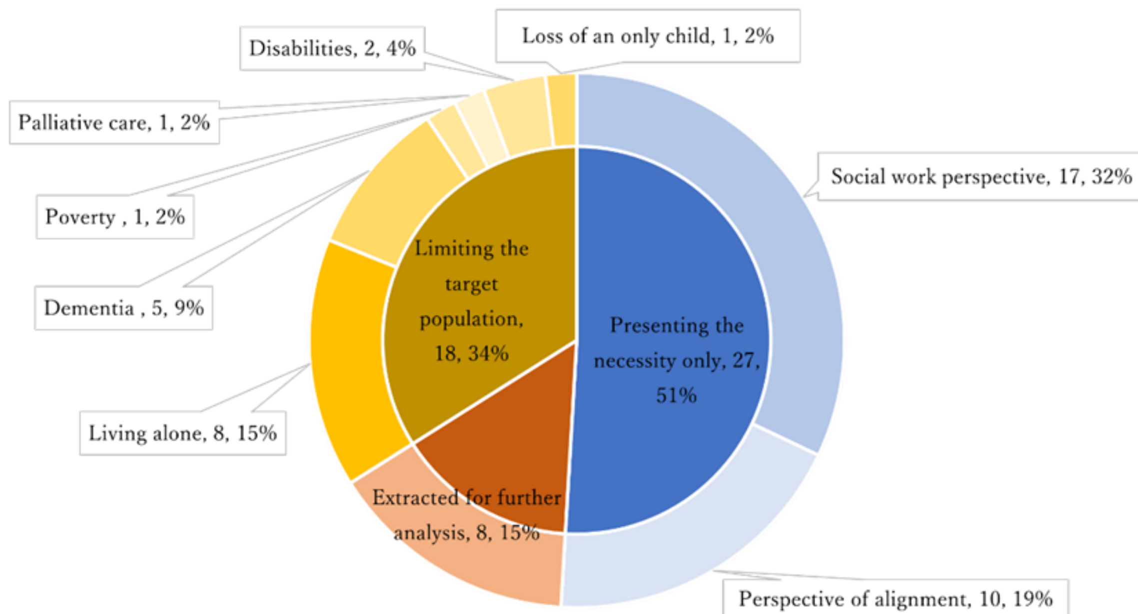

Figure 3 Distribution of 53 literatures extracted for further analysis. (Number of literatures; Ratio)

Among the 53 articles, 27 of them presented the necessity of establishing care management in their conclusions. However, they did not discuss specific methods or practices for implementing care management. 17 studies focused on the methods of intervention in the operation of elderly services from the perspective of social work, while 10 studies focused on aligning social resources in constructing service systems.

The remaining 26 studies focused on the implementation and practical aspects of care management. However, among these, 18 studies specifically targeted certain groups, such as elderly individuals living alone or those with dementia. Only 8 studies discussed the functions and roles of care management in service operation without restricting the target population. Furthermore, these 26 studies mainly analyzed practical examples of implementing care management from a micro perspective, discussing how social workers apply care management when supporting the elderly. In these studies, care management was employed as a technique of case work, and its usefulness in coordinating resources for the elderly was demonstrated.

C. Challenges in Care Management Research in China

As mentioned earlier, care management research in China views care management as an individual support technique, integrated within casework. However, these studies do not provide reasons or theoretical justifications for incorporating care management within casework. Consequently, even if the effectiveness of care management is demonstrated through individual cases, its universality cannot be ensured.

To address this issue, there are studies in Japan that discuss the relationship between care management and casework from a theoretical perspective. For example, Kono compares the characteristics of care management with those of casework and community organization, positioning care management as one of the methods in social work (Kono, 2021). Furthermore, Nakamura argues for placing care management at the core of social work and considering casework and community organization as components of care management (Nakamura, 2009).

Therefore, there is no definitive consensus on the relationship between care management and methods such as casework, but it is necessary to consider care management in conjunction with methods like casework and community organization.

Furthermore, the challenges identified in the practical examples described in the previous studies indicate the need to consider care management from meso-macro levels, in addition to micro-level perspectives. Specific challenges in the process of implementing care management include difficulties in acquiring sufficient social resources, lack of coordination and collaboration with various institutions, lack of comprehensive integration of resources, and a lack of trust in care managers as professionals (Zhao 2022, 28; Wu 2021, 41-42; Liu 2020, 69; Wei 2016, 43; Zhao 2013, 25). The fundamental cause of these challenges is the absence of cooperative systems among service providers and social resources, as well as the lack of a network formed within the community, making it difficult for social workers to coordinate resources.

Therefore, from a practical perspective, it is necessary to examine the requirements and directions for introducing care management from a meso-macro level, such as the organization of various related agencies. To address these issues, it is valuable to refer to the practices and previous studies on care management in various countries outside of China.

In recent years, the concept of care management in other countries has expanded to include not only direct service provision at the micro level but also reforms in support systems at the macro level (Kono 2021, 38). In the next section, the models, and developments of care management in other countries will be analyzed to examine the framework for the future introduction of care management in China.

IV. Care Management Models in Other Countries

As discussed in the previous section, care management has been introduced in many countries around the world, resulting in diverse approaches and models influenced by factors such as healthcare systems and the direction of community care. Therefore, it is not possible to simply introduce care management in China by following a single model or the practices of a specific country. It is necessary to comprehensively analyze the approaches and models of care management from various countries' diverse practices and initiatives.

A. Care management models

In this section, based on the care management models organized by Banks (2004), the trends in care management from specific examples in various countries will be examined. The respective models are presented in Table 1.

Table 1 Care Management Model

Model	Advantages	Disadvantages	Practice Case
Intensive care management model	Holistic approach to needs. Targeted at people with complex needs	Success is dependent on strength of inter-agency, inter-professional arrangements. Single agency models may restrict access to wider services and resources	Castlefields Health Centre in Runcorn, United Kingdom
Shared core tasks model	Allows for key tasks of care management – assessment, care planning and review – to be built into organizational procedures for large number of service users with less severe needs	Lack of continuity of staff for individual service users and less appropriate for older people with complex needs	Care management implemented by local authorities in the United Kingdom
Joint agency model/ key worker model	Good access to multi-disciplinary services	Nominated key worker may have difficulty balancing that role with their own professional input or service deliver	Government-regulated Elderly Care Assessment Team serves as a standard model for elderly care
Independent brokerage model	Strong advocates for older person and carers	Likely to lack influence in service system	Care management project conducted by an organization called 'Social Work Berlin' in the northern region of Berlin
Older person or carer co-ordinates care using direct payments	Older person able to control and choose own package of services	Support may be needed for older people who prefer to self-manage	Practice in the Netherlands

(Source: 'Practice Case' in Table 1 is added by the author based on Banks (2004, 106) 's Table 4)

(1) Intensive Care Management Model

In this model, care managers target elderly individuals with complex needs and aim to adjust service times and locations based on individual needs. Care managers are employed through agreements between a single institution (provider or service purchasing organization) or inter-agency agreements, regardless of budget availability, to coordinate services.

An example of this model is Castlefields Health Centre in Runcorn, United Kingdom (Banks 2004,103). The center serves as a base where care managers are stationed. They target high-risk elderly individuals or those who frequently use services and assess their needs according to the following steps, working in collaboration with the elderly: (1) Focus on the elderly person's opinion on how they want to improve their own life; (2) Identify problems; (3) Plan interventions; (4) Organize support; (5) Monitor and evaluate outcomes.

In this way, the concentrated care management model can provide comprehensive care management by assessing complex needs and focusing on the identified issues. However, since the execution of the care plan is delegated to other institutions, there is no guarantee that the plan will be implemented as intended. The continuity between care plan creation and execution relies heavily on the collaborative relationship between the involved institutions, and there is a possibility that access to a wider range of services and resources may be limited.

(2) Shared Core Tasks Model

In this model, systematic procedures ensure the reliable execution of core tasks such as assessing the needs of the elderly, developing individual care plans, and conducting regular evaluations. As a result, care management can be universally implemented for all elderly individuals, not just selected users. The United Kingdom and Sweden are indeed typical examples of the model where social workers employed by local authorities with budgetary authority serve as care managers.

An example of care management can be seen in the implementation by local authorities in the United Kingdom. While originating in the United States, a systematic care management system was established in the early 1990s in the UK, known as “arrangements,” to provide standardized services (Huxley 1993, 366). In this process, local authority care managers conduct comprehensive assessments of individuals requiring care, consult assessments made by other professionals, develop personalized care plans that prescribe the most suitable combination of services (care packages), and coordinate the provision of various health and welfare services according to the care plan (Nishimura 2000, 92). Over time, care management in the UK has evolved into a means of managing service provision for all elderly individuals, rather than exclusively targeting those with complex needs. However, the “shared core tasks model” delegates different core tasks to different departments, which may not be suitable for providing intensive therapeutic support in care management for elderly individuals with complex needs.

(3) Joint Agency/Key Worker Model:

In this model, care management is supported by a multidisciplinary team composed of professionals dispatched from various agencies. One member of the team functions as a care manager or key worker.

An example of this model can be found in Australia. In Australia, the government-regulated Elderly Care Assessment Team serves as a standard model for elderly care. This team comprises geriatric physicians, nurses, social workers, and other professionals (Ma-fi-, 2000). Elderly care is primarily managed through care management by the assessment team. Collaboration and teamwork with professionals from various disciplines are emphasized, and the case manager holds budgetary authority within this framework.

In this model, the services provided to the elderly are comprehensively coordinated based on individual assessments, and families are also provided with support, education, and skill training. One advantage of this model is that it enhances access to various services through the involvement of a multidisciplinary team, including nurses, physicians, and social workers. However, in a multidisciplinary team, collaboration and decision-making can be affected by differing perspectives and priorities among individuals with different specialties. Therefore, the care manager or key worker responsible for coordination may face challenges in balancing the values and ethics of each profession while providing services from a neutral standpoint. Additionally, in this model, care management primarily focuses on achieving clinical outcomes, with financial management playing a minor role.

(4) Independent Brokerage Model:

In this model, care managers are employed by independent agencies and act as service brokers. This allows them to serve as powerful advocates for users, but their influence within the service system may be diminished. In some cases, care managers primarily offer advice and information to users and their families.

For instance, in Germany, there is no formal care management system or procedure in place. However, there is an exemplary care management project conducted by an organization called “Social Work Berlin” in the northern region of Berlin (Okazaki, 2000). This project focuses on needs assessments by professionals and the provision of services based on care plans, with the goal of supporting independent living in the community. Moreover, German long-term care insurance provides benefits within certain limits, and there is a financial management system in place to ensure the effective utilization of limited resources.

(5) Older person or carer co-ordinates care using direct payments:

This is not a traditional “model,” but rather refers to a situation where elderly individuals or their caregivers take charge of and coordinate their own care and services. Specifically, instead of service coordination by external agencies, the elderly person (or caregiver) is provided with a care budget, which is a budget allocated for service utilization fees. This allows them to directly purchase services that align with their specific needs.

For example, in the Netherlands since 2003, elderly individuals who qualify for home care have the

option to receive care through direct cash payments instead of receiving in-kind care. “Elderly advisors” offer support by guiding the individuals through the necessary procedures and providing information about service availability. This empowers the elderly to arrange their own customized care packages. Some of these “elderly advisors” are elderly volunteers who aim to support the self-determination of elderly individuals by offering essential information, advice, and assistance in self-management.

B. The Need for Combining Different Models of Care Management

Among the five care management models mentioned, Models (1) and (3) are suitable for older adults with complex needs, while Models (2), (4), and (5) are more appropriate for older adults with milder needs or those who have self-care abilities and their families.

Models (1) and (3) share common features such as intensive and close involvement with older adults, comprehensive needs assessments, collaborative creation of care plans by multidisciplinary teams, and targeted support. These models focus on providing intensive care management for older adults with complex needs. On the other hand, Models (2), (4), and (5) incorporate care management functions into organizational procedures, allowing for service management while ensuring care for older adults with milder needs. They also leverage the strengths of older adults and support their self-determination to maximize autonomy in achieving self-care goals.

Overall, these models offer a range of approaches to cater to the diverse needs of older adults and their families, whether they require intensive care management or support for maintaining their independence in self-care.

However, it is important to recognize that a single model is insufficient to meet the needs and living situations of different groups of elderly people. Challis suggests the importance of distinguishing between providing “intensive care management” to users with complex needs and implementing “formal procedures” such as assessment, care planning, and regular reviews for all users (Challis, 1999). Therefore, Model (1) or (3) are optimal for older adults with complex needs, while implementing Model (2) that incorporates systematic procedures like assessment, care planning, and regular monitoring is more efficient and effective in meeting the needs of older adults with milder needs.

Therefore, when implementing care management, it is ideal to combine different care management models while considering the following six elements pointed out by Banks (2004, 111) that rely on the advantages and effectiveness of care management models: (a) the target group chosen, (b) clarity of objectives, (c) supporting organizational infrastructure, (d) budget control, (e) relationships with other organizations in the service system, and (f) availability of a range of local services.

V. Challenges in the Development Framework of Care Management in China

This paper established a foundation for discussion by referencing the five care management models outlined by Banks (2004) (mentioned in Section IV) and the seven-stage care management process based on the Department of Health (1991) (mentioned in Section II). However, it is crucial to acknowledge the dynamic evolution of care management over the past 20-30 years, both in theory and practice.

Despite significant changes in the field, this paper continues to utilize the six elements influencing the five models and the seven stages of the care management process. The rationale behind this choice lies in the recognition that while care management models have evolved, certain fundamental elements have maintained their relevance and applicability across changing contexts.

For example, over the past 20 years, the system of care management for the elderly in Japan still retains seven stages of care management. In addition, Japan has institutionalized care management under a long-term care insurance system, similar to Model (2), while also establishing mechanisms similar to Model (3) by actively participating in local care conferences to address cases requiring support.

Therefore, the six elements and seven stages encompass core principles and concepts that are foundational to effective care management. These enduring elements include aspects such as comprehensive assessment, collaborative teamwork, and ongoing evaluation, which are considered essential irrespective of

changes in the broader landscape. While care management models have evolved, these elements and stages can provide a consistent framework for care delivery, ensuring that fundamental aspects of customer management are not overlooked. This consistency is important when adapting care management practices to diverse cultural, organizational, or systemic contexts. This is particularly crucial when implementing care management in the context of China, which has unique healthcare challenges and cultural considerations.

A. Challenges in the Development Framework of Care Management

Based on the aforementioned information, introducing care management in China requires exploring a care management framework that is suitable for the Chinese context. This exploration should consider the six elements mentioned earlier, as well as reference practices and models from other countries. The following will provide suggestions for the development framework of care management in China based on the six elements that influence the 5 models mentioned in section IV, and the seven stages of the care management process outlined in section II (B. What is Care Management). The relationship between the seven stages and the six elements is presented in Table 2.

Firstly, it is crucial to clarify the purpose of introducing care management in China, as emphasized in point (b). As discussed in the previous section, care management serves as an effective means of balancing service coordination from the user's perspective and cost management from a financial perspective. However, achieving a perfect balance between these two aspects is challenging. Hence, the emphasis on different points and the models to be applied may vary depending on the purpose for which each country adopts care management.

In this study, the purpose is to provide services that are easily accessible to users, with a primary focus on service coordination from the user's perspective. With the purpose clearly defined, let us now consider the key aspects to be considered when implementing care management in China, based on each stage of the care management process.

Table 2 Relationship between the seven stages and the six elements

The stage of the care management process (Mentioned in section II. B.)	The elements should be considered. (Mentioned in section V.A.)
(1) Premise	(b) clarity of objectives
(2) publishing information screening or case finding	(a) the target group chosen (d) budget control
(3) Accessing need	(c) supporting organizational infrastructure
(4) Care planning (5) Implementing the care plan	(c) supporting organizational infrastructure (e) relationships with other organizations in the service system
(6) Monitoring (7) Reviewing	(f) availability of a range of local services

(Source: Compiled by the authors from the following sources: Department of Health (1991); Banks (2004, 111))

In the initial stages of (1) publishing information and (2) screening or case finding, two key elements should be clarified: “(a) the target group chosen” and “(d) budget control”. Considering the substantial elderly population in China, providing intensive care management to all elderly individuals is not feasible. Moreover, with the current “aging before becoming affluent” situation in China, it becomes imperative to exercise budget control when allocating resources for service provision.

To effectively address the challenges posed by the large elderly population, it is essential to categorize elderly individuals into different groups based on their specific needs and direct them to institutions or procedures that implement different care management models. For instance, elderly individuals who are self-reliant and have relatively simple needs could receive information-only services, which falls under the

purview of “(a) the target group chosen”.

Let's further elaborate on the reasons for implementing “(a) the target group chosen” in this context. According to Shirasawa, care management involves developing care plans and providing ongoing monitoring, which requires substantial support and incurs costs. To optimize the use of resources and achieve cost reduction, it is crucial to differentiate between care management and information providers (Shirasawa 2018, 443). Drawing from Shirasawa's perspective, during the stage of (1) publishing information, it becomes feasible to identify elderly individuals who may potentially encounter difficulties in managing their own lives. In such cases, only these individuals can be referred to institutions that implement “heavy-duty” care management models, akin to Model (2) and (3). This approach ensures that resources are optimally allocated to those who require more intensive care management, while still providing valuable support to other elderly individuals based on their unique requirements.

Moving on to the stage of (3) Accessing need, it is necessary to establish the element of “(c) supporting organizational infrastructure.” Specifically, in order to implement care management with “heavy equipment” like Models (2) and (3), it is crucial to determine the institutions responsible for assessing the needs of the elderly and the base where the assessment team operates. These institutions or bases should be established and developed accordingly. For example, if adopting Model (3), it becomes imperative to determine the extent of involvement of relevant institutions, such as service providers, residents' committees, streets, civil affairs departments, hospitals, etc., in the assessment of the elderly. The decision needs to be made whether to include all these institutions or only select ones. Subsequently, a leading institution or care manager should be designated, and a collaborative teamwork mechanism for conducting assessments should be established among these institutions. This mechanism must encompass clear assessment criteria and team rules to effectively resolve conflicts.

The implementation of such a process necessitates the establishment of a strong organizational foundation to support the comprehensive assessment of the elderly's needs. This foundation would facilitate a coordinated effort among various stakeholders, ensuring a holistic approach to elderly care management and service delivery.

In the stages of (4) Care planning and (5) Implementing the care plan, two elements need to be clearly defined: “(c) supporting organizational infrastructure” and “(e) relationships with other organizations in the service system”. To illustrate this, the example of Model (3) will be used again.

When implementing (4) Care planning, it is necessary to determine the relevant agencies and leaders. However, it is also essential to ensure continuity with the subsequent stage (5) Implementing the care plan. Therefore, it is important to discuss the methods to secure continuity based on the feasibility of care plans, which refers to the availability of services and social resources identified during the (4) Care planning stage and the actual access of the elderly to these resources during care plan implementation.

The feasibility of care plans heavily relies on the team's ability to effectively coordinate services and the extent of collaboration with various organizations within the service system. This interdependence is supported by Tsutsui (2003), which highlights the correlation between collaboration and service utilization. When teams engage in effective collaboration, there is a positive impact on service utilization, making care plans more feasible and successful (Tsutsui, 2003). This underscores the importance of fostering strong teamwork and cooperation among various organizations within the service system to enhance the overall effectiveness of care management.

Therefore, for the smooth progress of (4) Care planning and (5) Implementing the care plan, it is essential to constantly work on interagency collaboration and strengthen interagency coordination. This will help maintain cooperative relationships among the various institutions and organizations within the service system.

In the stages of (6) Monitoring and (7) Reviewing, it is essential to verify “(f) availability of a range of local services”. This entails evaluating the implemented care management models and mechanisms at both the individual and system levels. At the individual level, evaluation aims to determine whether the specific needs of each elderly person have been addressed and if the care plan objectives have been achieved.

At the system level, the assessment focuses on evaluating the suitability of the models and mechanisms in line with the common culture and characteristics of the community. If there is a wide availability of community services, it opens the possibility of expanding these successful models and mechanisms to a broader region and potentially even nationwide.

One effective method to verify the "availability of a range of local services" is to collect feedback from elderly individuals, their caregivers, and relevant organizations. By utilizing feedback as a means of monitoring and evaluation, it becomes possible to gain valuable insights into the realities of care management and to reevaluate its mechanisms. Through feedback, the availability and effectiveness of current care management mechanisms within the community can be assessed, and any shortcomings can be continuously addressed and improved. This process ultimately leads to the formulation of a strategic plan for enhancing the entire service system in the community.

By sharing and disseminating successful care management practices through this feedback-driven process, the possibility of introducing an effective care management system in China becomes more feasible.

B. Suggestions for the introduction of Care Management in China

Through the above analysis of the development framework of care management, the following three points need to be considered for the introduction of care management in China from the perspective of the development framework:

1. Clearly define the objectives of care management and conduct assessments and care plan development based on the needs of the elderly and their families.

2. Ensure that the elderly can access services based on their care plans by attempting to coordinate and maintain the continuity and consistency of care services.

3. To establish care management, involve all services and relevant organizations and formulate a strategic plan based on the overall service system in the community.

By addressing these three crucial points, an effective care management model can be developed in China, aligning with the needs of the elderly and their caregivers. Moreover, through the establishment of a care management system, various service providers can be connected, forming a robust network for community-based elderly care services.

Finally, this paper will also provide some specific recommendations based on the Chinese context and international experiences and theories.

Firstly, it is considered that the integrated care service center mentioned in Section III can be the base for care management, and the elderly care consultants at service centers can act as care managers.

At present, service centers in China actually administer all its operations. In that case, the authority to decide the service is given to private corporations. Therefore, when a care plan is created by the service center, the elderly can quickly use the service. However, it is necessary to pay attention to the fact that the care management is operated from the standpoint of the consultant and the user, not the service supplier or the administration, when care management is carried out by the service center.

Secondly, when care management is introduced in China, it is necessary to emphasize that this is not only to develop care plans for managing long-term care insurance services but also to provide a comprehensive support to the elderly.

As described in Section III, the current situation in China is that the content of home visit care services (selected by users themselves) is understood as a care plan. One of the reasons is that care management has not been fully understood. But in China, where government leadership is emphasized, care management may be used in financial administrative institutions such as the long-term care insurance system and the service subsidy system. In other words, in the name of care management, it may only realize the function of cost management. To avoid this possibility, before introducing care management, it becomes very important to confirm that the purpose of care management is comprehensive support for users. This is similar to the first point mentioned above.

Finally, as mentioned in the third point based on international experience and theory, it is necessary to

involve all services and relevant organizations and formulate a strategic plan based on the overall service system in the community. Therefore, based on the current state of elderly care services in China, this paper proposes a suggestion for implementing care management. It is suggested that the service center be the base, and a team consisting of professionals, administrative agencies, residents' committees, and other representatives who are prepared at the center should be formed to implement care management through regular joint meetings. It is necessary to ensure collaboration among various organizations and representatives to implement a comprehensive assessment. Then, hold regular joint meetings where the team discusses community health issues and focuses on the specific needs of elderly residents. The team collaboratively develops individualized care plans for the elderly, maximizing the utilization of community resources to provide comprehensive support.

VI. Conclusions

This study explored the need for care management in the supply system of community-based elderly care services in China. It investigated the current state and trends of care management, highlighting challenges. Drawing insights from the developments and models of care management in different countries, this study aimed to provide guidance for its potential implementation in China.

To effectively implement care management, based on international experience and theory, three key points are emphasized. First, clear objectives for care management are defined, conducting assessments and care plan development based on the needs of the elderly and their families. Second, reliable access to services aligned with care plans is ensured through coordination and maintenance of care service continuity. Finally, a sustainable care management system is established by involving all relevant services and agencies, developing strategic plans within the broader community service system.

It is hoped that by combining these suggestions, an effective care management system based on service centers can be achieved. However, regarding how to form a team to implement care management, and how the team will divide labor, these need to be discussed in depth based on the specific state of the community through a survey of the current state.

In addition, this paper only provides directional suggestions for the introduction of a care management system in China based on international experience and theory. Due to significant differences of China's political system, economy, and culture from the countries listed in this paper, it is necessary to conduct an in-depth investigation into Chinese communities in the future. And based on that investigation, to propose specific methods for implementing a care management system based on the specific state and issues of the community.

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