Hospice Foundation of Taiwan

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Forever Love, Endless Care

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Walking with You Through Life's Final Lesson

Healthcare Should Not Be Absent at the Last Moment

Home-Based Emergency Care: Building a Safety Net for Peaceful End-of-Life at Home

Plahan's Dream of Symbiotic Communities

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The First Step Toward a Good Ending Is Talking About Death.

Walking with You Through Life’s Final Lesson

At the end of life, can we truly have the right to choose our medical treatments and make the necessary preparations? Since the Patient Right to Autonomy Act was implemented six years ago, the number of people signing has steadily grown. But is this conversation happening widely enough? For many, it’s not refusal—but simply not knowing how to begin. Families and patients often hold different views, and talking about death remains unfamiliar. Through interviews with frontline advocates and stories from medical settings, this article uncovers the challenges of putting the Act into practice.

“I wanted to sign, but my daughter wouldn’t let me—she said it would bring bad luck.”

At a community event promoting the Patient Right to Autonomy Act (often called the Autonomy Act), a grandmother in her seventies raised her hand and softly said this. The room fell silent. It revealed a core difficulty in promoting this law—not that people don’t understand it, but that some things are simply too hard to say.

Six years into the Autonomy Act, the number of signed directives continues to rise, seemingly signaling progress in institutional adoption. Yet, in many outreach and education sessions, hesitant eyes are still common, and long stretches of silence often linger as no one is willing to be the first to speak up.

It’s Not Opposition—It’s Not Knowing How to Begin

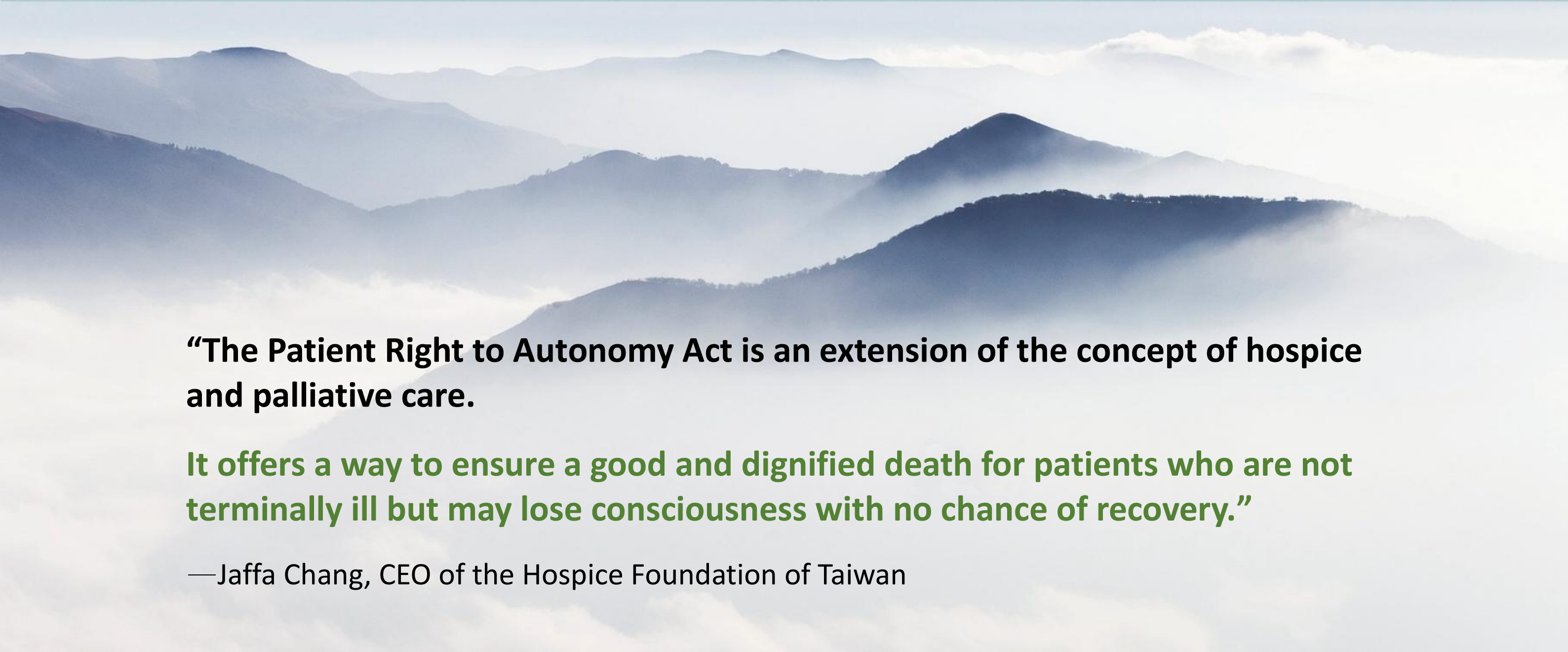
Twenty-five years ago, the Hospice Foundation of Taiwan helped launch the Hospice Palliative Care Act, ensuring that terminally ill patients could legally refuse aggressive resuscitation. “Since 2010,” said Jaffa Chang, CEO of the Foundation, “we began promoting Advance Care Planning because we saw many non-terminal patients fall into irreversible unconsciousness.” If people can express—while still conscious—what treatments they do or don’t want, their wishes can still be respected even after they lose the ability to speak. This was the origin of the Patient Right to Autonomy Act.

“The Act extends the work of hospice care—it offers a solution for those who aren’t terminal yet may lose consciousness,” Chang explained. Hospice isn’t passive waiting for death; it’s helping people carry their values to their final moment. Through Advance Care Planning (ACP) and the signing of an Advance Directive (AD), the Act gives people a chance to discuss these choices earlier—while they still can.

The process of life winding down requires not only medical care but also spiritual grounding and the mending of relationships. Yi-Lin Yeh, Assistant Professor in the Department of Social Work at Tunghai University, explains that hospice and palliative care provide gentle support, while the Autonomy Act offers choices and direction. ACP is not about teaching the law—it’s about helping people practice saying something deeply difficult.

“When I lead ACP sessions, I often see families talking about death together for the first time,” said Yeh, who previously served at Taipei City Hospital and worked as a hospice social worker. “Many people never realized they had the right to choose, to refuse, or to leave clear instructions.”

As a legislative advocate for the Act, Yu-Hsin Yang, Founder of the Action for Love Social Welfare Foundation, highlighted another major issue: “The biggest problem



> **“The Patient Right to Autonomy Act is an extension of the concept of hospice and palliative care.**
>
> **It offers a way to ensure a good and dignified death for patients who are not terminally ill but may lose consciousness with no chance of recovery.”**
>
> —Jaffa Chang, CEO of the Hospice Foundation of Taiwan

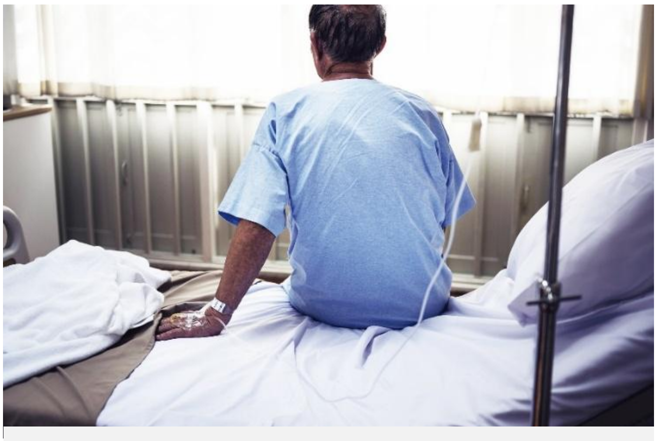
is that many people don’t even know the Act exists.” During her advocacy work, she often encounters people saying, “Oh, I’ve already signed it!” But in reality, some mistakenly think that an Advance Directive is the same as a Do-Not-Resuscitate (DNR) order, while others assume that it has legal standing to have vaguely told their family, “Don’t make it too hard for me when the time comes.” These misunderstandings are widespread.

Our Society Is Still Not Used to Talking About Death

Jaffa Chang pointed out that in promoting the Autonomy Act, the Hospice Foundation of Taiwan most often encounters not opposition, but misunderstandings—either overly simplified or one-sided. “The issue in our society is not that people refuse to talk about death, but that they have never practiced talking about it properly, nor developed the habit of discussion,” she acknowledged. Many people skip the step of preliminary discussions (Pre-ACP) with their families and go straight to scheduling an ACP consultation. As a result, many concepts, values, and preferences are never thoroughly discussed. Though society has become more open to discussions of death and opportunities to encounter the topic are more common, most people still do not know how to begin. Many assume that simply signing an AD equals a good death, and once the form is signed, the conversation ends. Years later, even they may not remember what they signed. When the time comes, this lack of clarity can create tension between families and medical staff.

Yi-Lin Yeh also shared her observations from Taipei City Hospital, saying this silence is not accidental, but a form of collective suppression. “Everyone actually knows what the others are thinking, but no one wants to speak first.” Some terminally ill patients are fully aware of their condition and do not want futile treatments. Yet they remain silent because they fear that if they bring up death, their family members will cry. On the other hand, family members feel that mentioning it first is like casting a curse—so they stay silent too. And so the most common scenario is mutual pretense: one side is afraid to speak, the other is afraid to ask.

Only when the patient is critically ill does the medical system, by default, proceed with full resuscitation. This is the scene Yeh finds most unbearable: the patient is dying, the doctor stands by the bed and asks the family, “We need to intubate now—do you want us to resuscitate?” At that moment, the family cannot think rationally; emotions take over, and their instinctive answer is, “Save them!”—allowing treatment to continue through tears and hesitation. In truth, the key to promoting the Patient Autonomy Act is not the medical procedures themselves, nor the paperwork—it’s the willingness to have the conversation.



Some terminally ill patients actually do not wish to undergo futile treatments, but they fear that if they bring up the topic of death, their family members will cry.

A Good Death Should Be Defined by Each Individual

“My father did talk about a good death—he said he didn’t want to be saved,” Yeh said. But when she hears family members say this, she always asks, “Do you know what he meant by a good death?” The answers are often quite different from what one might expect.

Today, the idea of a good death seems to have been reduced to a rigid public definition. Many elders only say, “I don’t want any tubes,” but never clarify—which tubes? A urinary catheter? A nasogastric tube? Or an endotracheal tube? Yeh suggests that people practice communicating more completely, saying things like, “If there is no chance of recovery, I don’t want to be intubated,” or “Which treatment will keep me more comfortable?” In clinical settings, there have even been cases where refusing a urinary catheter caused painful urinary retention.

“Some people believe that refusing intubation is dignity. But for those who choose to be treated until the very end, that should also be respected—because it reflects their personal beliefs about life,” said Jaffa Chang. That is precisely the spirit of the Patient Autonomy Act: to think clearly, to be willing to talk with family, and to respect each person’s autonomous decision. A good death shouldn’t have a standard version. It should reflect each person’s life story, values, and faith. Ultimately, the real

The Patient Right to Autonomy Act is like a letter written to one’s future family—expressing a patient’s final hopes for life and how they hope their loved ones will accompany them.

conversation is not about “how to die,” but about “how I want to live—right up to the final moment.”

Yu-Hsin Yang later stopped using technical or legal terms to introduce the Act. Instead, she would say: “This is a letter you write to your future family, telling them how you hope they will accompany you on your final journey.” She explained that if the language is too cold or unfamiliar, people instinctively reject it. Signing the form is not the goal—quality consultation is. The Patient Autonomy Act is not only about the moment of removing machines or stopping CPR. It is a conversation about life and relationships: How do you want your farewell to be held? Where do you want your children to remember you? What do you hope to leave behind in this world? These expressed choices are not only medical decisions but reflections of values.

Advocacy Cannot Rely Solely on Passion

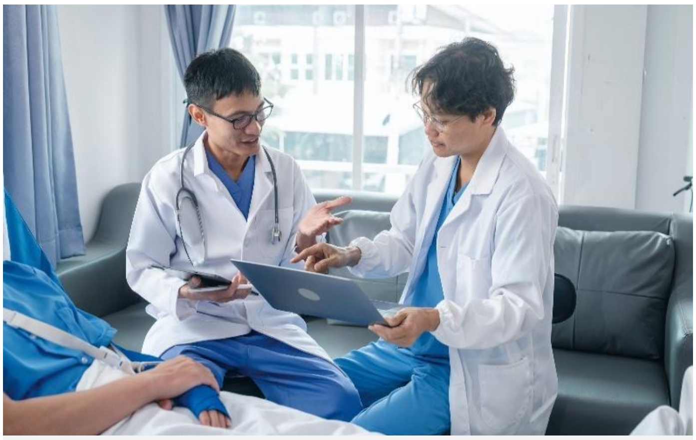
But to make these conversations happen, slogans and institutional mandates aren’t enough—and they cannot be pushed along the way by the healthcare system.

“In fact, once a patient has gone through the ACP process, even if they can no longer express their will, as long as the physician follows the Advance Directive, they are fully protected under the law. It protects doctors and forms the foundation of trust between patient and physician,” said Yang Yu-Hsin. Yet under current regulations, only medical institutions are authorized to conduct ACP. “If more community organizations could participate, we could expand service capacity, help people complete ACP earlier, and reduce the burden on hospitals.”

Chang agreed, stressing that ACP requires time, space, and emotional support. Yet the current system places a heavy clinical workload on frontline healthcare, making it hard for even major hospitals to consistently allocate staff—let alone rural facilities.

“We’ve turned ACP into a bureaucratic process, not into a part of medical culture. If frontline medical staff are not trained, and don’t grasp its core values, they won’t truly want to do it,” said Yeh Yi-Lin. Reflecting on Taipei City Hospital’s experience, she recalled how change began with the superintendent’s determination and a focus on life literacy. Looking ahead, she believes community caregivers—home aides, long-term care workers—should become the first point of contact, helping elders think through these issues before being referred to hospitals for formal consultation and signing.

This difficulty in implementation is also a question of resource allocation. One ACP consultation costs about NT$3,500. It may sound reasonable, but expectations differ between healthcare providers and the public. Chang admitted that the current system is sustained by passionate good people, which is not sustainable. A sound structure is needed—one that allows willing practitioners to continue, and provides incentives and accountability so medical institutions see ACP as a core responsibility, not an optional extra.



The current ACP system is sustained by a group of passionate good people, but what is needed is a sound structure that allows those who are willing to continue their work.

The Vulnerable Must Not Be Left Behind

To raise the quality of ACP, gaps left by the system must be filled by civil organizations. According to Yang, the first step is ensuring that vulnerable groups—those burdened by illness, lacking access to information, or living with disabilities that hinder communication—do not lose their right to choose. She remembers one advocate most clearly: Xiuxiu.

Xiuxiu had spinocerebellar atrophy. She was fully conscious but unable to speak. After watching many patients spend years bedridden without dignity or quality of life, she resolved to choose differently. At Yang's invitation, Xiuxiu joined advocacy efforts for the Autonomy Act, struggling but determined to express her will with her hands. Her mother fully supported her desire to sign an Advance Directive and to donate her brain for medical research. Looking back, her mother said that although her heart was breaking, honoring her daughter's wish brought peace—even in the pain of a parent sending off their child.

"The Autonomy Act is not just about terminally ill patients. We've long promoted the Vulnerable Service Program to support families caring for disabled or severely ill members," Yang said. Not every patient receives a chance to understand the law

The purpose of promoting the Patient Right to Autonomy Act is not only to help people learn how to make choices, but also to let them know:

"When you are ready to speak, someone will be there to listen, and your words will matter more than anything else."

like Xiuxiu did. Often, caregivers collapse first under the pressure.

This is why the Vulnerable Green Pathway was created—a network of 28 hospitals nationwide helping people in rural areas, rare disease communities, people with disabilities, or high-risk families complete ACP. In the beginning, the obstacles were immense—no funds, no staff. So organizations like the Patient Autonomy Research Center and Action for Love Foundation raised money and trained personnel themselves to make this pathway possible.

“This isn’t how a system should work,” Yang said, “but if even we don’t do it, who will protect them?” She is now promoting One plus One, One plus Two, allowing patients to bring one or two family members into consultations. The goal is to build a shared understanding of medical decisions so that loved ones don’t face the last journey burdened by ignorance, fear, or lifelong regret.

An Unfinished Journey: Staying Until the Last Word Is Spoken

For frontline advocates, the hardest part of the past six years of promoting the Autonomy Act has not been explaining the law itself, but encouraging people to speak. No matter how many signatures are collected, nothing compares to that one moment—when someone finally sits down and says to their loved ones: “When the day comes, this is how I want to go.”

Conversations like this do not happen on their own. They require someone to be present—to guide, to explain, to wait patiently as a family slowly finds the words. For now, advocates often fill the gaps with passion, investing time to build trust

while hoping for a more complete system in the future.

We have not yet reached the ideal destination, but the journey cannot stop. The true meaning of promoting the Autonomy Act is not only to help people learn to choose, but it is to assure them: “When you are ready to speak, someone will be there to listen, and your words will matter more than anything else.”

Healthcare Should Not Be Absent at the Final Moment

Home-Based Emergency Care: Building a Safety Net for Peaceful End-of-Life at Home

When a terminally ill patient chooses to spend their final days at home, an unexpected fever or a night of struggling to breathe can plunge family members into panic and helplessness. Beginning in 2024, Taiwan officially extended the Home-Based Emergency Care system to include patients receiving home palliative care, filling the gap between regular home visits and sudden emergencies. From policy trials to community practice, this initiative is helping uphold the dignity of end-of-life choices and making dying peacefully at home no longer just a wish.

At 2 a.m., an elderly woman under home hospice care developed a persistent high fever and severe shortness of breath. Her desperate family, voice trembling, called the emergency department: “We don’t want to send her to the hospital… but what should we do now?” This phone call was not only a request for medical assistance but also the family’s final effort to honor their loved one’s wish—to complete her journey at home, surrounded by love.

In recent years, more families have chosen home-based end-of-life care. However, even when a hospice patient’s condition seems stable, sudden crises such as infections, electrolyte imbalance, or breathing difficulties may arise. When patients can only rely on weekly hospice visits, but emergencies strike at midnight, families are forced into difficult decisions. These abrupt hospital transfers cause not only physical suffering but also disrupt the trust and continuity built between patients,

caregivers, and medical teams.

Why Hospice Patients Need Home-Based Emergency Care

Even when their condition appears stable, patients receiving home hospice care can suddenly face crises such as infections, electrolyte imbalances, or breathing difficulties.

“Home hospice care doesn’t mean someone visits every day—but when emergencies arise, they can’t wait,” said Chung-Liang Shih, Director-General of the National Health Insurance Administration, Ministry of Health and Welfare, explaining the motivation behind this system.

According to Ministry statistics, about 200,000 people in Taiwan currently receive home medical care, long-term care, or live in institutions. Each year, around 70,000 of them are hospitalized due to emergencies, 80% of which are caused by infections. In other words, even when patients have chosen to die at home, pneumonia, urinary tract infections, or other acute conditions often force them into hospitals—against their original wishes.

To address this care gap, the National Health Insurance Administration launched the Home-Based Emergency Care pilot in July 2024, initially focusing on infectious diseases. Medical teams visit patients at home to provide prompt assessment and treatment. If fully implemented, the plan could reduce the burden on hospitals by roughly 4,000 beds each year, decreasing unnecessary admissions and easing ward pressures.

In 2025, the program was further expanded to include hospice patients. In reality, when terminal patients develop sudden complications, families often do not know what to do. Weekly visits are not enough during a crisis. Home-based emergency care becomes the key support that allows patients to remain at home.

“We want to give patients a real choice—to stay where they feel safe and walk their final journey steadily,” said Shih. “It’s not about moving the ER into the living room, but about ensuring patients have the right to choose and are cared for in familiar places, by familiar hands.”

Facing Emergencies in the Familiar Space of Home

“She doesn’t want to go back to the hospital.”

Dr. Ying-Chao Chen, Director of Wei Yang Clinic in Luodong, has heard this countless times. For years, he has been dedicated to home medical care, including caring for patients in home hospice. These families are usually prepared—not for recovery, but for their loved ones to finish life’s last mile in familiar surroundings and rhythms. Nevertheless, reality is harsh: even stable terminal patients may suddenly face infections, electrolyte imbalance, or acute breathing problems. “When an emergency strikes, everyone panics—it’s unavoidable,” he said.

He recalls one patient who suddenly developed a high fever and was gasping for breath, unable to speak. The daughter called, crying: “Dr. Chen, I don’t know what to do.” Fortunately, the team arrived quickly, provided oxygen, fever-reducing medicine, and antibiotics, and stayed with the family through the night.

Some may ask: “If the patient is already terminal, is it necessary to treat these symptoms?” Dr. Chen’s answer is clear—it’s not about prolonging life, but about reducing suffering. High fever, dehydration, and suffocation bring unbearable agony not caused by the disease progression itself. “The goal isn’t to extend life, but to make these last days less painful.”

“If you delay treatment until the ER, hospitalization is likely—and the patient may die in an unfamiliar room,” he added. But with timely care at home, the next day the patients can still lie in their own bed, speak with family, even eat a little porridge—finishing their life journey with dignity and comfort. This, he believes, is the essence of hospice care. Emergencies are not exceptions in medicine—they are part of life. Hospice care must prepare not only for calm days but also for moments of crisis.

Care Is Not About Counting Visits, but About Being Present

Frontline experience shows that the teams most capable of handling emergencies for terminal patients are often the hospice teams that know them best. Yet this exposes another issue: Can the system keep up?

“If a patient needs us three times in a three-day period, under the current system we are exceeding the National Healthcare Insurance (NHI) quota, and as a result, points are deducted,” Dr. Chen said calmly, though the frustration was evident. The current model reimburses home hospice on a per-visit basis, which may work when conditions are stable, but for patients with fluctuating needs and frequent crises, it becomes restrictive.

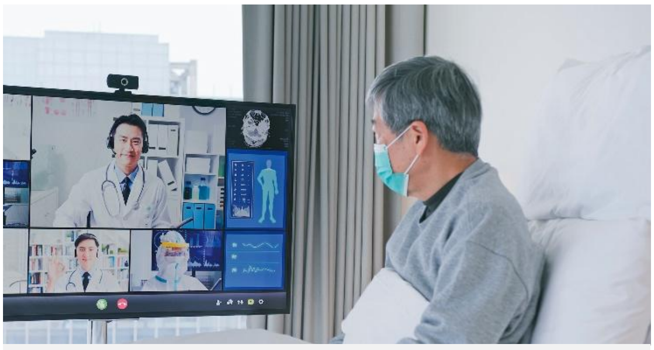
“Sometimes we just check blood oxygen, talk with the family, or simply reassure the patient that someone is coming to see him. These moments don’t fit neatly into NHI claim forms,” Dr. Chen explained. End-of-life care is not linear; what truly matters is not always prescribing medicine or giving injections, but simply presence so that patients and families know they are not facing the end alone.

Chung-Liang Shih acknowledged that the home hospice payment system needs reform. He suggested moving toward a monthly capitation model—payment per patient, not per visit. This way, medical teams receive a fixed monthly amount based on responsibility for a patient's care, and can adjust visit frequency as needed—whether intensive or minimal. As long as the patient feels secure and the family feels reassured, that should be the right arrangement.

Beyond Medicine: Community Networks Matter

Dying at home is not just a medical issue—it is a life issue.

At home, there may be no doctors or nurses nearby, no monitoring equipment, and sometimes not even access to needed medications. Even with hospice teams in place, without community support, emergency responses often stumble over questions like "Who can come first?" "Where are the medical records?" "How do we get the medicine?"



The National Health Insurance Administration is developing a Home-Based Medical Care Information Platform, allowing technology itself to become an extension of care—an extra set of hands and feet.

Shih revealed that the NHI is building a Home-Based Medical Care Information Platform to integrate medical, caregiving, and long-term care records. In the future, if different providers can access a patient's medication history, clinical updates, and contact points, redundant procedures and information gaps can be avoided. For example, if a patient is flagged as high-risk by the hospice team, local clinics or home nursing stations can immediately step in during emergencies without repeating the same assessments.

Technology will also play a role. Tools like real-time blood pressure monitoring, telemedicine, simple blood tests, and infusion devices allow medical teams to see without being there. Each night a patient spends at home instead of being rushed to the hospital means less risk and more peace.

But ultimately, it still comes down to people.

“We often talk about ‘bringing healthcare to the rural areas,’ but in fact, it’s about mobilizing the community itself,” Dr. Chen said. At Wei Yang Clinic, he has built close working relationships with local pharmacies, home nursing stations, and nearby clinics. Each knows their role—who can deliver medicine quickly, who can draw blood, who can check a patient’s breathing. They operate separately, yet function like one team. That is what a resilient local care system looks like.

Allowing people to die at home is not just a policy—it is a web. This web is strong enough to meet needs, connect people, and hold the final tenderness. This is not a future ideal, but a responsibility to uphold for today. The system is still evolving, but the direction is clear: more people should be able to end life in familiar places, surrounded by love—not alone in a hospital room.

We can make that final path just a little steadier.

Plahan's Dream of Symbiotic Communities

Lighting a New Path for Elder Care in the Mountains

As Taiwan gradually enters a super-aged society, long-term care has become an urgent challenge. In rural areas, where resources are scarce, caring for elders is even more difficult. Plahan has chosen a different path: through the idea of symbiosis, it not only provides long-term care services but also integrates community economy, culture, and human connection. This allows elders to age with dignity on familiar land—igniting the way for sustainable elder care in rural Taiwan.

Plahan founder Yi-Ying Lin first envisioned the idea of a cooperative model in university, believing it to be the best way for Indigenous communities to achieve true self-governance.

At ten o'clock in the morning, in the Daguan community along the Daan River in Taichung, some elders sit together in a courtyard, enjoying the sun while chickens peck leisurely at their feet. This is not a traditional nursing facility but a place for living and belonging: the Plahan Symbiosis Care Labor Cooperative (hereafter "Plahan").

Unlike conventional long-term care centers, Plahan does not operate on strict timetables. Instead, elders follow the natural rhythm of tribal life—collecting eggs, planting herbs like mint, or helping with small daily tasks. Through these everyday activities, elders receive restorative care that helps them return to a life of being fully human.

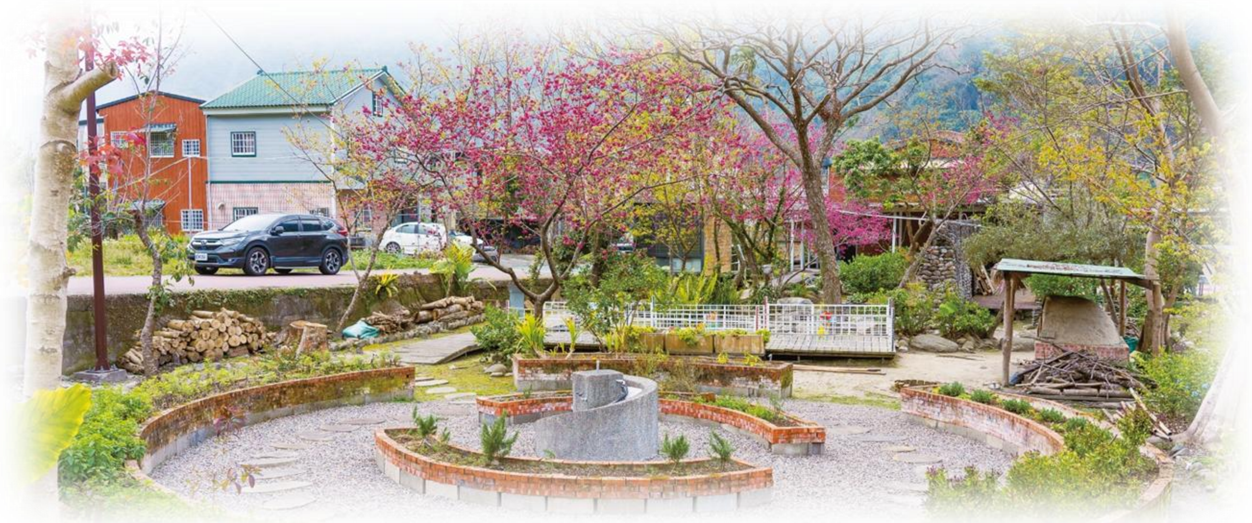
This is a social experiment centered on symbiosis—integrating local labor, culture, and economic resources. It not only provides care but also reimagines the future of rural communities.

All-in-One Symbiotic Care: Aging at Home with Dignity

In 2019, after completing her service as Deputy Mayor of Taichung City, Yi-Ying Lin stepped into frontline work as a home care aide. While training and serving in Heping District, she saw firsthand the shortage of care resources in Indigenous communities. She decided to stay and develop a model of symbiotic care.

Unlike traditional institutions that work in isolation, Plahan emphasizes cross-disciplinary teamwork—nurses, doctors, and caregivers forming a unit. “We coordinate with hospitals before elders are discharged—covering medication, nutrition, wound care, and even home environment planning—so that every step is seamlessly connected and elders can transition back home smoothly.”

Lin describes this “All-in-One” approach as a well-trained special forces team. Tailored care plans are designed for each elder, with caregivers rotating in 24-hour shifts. Through short-term intensive care, even critically ill elders can be weaned off feeding tubes, catheters, or tracheostomy tubes—freeing them from long-term bed confinement and returning to normalcy.



In the small garden, cherry blossoms bloom in February, offering elders a peaceful and natural living space.

One of the most remarkable cases is Grandpa Boshan. Once bedridden and dependent on a feeding tube, he regained his independence in just over a month. With the team’s support, he was able to eat, speak, and attend church again. His transformation moved his family and renewed hope within the whole community.

However, Lin admits, “Round-the-clock care is often too expensive for ordinary families.” To solve this, Plahan established a time-bank system—volunteers and caregivers can deposit their service hours and later withdraw them when they or their family members need care. This reduces financial burden and strengthens community mutual aid.

Raising chickens, feeding them, and collecting eggs allow elders to engage in rehabilitative exercises that restore strength and independence.

Today, Lin’s phone is filled with active LINE groups. “Families stay connected to their elders’ health updates in real time, and even those living far away can video call to say goodbye with love and dignity.”

Returning Home to Write the Final Chapter

For elders, home is the safest haven. Plahan actively promotes community-based palliative care, enabling elders to spend their final journey in familiar surroundings. “In Indigenous communities, death is not taboo—it is part of life.”

The open courtyard at the front of Plahan serves as a space for elders to stroll and spend time with the chickens.

Lin believes culture is the root for community elders. This is why Plahan integrates cultural elements into long-term care, helping elders find renewed strength in their own traditions. For example, the Atayal and Paiwan practice of squatting burials reinforces a sense of family and community connection at the end of life. Elders are also encouraged to join in festivals, songs, dances, or even feed chickens—ordinary activities that restore dignity and a sense of accomplishment.

“Cultural care isn’t a formality,” Lin emphasizes. “It is care that reaches into the elders’ hearts—making them feel that here, they are not just being cared for, but truly at ease and respected.”

A Cooperative Model for Sustainable Long-Term Care

One of the greatest challenges for rural long-term care is the lack of resources. Plahan’s solution is to strengthen community power through a cooperative model.

Having studied in the Department of Cooperative Economics and Social

Enterprises in university, Lin knew that a cooperative was the most effective way for a community to achieve self-sufficiency. “I may not always live here in the community, so for the village to sustain itself, the cooperative is the best approach,” she explained.

Unlike the profit-sharing model of the home-care market, a cooperative emphasizes shared ownership and governance. Every community member is a shareholder, and surplus earnings are distributed based on labor contributed, not social status. “Through economic mutual aid, long-term care services can become a sustainable business while also creating more jobs within the community.”

One Egg, Many Hopes for the Community

Plahan’s Friendly Chicken program encourages elders to raise egg-laying hens and sell eggs, helping them regain financial independence.

Beyond its core long-term care services, Plahan developed Friendly Chicken Life, a program designed to help both elders living alone and young people returning home to achieve economic independence. By raising egg-laying hens and selling farm products, elders regain financial autonomy while bringing new vitality to the community.

In fact, Friendly Chicken Life is not just an industry—it’s also a model of care. Huan-Ching Yang, known affectionately as the Chicken Principal, explained: “Raising chickens gives elders a sense of purpose. Feeding them, collecting eggs, or simply keeping them company are all forms of rehabilitative practice. Elders also build companionship through the shared experience of raising chickens.” The program promotes environment-friendly farming that protects nature, provides healthier eggs for consumers, and generates income for caregivers—creating a virtuous cycle.

Plahan has even woven chickens into community services and events. Initiatives include a chicken leash project where chickens help with weeding while keeping the elders company, as well as Taiwan’s only chicken racetrack and the unique Plahan Chicken Sports Games. These events bring joy to the community, strengthen bonds between elders and animals, and brighten daily life with play and laughter.

Extending Love through Community-Based Palliative Care

Plahan’s vision has expanded beyond its Symbiosis Care Base. In Shuangqi, it built Taiwan’s first Two-Line Poetry daycare center, and it is developing a Share House modeled after Japan’s HHM Kasan’s House. This Share House will feature a hostel for visiting caregivers to train and work, while also offering after-school programs for children and co-living spaces for elders. At the same time, Lin is working to integrate community-based palliative care into Plahan’s services, ensuring that elders receive proper medical support and spiritual comfort in their own homes.

“Our goal is to help elders complete life’s final journey with peace and dignity,” Lin said. Even during her time as Deputy Mayor, she had recognized the urgent care needs of elders in remote mountain and island communities. For years, she has promoted mutual-aid home care models for critical patients and has advocated reforming Taiwan’s fee-for-service long-term care system into a “bundled payment” model based on individuals rather than hours in an effort to address the real pain points for families.

As Taiwan moves into a super-aged future, Plahan is more than a successful care institution—it is a seed of hope, blending elder care with tribal culture, economy, and heritage to create a sustainable path for rural communities.