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EUROPEAN RURAL FUTURES

Proceedings of the 3rd EURUFU Scientific Conference:

Social Issues and Health Care in Rural Areas

CENTRAL EUROPE COOPERATING FOR SUCCESS.

EUROPEAN UNION EUROPEAN REGIONAL DEVELOPMENT FUND

FREISTAAT THÜRINGEN

Thüringer Ministerium für Bau, Landentwicklung und Verkehr

Berichte des Instituts Verkehr und Raum ISSN 1868-8586

Band 19 (2014)

Social Issues and Health Care in Rural areas

in the context of demographic change

Proceedings of the 3rd EURUFU Scientific Conference

(Sondershausen, Germany)

The EURUFU project is implemented through the
CENTRAL EUROPE programme co-financed by the ERDF

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25th of March 2014

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ISSN 1868-8586

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INTRODUCTION

In May 2011 the EU-funded transnational cooperation project EURUFU (European Rural Futures) started in different regions of Central Europe. EURUFU analyses the challenges of demographic change for municipalities and towns in rural areas as well as the options for maintaining the level of public services and infrastructure. New strategies for

- health and social care,
- education,
- local economy and job opportunities, and
- mobility and transport

are developed in order to support local and regional competitiveness. Several pilot actions in the mentioned key topics were developed, practically implemented and tested and evaluated to assess their effects.

The consequences of demographic change require a fundamental review and adjustment of the public services in many places as well as a new definition of standards. It has been identified that demographic change is one of the new global issues that several countries and regions are facing. Regions need a sufficient framework to be able to share experiences and information and to adapt to the relevant changes in order to react on the demographic changes. The overall goal of EURUFU is to promote actions for the provision of innovative solutions to restructure services and infrastructure in shrinking regions and thus support the sustainable development by developing and adapting integrated measures and strategies for regional problems at a transnational level. A range of regional and balanced services, economic and cultural opportunities should be implemented to hold and attract inhabitants, entrepreneurs and investors[1].

"The specific objectives of the project are the

- sensitization of stakeholders by creating transparency about the coming challenges of demographic changes and highlighting the possibilities and opportunities for active action,
- active framing of demographic change in close cooperation between the different partners and stakeholders (administration, politics, business, schools, associations ...) in the regions,
- mitigation of population decline and a long-term trend reversal,
- adaptation of infrastructure to the negative consequences of the changing population structure,
- initiation of pilot projects to frame and adapt to demographic change,
- transfer of knowledge at European level and initiate a long-term intensive and continuous dialogue between actors of regional development"[1].

The partnership consists of 11 different entities from 7 European countries (AT, CZ, DE, HU, IT, PL, SI), which fulfil specific functions within the project and represent regional and local authorities, regional development agencies and educational organizations. International cooperation is vital for the achievement of the expected results due to the complexity and transnational dimension of demographic change in Central Europe. One focus is to sensitize regional stakeholders for the current situation and future of demographic

[1] Application Form. European Territorial Cooperation Objective. CENTRAL EUROPE Programme. European Rural Futures (2011)

change in their area. By the development of a benchmarking system including relevant possibilities and opportunities for active adaptation a common strategy has been elaborated. Related to that common strategy, 10 regional pilot actions have been initiated and implemented to find crosscutting solutions to cater for sustainable public service provision. Subsequently their potential for transferability and exchangeability between the regions was evaluated to become part of a transnational action plan[2].

Within EURUFU, the Transport and Spatial Planning Institute of the University of Applied Sciences Erfurt is responsible for the part "mobility and transport" with a focus on sustainable concepts. A further task of the Transport and Spatial Planning Institute is the planning and organisation of three EURUFU Scientific Conferences which provide an input from researchers to the project partners and other interested people form the project regions. Furthermore, the conferences should improve the cooperation and knowledge exchange between scientists dealing with different topics related to rural areas.

The first conference was held on the 14th of May 2013 in Fehérvárcsurgó, Western Hungary and dealt with "*Transport and Mobility in Rural Areas in the context of demographic change*". The results are documented in the proceedings of the 1st EURUFU Scientific Conference[3].

The second conference was held on the 8th of October 2013 in Asti, Piedmont, Italy and dealt with "*Education, Local Economy and Job Opportunities in Rural Areas in the context of demographic change*". It is documented in the proceedings of the 2nd EURUFU Scientific Conference[4].

The third conference, which forms the basis for these proceedings, took place on the 25th of March 2014 in Sondershausen, Kyffhäuserkreis/Thuringia, Germany.
The following table gives an overview of all EURUFU Scientific Conferences:

No	Month	Place	Topic
1	May 2013	Fehérvárcsurgó, HU	Transport and Mobility in Rural Areas
2	October 2013	Asti, IT	Education, Local Economy and Job Opportunities in Rural Areas
3	March 2014	Sondershausen, DE	Social Issues and Health Care in Rural Areas

These proceedings of the 3rd EURUFU Scientific Conference represent the collection of papers which were presented by the authors in Sondershausen as well as further papers which could not be presented due to time constraints.

The papers deal with various aspects of social issues and health care in rural areas. These encompass on the one hand regional studies about current social issues and developments taking place in rural areas and on the other hand provide some concrete examples of projects in the field of social and health care carried in Europe to tackle challenges of demographic change for rural communities.

After presenting the issue of social farming as an instrument to implement social sustainability in rural areas, innovative solutions from Scotland are outlined which try to answer rural health and social care needs. In the following paper the role of networking at local end regional level to organise health care in rural areas is approached and first results

[2] www.fh-erfurt.de/fhe/en/transport-and-spatial-planning-institute/metaprojektliste/2011/eurufu/
[3] www.thueringen.de/imperia/md/content/eurufu/en/media/events/eurufu1_proceedings_v11.pdf
[4] http://www.thueringen.de/imperia/md/content/eurufu/en/media/events/meetingasti/eurufu2_proceedings_v18.pdf

of a model project dealing with these issues are presented. The next article deals with the handling of rural emergency care against the background of demographic change and presents innovative approaches from Scottish rural areas. Afterwards the current state of social services in Spanish rural areas is being examined and positive as well as negative aspects are pointed out. The following paper deals with the demographic change and the marginalization of different social groups on the labour market in the rural parts of the Czech Republic, while the next article considers one group in particular and assesses the role of the Roma ethnicity in the perceptions of rural Hungarian professional municipal care and support givers. Finally the last contribution deals with the handling of health care issues in rural Romania in the last recent decades.

The authors of the papers collected in these proceedings represent universities, research institutes and official associations and institutions from the Czech Republic, Germany, Italy, Romania, Scotland, Spain, and Sweden.

INNOVATING RURAL WELFARE IN THE CONTEXT OF CIVICNESS, SUBSIDIARITY AND CO-PRODUCTION: SOCIAL FARMING

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ABSTRACT

The debate on the welfare crisis is not always considered within the rural development debate, at least at EU level. However, in the meanwhile, a strong crisis of public services is emerging on the ground as a crucial issue concerning the economic development. As a consequence of the global economic regime the creation and distribution of value according with the Market/State divide does not seem to represent anymore the social and the economic engine at EU scale. The article explores some new concepts of the definition of an innovative welfare based on a diverse collaboration between State, civil society and private sector. In this perspective, and according with the Italian experience, the concept of social farming and the principles of subsidiarity, co-production and civil economy that are behind are explored. Some lessons emerge regarding methods and innovative concepts for the quick promotion of pathways of transition. As the article states this is a possible mission when public and private actors are willing to act in the direction of change. What is also clear is that rural development is not anymore an issue just of economic development and that policies should better explore policies able to support social sustainability in rural areas.

1 INTRODUCTION

Rural areas are facing economic, social and environmental challenges as a consequence of the crisis and the reorganisation of the accumulation regime[5] that is happening worldwide with the effect of reducing economic resources for redistributive policies.

The State/Market regulation was pivotal in the modern regime but does not seem to be able anymore to ensure production and distribution of the economic-wealth for the less-empowered people and areas such as the rural ones. In rural areas the crisis has diverse impacts: Climate change is creating difficulties to traditional agricultural processes; farms are experiencing economic difficulties due to global competition; rural areas are facing growing difficulties in meeting the needs of a changing population (elderly vs. migration in the light of the fiscal crisis of the State and due to a limited economy of scale in the provision of health services). As a result living condition in many European rural areas are becoming more and more difficult for all diverse social categories. In fact, in rural areas the converging of a low population density but at the same time the presence of many diverse vulnerable groups

[5] Nowadays a small number of enterprises (less than 1500) produces a larger part of the world economic income (60%). In the main while one third of the wealth moves towards fiscal paradises and the Gini index is decreasing since the '80 of about 10%.

increases the difficulties in providing adequate social services and in supporting the organisation of vibrant communities. The social dimension in the rural areas seems to widely impact not only on the quality of life of single persons, but also on the collective dimension of local communities, on the quality of the agricultural processes as well as on the territorial economic viability.

From this perspective social issues and health care are not only an economic matter but more and more an issue of re-designing of solutions and relationships based on innovative principles, able to redefine in a new perspective the relationships between social and economic spaces.

The crisis has made this more evident as the social issues are less and less a step backward the economic development but also that social and economic values should be co-created in order to achieve a better quality of live in the long run. In such a perspective the idea of subsidiarity and co-production – between public and private actors, of economic and social values – may become a supportive engine in the view of a new welfare system able to support rural life due to new shared responsibilities and a stronger civicness.

In the frame of the EU 2020 strategy, transition pathways and social innovation in rural areas may mobilize unexpected local resources to face emerging and traditional social issues and health care, like the case of social farming.

Starting from a long process of research action on rural services and on social farming (SF) in Italy and in Europe, the authors will address the:

- Opportunities that SF may offer to fit social issues and health care in the context of demographic change in the perspective of social sustainability;
- Features and innovative concepts which are behind SF;
- Transition paths that can facilitate social innovation and support SF diffusion;
- Policies able to support transition management in rural areas;
- Opportunities and disadvantages of active participation of researchers in the creation of social innovation.

2 SOCIAL TRENDS IN RURAL AREAS AND THE DEMAND FOR INNOVATIVE PATHWAYS OF CHANGE

Rural areas are facing critical challenges due to population trends (elderly, migrations, young disaffection or re-affiliation), economic pressure (crises, globalization and competition), environmental changes (climate changes, resource scarcity, food crises) that are disconnecting rural localities from the formal representation of rurality and the everyday lives [1][6]. During the phase of agricultural modernisation, rural areas experienced economic growth and an organization of social services able to support the life of local inhabitants and to accompany the passage from traditional rural/peasant communities to modern ones. In most European Countries, this transition was supported by market penetration and State distribution, as a consequence of EU-CAP and the national expenditure on public services. More recently, the world accumulation regime based on the management of the mobilities of different resources such as workforce, capital, information, goods and services, businesses ([2, 3, 4] has set a new scene, concentrating economic power in fewer hands, and more

[6] Perhaps, Nations and regions are defining their diagnosis and swot analysis in the preparation of new 2014/2020 RDPs, something that would be interesting to read in a cross section study.

often in the fiscal paradises[7]). At rural level the creation of social and economic empty spaces and the impoverishment of local communities expose territories and local inhabitants at risk of abandonment and new exploitations.

Management of mobilities - or resources flows - takes on a strategic value in the new regime of accumulation and it is the prerogative of a small number of businesses operating on the network [6]. Such businesses have little interest in the social components of production and the related redistribution policies, as shown by the tendency to maximize gross profits - and therefore before - taxation [5]. Those excluded from these processes are the people who, despite having stocks of local resources, are not able to make them part of international flows; or on the other hand, are people who take part in the flows (i.e. migrants) and having no direct control of relations with the localities in which they enter. The ability to connect resource stocks with the flows is, in fact, the key to success for some players, but also the exclusion of those who cannot, for various reasons, exercise this ability. Also this is reflected in agriculture and in rural areas with regard to agricultural products as well as to the symbolic values of the localities.

Perhaps the global resource scarcity and the climate change are demanding urgently for alternative pathways where prosperity is not often linked to the only economic growth, but also to the possibility to provide environmental and social sustainability [7].

According with the emerging regime and trends, rural areas are engaged in a strong process of transition. It involves aspects like access, control, promotion and mobilization of local resources in the perspective of the definition of sustainable and resilient pathways of change. In this innovative dimension the provision of social services not always follows the economic development but it should be co-produced with private economic results avoiding the current scarce effectiveness of the public redistributive action.

The organisation of an innovative more sustainable regime is highly demanding in terms of technical, social, institutional and environmental innovation. It asks for trans-disciplinary research, a strong dialogue and brokerage of knowledge among public and private actors, a pro-active debate able to analyse public and private outcomes of the solutions adopted.

Despite the concept of sustainability is based on economic, social and environmental issues, most of the debate on rural development focuses on the exploitation of local resources, of cultural repertoires and on environmental issues in the development process [8, 9]. Other authors have focused on possible social and economic exclusions that can occur in rural areas [10] despite rural development trends. This debate normally takes the intervention of the Welfare State for granted in the provision of public services, in accordance with the idea of the market-state divide. In the EU this divide is perhaps accentuated because social and health policies are the responsibility of member states, whereas RD policies are under the influence of CAP.

As a matter of fact EU rural policies are mainly focused on economic growth blended with a stronger attention on environmental sustainability, the social dimension of sustainability still being far from the debate [11].

Today, the social stability of rural communities is again of urgent importance, especially when the State is traditionally weak and/or due to the fiscal crisis and the increasing de-territorialisation of the production systems [12]. Rural trends in Europe currently include the following: Ageing, difficulties in generational turnover, isolation, decrease in cultivated land, and the emergence of social unrest due to migration. As a result of these trends, local

[7] Nowadays a small number of enterprises (less than 1500) produce a larger part of the world economic income (60%) [5]. In the main while one third of the wealth moves towards fiscal paradises and the Gini index is decreasing since the ’1980 of about 10%.

communities are fragmented and tend to be involved in less equitable economic systems in terms of human and natural resources.

Consequently, a more comprehensive focus is needed on the social dimension of rural development [11]. During the discussion of the EU welfare model, also the rural development paths need to be re-designed. This is possible not just by rethinking how social services are provided, but also by re-designing a regulatory model different from the State/Market divide and by directly involving local communities as well as local firms in the perspective of subsidiarity [13]. However, such a change leads to the following issues: How to ensure the provision of private and public goods, innovative solutions and paradigms that may support such a provision, as well as how to ensure a transition to a more sustainable model of RD. The social farming practices seem to move forward that direction.

3 BUILDING SOCIAL SUSTAINABILITY IN RURAL AREAS

According with Touraine [14] the actual regime de-institutionalizes and de-socializes production models, separating the economy from culture, markets from identity, trade from territory. The debate on a new coherence able to create a new overlay among economic, cultural environmental and social aspects is only at an early stage[8]. The same concept of social sustainability has been only recently analysed and mainly regarding urban contexts and environmental changes. In rural areas social sustainability has been recently investigated in the perspective of three different dimensions [11]:

- *Territorial Social Sustainability*: Where social sustainability is a prerequisite to ensure the tangible and intangible resources used by people and communities involved in the management of agricultural production and mainly related to the organization of human capital (social structure and changes, accessibility to services, education and knowledge creation, social aspect related to access to nature, share capital – like identity, belonging, sense of place- institutional capital – like participation claim, governance [15,16];
- *Practical-procedural Social Sustainability:* Which assesses the social implications of agricultural production. In this case, after examining the positive and negative externalities in the production of social public goods, we will refer to the environmental vision of social sustainability looking at the application of themes from the "bridge" to the "maintenance" of sustainability [17] in the evolution of agricultural and land management in a key to environmental sustainability;
- *Relational Social Sustainability*: Whose dynamic nature refers to the social relations - often beginning with food - established between different social groups, and which configure new topographies in the same relationships between rural and urban areas and new design concepts of rurality and habitus.

[8] Stiglitz-Sen-Fitoussi report, stress the need to find a new set of indicator able to better orient policies in the perspective of a new equilibrium in development pathways able to ensure capabilities and entitlement to local inhabitants.

Table 1: Social sustainability in agriculture: Three dimensions (Source: [11])

SS	SS Agricultural / Rural		Urban
	Actions on	**Impact on**	**Outcomes of SS in other territories**
Territorial	**Human capital:** • social structure and changes • accessibility of formal and informal services for people, • education, and integrated development of tacit and codified knowledge **Natural capital** • Social aspects related to access to basic, natural and productive resources **Share capital** • identity, pride, belonging, sense of place, local culture • connectivity **Institutional capital** • participation and management of local governance, claim	• Social inclusion and employment less empowered people, and gender issues, active participation in the communities of young and old, generational transmission of knowledge and social resources • Identity, professional and local pride • Accessibility to production processes by young people and new entrants to local areas • Replacement, stability of the population • Social mixing and integration between old and new inhabitants of a locality • Equity, quality of life, well-being, stability	**Human capital:** • Cultural diversity **Natural capital** • Use of natural resources in a non-urban context • Stability of local areas and civil settlements • access to basic resources: water, landscape, green infrastructure
Practical/ procedural	• Organization of processes: • Externalities -negative/positive-production processes • SS as a function of environmental change of management of processes and local areas		• Education and introduction to nature and its management • Nutritional education and critical consumption • Availability of food • Symbolic characteristics and quality of food consumed • Food stability and security in terms of shocks • Affordable access to food
Relational	• Building new identities and new visibility, professional pride • Social justice • Human and gender rights • Equity • Social mixing and cohesion • Participation in the construction of the future and new identities • Inter-regional solidarity pacts		• Co-production of food • Knowledge building for the future • Construction of new identities • Construction of stability • Ethical attitudes of consumption • Inter-regional solidarity pacts

The reinforcement of social sustainability in innovative pathways of change is highly demanding in terms of transition paths [18, 19, 20, 21, 22, 23], that should be able to re-design the way of providing social services, build active and vibrant communities, qualify agricultural processes, organise better and more dynamic evolution in urban-rural relationships and re-build a wider shared and coherent identity about the idea of quality of life and the overall contribution of diverse public and private actors.

In the search for solutions outside of the lamplight [24] new ways of creating economic and social values, but also redistributing it through appropriate forms of welfare should be designed. On this scale of reasoning, the new variations of issues such as rights, solidarity and responsibility, can be found through innovative pathways of change based on principles like subsidiarity, co-production and civic economy:

- *Subsidiarity*: According to which the State reduces its direct universal and standardized intervention, while maintaining its responsibilities and acting in support of private action in understanding and solving territorial problems also on social issues and services [25, 26]
- *Co-production*: With planning between users and different providers of innovative solutions aimed at responding more effectively and with non-specialist and less costly resources, in the organization of responses consistent with the needs of the community (i.e. by simultaneously creating economic and social values, of public and private goods) [27, 28,, 29 30, 31, 32]. Co-production can be related to different elements, like:
    - the opportunity to co-design services among providers and users of the services;
    - the possibility to co-create economic and social values (e.g. food and social inclusion);
    - the opportunity to produce public and private goods at the same time (e.g. food and social inclusion);
- *Civil economy*: The building of new business attitudes, based on responsibility and the ability to include the values of sociality in economic processes, within production processes as in the construction of markets, based on reputation, trust and the creation of new networks, including consumption networks [33, 34, 35, 36].

By adopting the principles of subsidiarity, co-production and civic economy, a new rural welfare may be designed in order to revert the actual trends in services provision.

The goal is to lay the foundation for a new congruence between the economy and sociality in the context of a given resource, or, in the vision of Halfacree [1] between rural localities, the formal representation of rurality, and everyday lives. The aim is to promote an alignment between public, private and third sector in terms of the way people perceive, think and live rural areas [37], and the relationships with urban areas in a perspective of social sustainability. The aim is to overcome the contradictions and chaos which in rural areas are being generated under multiple economic and social pressures, to develop new consistencies within a plan in which the contradictions of the current regime of accumulation are dampened in favour of a plan that is more extensive and has a lasting stability. A view of the future that requires a substantial transformation [21, 22] of the plurality of actors in local areas - of private enterprise, social, agricultural and non-agricultural institutions, citizens, consumers - and which also requires paths of social innovation [38, 39] and policies in support of the management transition.

In the next chapter the case of social farming will be presented as a pivotal practice at the crossroad among the role of the State, the third sector and the private, among citizens and consumers in the perspective of subsidiarity, co-production and civic economy.

4 SOCIAL FARMING

4.1 An innovative aspect for multifunctional agriculture

Social farming is a still not totally explored aspect of multifunctional agriculture devoted to promote social values at farm level. It makes use of plant and animals, of the rural setting and of the possibility to live in small groups of people – family farms, social cooperatives active in agriculture – in order to ensure diverse services to local people both in rural and peri-urban areas [40].

Social farming is normally organized in farms run by private farmers or by third sector (social cooperatives or volunteer associations) or in partnership among these actors. It is based on different use of farm resources – agricultural and animal production activities, farm structures, time management associated with agricultural processes – reorganised in order to provide a quite wide range of innovative services and facilities to diverse target groups of less empowered people and, more in general, to answer to local needs, both in rural and peri-urban areas. At European scale, social farming practices are already providing co-therapy, educational activities, vocational training, social and work inclusion, and social services for groups like mentally disabled, psychically ill persons, physically disabled, youngsters with learning difficulties, elderly people, children, prisoners.

On a farm the resources offer the possibility to design a large variety of settings able to fit in a flexible way to the need of the persons involved, but also to include people in a more interactive way, in a pleasant and open environment that activates and enhances people's capabilities [41]. The interaction with plants and animals frequently facilitates and stimulates people's capacities, offering them the possibility to take responsibility far from direct human judgments, to increase their self-esteem and – step by step – to be better integrated at work as well as in the social and economic life. In many cases social farming offers the possibility to reduce the gap between wishes and the experiences for less empowered people. Perhaps, according with people needs not always social inclusion at work should be the main goal in a pathway of active social inclusion. For some persons the contact with nature and the possibility to experience life in small groups of people, thanks to the family farm or the groups of people involved at farm level, may have a positive impact on the quality of life for people experiencing disabilities as well as for elderly people. On the other hand social farming is also related to educational services offered to children and young people in different needs.

In rural areas social farming is able to fit to local services demand by reinventing connections among the public protection net and informal support from responsible farms and civic groups. It mobilizes local non-specialized and in some way also unexpected resources to renew and reinforce the social protection net, especially in a phase of fiscal crisis.

4.2 Social farming in Europe

At European scale social farming is a retro-innovative practice [42] as well as an emerging trend. It's rooted in traditional farming practices and a way of taking care of the vulnerable groups in rural communities, traditionally members of the farmer families, but also connected to the self-help nets. In the meantime, there is documentation of the connection between medical centres and institutes and farmers. As always for other aspect of multifunctional agriculture, also in this case such practices were put aside with the modernization and the specialization of the primary sector.

During the seventies in most of the European countries the social use of agriculture

has been re-introduced by newcomers, religious communities or groups of youngsters claiming against the industrial society and involved in innovative projects of counter-urbanization. Such practices are sometimes still active although in different perspectives. More recently by following the multifunctional discourse, farmers and their unions started to establish innovative practices. The features and trends of social farming across Europe may differ in accordance with local culture and the organization of the welfare system. The similarities are related to the way of using farm resources and to a common increasing abundance of the practices, of the public intervention and of the actors involved. However, it seems that social farming initiatives focus on diverse aspects, are differently developed according with a transition process and are organized according with the local welfare tradition, regulations, public support as well as local needs. In Austria and Switzerland the implementation of a broad idea of green care regards a quite large number of farms but not all overlapped to a social farming concept. In Norway there are projects in rural areas promoting on a national scale alternative educational pathways for youngsters at the secondary school. In the Netherlands, Social Farming practices benefits from a strong institutionalization and support from the agricultural policies, as well as from the full recognition of farmers in the health system in the frame of a diversified agriculture in the social field. In Poland mainly specific practices of hippo-therapy are developed. In Slovenia innovative projects are emerging thanks to the collaboration among institutions and farms. In Ireland a network of social farms has been established after the SoFar project and it's still active with innovative experiences in the border area with Northern Ireland. In Germany mainly the so called sheltered workshops are developed with farms funded with public funds, but producing also economic values towards agricultural processes and hosting a large number of people with diverse difficulties. In France the organization of social farming initiatives is based on diverse typologies devoted to diverse people in needs. Such structures are mainly driven by associations and may have a different design from more medicalised ones to those more oriented to social and job inclusion and to the participation of the family life. Most activities are supported by public funds, but since the share of the public budget is decreasing project holders are struggling to increase direct economic sources of income. In Spain and Portugal initiatives are driven mainly by social cooperatives in the peri-urban areas for disadvantaged people. In Italy social farming initiatives are increasing since 2003 and are differently run by social cooperatives, volunteer associations and private farmers although more and more in a collaborative way. In any case, in most European Countries social farming initiatives are activating a new debate differently articulated within diverse sectors, but always driving to more precise knowledge, rules and policies on the topic.

4.3 Regulatory aspects and outcomes in social farming: The Italian case

According with the different needs of the people and the territorial situations, SF works in a grey zone among agriculture, social sector, education, justice, work inclusion and the health sectors and competencies. It is in the border among sectors and competencies. By being based on new concepts, ideas, values, and attitudes the initiatives of SF emerge from a process of knowledge brokerage among diverse actors (private farmers, third sectors, public bodies, local consumers, and civic society) normally facilitated in boundaries organisations where subsidiarity and co-production take form. At the very centre of such a process of social innovation, there is the reorganization of some key concepts that are normally linked to sectorial/scientific competencies, to the possibility of resource sharing (agriculture vs. social and vice versa), to the overcoming of the market/state divide and the provision of public goods in the social sphere, also by directly involving private actors.

However the discussion not always considers every aspects, but it depends on the cultural frame in which agricultural resources are mobilized. Social Farming is in line with diverse welfare systems and in agreement with the public sector responsible for these services. There are two main models of Social Farming in the EU: the Northern European Model and the Mediterranean Communitarian Model that is typical in Italy.

In the Northern European model the agricultural resources are mobilized in the frame of State intervention and according with on farm diversification. In these cases farm activities are re-designed under the direct State support. The aim is to deliver innovative, more flexible and effective services better able to mobilise less empowered people and their capabilities, under the public intervention and, in any case, to enlarge the suitable offer for the users. Private farms are normally accredited by the public services in standardized services controlled in order to ensure rights to the clients. Farmers are asked to invest in their material (structures) and immaterial resources (skills and knowledge) in order to provide services supported with public funds. The outcomes of such a process is to enrich local services with new initiatives, to support farm initiatives, but also to forward farmers from agricultural production to services provision. In many cases the agricultural processes lose their relevance and most of the income starts to come from the direct payment the State. In this model agricultural processes are designed in order to fit co-therapeutic and inclusive needs of the clients and mainly devoted to them. Users are ensured about the standards of the services delivered to them. In the meanwhile users can be mainly identified as clients of the farms instead of persons involved in a project of change.

Perhaps, more recently cuts in public budgets are re-orienting social farming projects to a more independent source of income by valorising agricultural products according with a community based approach and in the frame of social justice.

In Italy social farming initiatives are normally bottom-up driven practices established by local actors – farmers, volunteers associations, social cooperatives – involved in the design of innovative project able to co-create social and economic value. The aims are: i) To recreate on a community sound the ways to better include less empowered people in an active process of social inclusion besides the State intervention and ii) to co-produce progressively with public institutions a diverse and more active and less paternalistic way of facing social needs. Social farming initiatives are often based on the organisation of viable agricultural processes able to create products, services and to be economically sustainable. The presence of well-established economic activities provides the environment (structures and agricultural processes) to accompany and to empower the people involved in a process of active social inclusion, whatever their abilities and needs are. Local projects start as isolated initiatives but they are often introduced in a dynamic path able to reinforce and enlarge their spectrum of action. This path of social innovation is rather complex due to the need to define a new knowledge, a diverse organisation, as well as a different way to act for many private and public stakeholders. The development of such initiatives of social farming can be analysed considering five different levels of complexity.

On the ground are always present isolated initiatives started by pioneering project–holders, being developed by single farmers, associations or social cooperatives[9], as well as public bodies (health institutions, research centres, municipalities).

Along the development of such initiatives a second level of complexity arises with the organization of a partnership between farmers and members of the so-called third sector

[9] In Italy there are two kind of social cooperatives recognized by law since 1991 and independently from the social farming initiatives. Social Coop. type A does normally provide services for the public institutions and are paid with a per-diem for each person receiving different kind of services. Social cooperative type B do normally acts in order to provide social and job inclusion for less empowered people by starting social enterprises their field of action being also the agricultural sector.

(social cooperatives and volunteer groups). The complementarity of the pooled resources within the partnership increases the impact as well as the overall competencies and opportunities inside the initiative of social farming[10]. The partnership produces a hybridization of knowledge and networks (social and agricultural) and a fertile environment for new opportunities and strategic visions. Sometimes new projects take base on a hybrid juridical status able to meet the social and agricultural legislation directly (agro-social cooperatives[11]) as well as the creation of social and economic values.

A third level of complexity regards the territorial scale where project-holders strive to achieve visibility and stability of the solutions developed. In this perspective they start networking in order to increase coherence and relationships among them and with public institutions. The organisation of small - or larger - clusters of social farming projects creates the condition for the establishment of local public arena where technical and political debates on the topic may start. Inside such arenas social farming projects may be analysed and better understood in their diverse elements according with a collective process of knowledge creation able to blend agricultural, social and health elements. The organisation of new knowledge represents the premise for the definition of new rules and procedures able to recognize and formalize relationships in the social farming sector. The innovation process in social farming moves from isolated initiatives towards a more complex system where a plurality of stakeholders is able to share new principles and ideas and to organize new social protection nets.

A forth level of complexity regards the reorganisation of public services. There in the perspective of subsidiarity the formal and informal nets of social protection take a different form and the public servant operates by including social farming initiatives into their way of operating at local level.

A fifth level of complexity arises at policy level with the definition of new laws, procedures and administrative standards by which social farming initiatives can be fully recognised (cf. Figure 1 showing the dynamic in the area of Turin).

As a research group we have actively supported local initiatives in different Tuscany areas – Pisa, Amiata-Grosseto – www.amiataresponsabile.it, AEIDL, Lucca, Turin, and in Tuscany at regional level. Such dynamic in the case of the Turin area is illustrated in Figure 1. In this area from a small group of farmers the local network of social farming is nowadays involving around 65 actors (38 farmers, 15 social cooperatives, 8 municipalities and 5 public health bodies). The agricultural gross income of the farmers is about 3 million €, 36 less empowered persons have been included at work. In the meanwhile about 120 persons have received social farming services every year.

[10] See as example the initiatives in the Turin area of Piedmont (AgricooPecetto), or the one in the Pisa area in Tuscany (www.ortietici.it)
[11] See as example the initiative named “Cavoli Nostri” - www.facebook.com/CavoliNostri

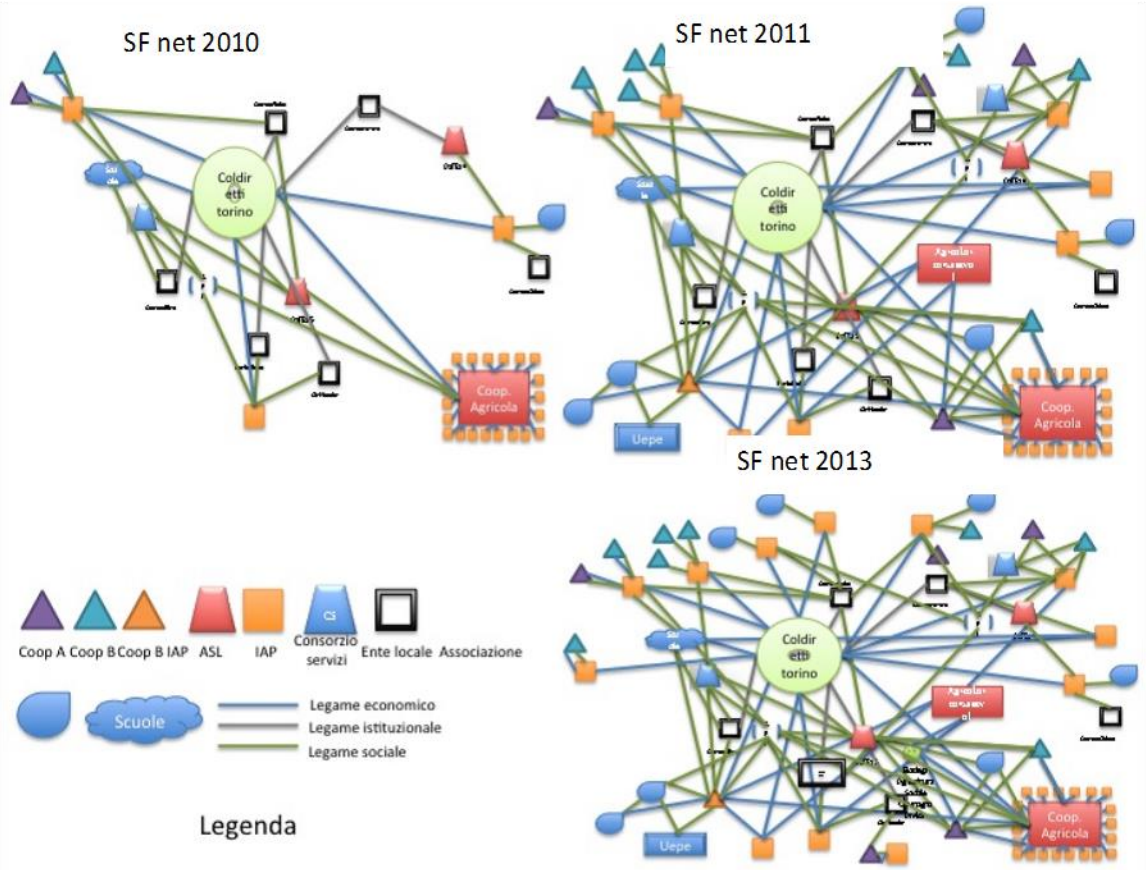

Figure 1: The dynamic change of social farming (SF) in the Turin area (Italy) (Source: Authors)

The rationale of the new environment is different from the traditional State intervention. An increasing number of less empowered persons is included in a true and lively environment where the everyday life is shared on a farm with farmers and other project holders. People are not considered as clients of a service but part of a common project that may evolve from a social and economic point of view and create new opportunities in the perspective of social justice. Projects are normally connected with local communities by local products through local markets. Local production is highly recognised due to their ethical contents by local citizens. However, in this situation it seems crucial to define win-win solutions where farmers, user's families, public services, municipalities, local consumers and citizens may find their personal/common interest and advantage in a participatory way and in a common process of knowledge creation. In social farming the costs of services are kept lower according with the principles of:

- The scope economy: Based on the possibility to use existing structures and processes in a multipurpose way
- The multifunctional use of existing agricultural processes supported by the economic value of the products delivered.

Project-holders are not necessarily asked to organize devoted structures and processes but they may accompany in innovative ways the people in need in the everyday inclusive practices.

Although project-holders may be qualified and carefully organised in order to welcome newcomers and users, through social farming they valorise the multifunctional aspect of resources present at farm level. During the activities, the active presence of farmers is crucial in order to reduce the cost of the initiatives as well as of their start-up. The enlarged use of existing agricultural processes to social issues reduces the transaction costs for the start up

of these initiatives as well as their risk of failure.

According with the project typologies, public funds may directly support some specific activity costs. This is the case of the agro-touristic structures opened in wintertime to support the everyday independent life of rural inhabitants such as local elderly, reinforcing proximity and community support, or the case of other structures supporting educational projects with schools. In some cases, specific services are organized in order to promote co-therapy by using plants (horticultural therapy) and animal (animal assisted activities and therapy) or to welcome children in kinder-garden organised on a farm. Such initiatives provide services that are normally funded by municipalities and families.

However, in all cases the innovation process of the use of agricultural resources in the provision of social services is highly demanding in terms of social innovation. The mobilisation of local agricultural resources in order to fit local needs of less empowered people is normally the outcome of a process of collective knowledge creation able to reset competencies, strategies, visions and attitudes of the people involved (from farmers to consumers, from third sectors to public bodies and servants). In this perspective such a process may be analysed according with the transition theory [43]. In a positive way the Transition management theory may be supportive in the design of policy intervention and demands an active involvement of researchers in the actions designed. In the next chapter some reflections will be devoted to the organization of the social faming initiatives in the perspective of an innovative welfare able to support rural areas in their path of change and adaptation to the emerging trends, also in social life.

5 RESULTS AND DISCUSSION ON SOCIAL FARMING INITIATIVES

For a long time and still today in the European debate on rural development the social issues have had a minor consideration. In the ordinary approach the social issues can be faced once the economic development has taken place and the State has redistributed resources also to less favoured and populated territories, like the rural ones. Perhaps in rural areas the provision of social-health services is normally made difficult from the low density of the inhabitants, the increasing concentration of elderly people, the need of generational change as well as the large variety of needs deriving from emerging members of rural communities as a consequence of new flows of migrants (from poor but also from wealthy Countries). However, the fact that social and health issues are not integrated in the EU approach to rural development does not help to pursue in this direction.

However, it seems quite evident that the traditional approach has to be reconsidered in light of recent global economic and environmental issues and innovative solutions should be defined. Again that in rural areas social development is strongly connected with the immaterial values of the local offer (product, identity, symbolic values) and that social and economic development cannot proceed separately. This also to avoid the rise of new trends of exclusion and social unsustainability as well as new phenomena of exploitation linked to an unfair use of migrant work. To avoid such threats a larger reflexion on social sustainability in rural areas should be developed also in the perspective to define smart, inclusive and sustainable pathways of change.

In this perspective we have introduced the idea of social farming. In fact, social farming connects the co-production of economic, social, and frequently also of environmental values (most of the social farming initiatives are organically driven) in a different perspective of prosperity based on the regeneration of vibrant and proactive communities. In such a trend the production of health takes directly origin from the territory and community in a

perspective where human wellbeing is part of a process able to establish new interdependencies among people, nature, and knowledge.

According with the Italian situation, social farming has an impact on the three dimension of social sustainability because it offers:

- Territorial SS: Social farming enlarges the provision of innovative service able to support local communities and human capital. It promotes the reorganisation of local knowledge and a contemporary rethought of community values (gift, reciprocity and exchange) in the perspective of a new stability and of the definition of new opportunities, sense of belonging and identity;
- Practical-processual SS: Enhancing the agricultural process able to actively promote positive social externalities and social inclusion for different target groups and at different level, but also to increase the availability of quality and secure food, education and awareness;
- Relational SS: Due to the consequences of a more interactive and collective process of co-creation of knowledge and values where the actors involved – rural and urban – are able to rebuild together identities, social justice, human rights and new coherence among perceived, conceived and lived values.

In the perspective of innovation, social farming seems to be a fertile environment of investigation. It defines a possible pattern of work that cannot face all the welfare issues but introduces and tests useful principles.

In social farming initiatives subsidiarity among public and private actors emerges as a process of negotiation of knowledge, organisation, mutual support and complementary use of resources.

The co-production of economic and social values is the consequence of the organisation of innovative processes able to link agricultural activities and structures into a process of co-therapy and social inclusion. This connection may reduce costs of social services, increases flexibility in meeting the needs of people as well as the social needs in disperse rural areas, but it is also able to increase the effectiveness of social initiatives (in Orti ETICI initiative the rate of recovery is about 50% of the people involved in the project instead of 15% of the normal social inclusive initiatives).

Civic economy emerges as the result of new alignment among views, strategies, attitudes and ways of operating of the actors involved in markets where reciprocity and gift are reorganised in a non for profit/for project economy. In civic economy initiatives social results are obtained under the condition of economic viability and not vice versa. In this process the provision of private and public goods has to be continuously negotiated between public, non-profit and private actors – farmers and consumers – in order to reorganise production and distribution of economic and social values. As we already discussed this reorganisation may regard a single project, and in a process of progressive contamination, also the territorial level, reshaping the way of organising parts of the local economy.

Subsidiarity, co-production and civic economy are normally the outcomes of a process of social innovation, able to mobilize local resources in a completely different perspective. Such a process is highly demanding both in terms of participation, commitment of a plurality of local actors and in terms of willingness to act in a supportive way in the medium run. A transition process that may be carefully designed and supported according with transition management theories and methodological tools.

In order to face the crisis adequate methodological supports and tools should be designed to promote a quick adaptation in the local system. With the same purpose, specific steps can be identified to promote the change [43] like:

a) Scouting of local pioneering initiatives and potential forerunners;
b) **Pro-active planning** of paths able to support innovation started by forerunners and to facilitate new solutions;
c) **Understanding and coding** of features, meanings, implications of the innovative solutions, and organizational changes required for key stakeholders;
d) **Selecting and mapping** actors able progressively to share initiatives and knowledge;
e) **Supporting dialogue** to facilitate the actors involved in the processes of change, in order to tackle: rational choices, collective sense making, power conflicts and coalitions, the acceptance of new cultural symbols and repertories. Consequently, to enable the dialogue among stakeholders in order to reinforce broader alliances and to avoid the fragmentation of arenas and meanings;
f) **Opening, mediating, extending**, in a progressive and gradual way, the arenas where debate may run and enlarge from forerunners toward actors of the existing regime, to share key principles of innovative initiatives and to integrate them in the ordinary governance arenas, at different institutional levels.

According with such steps, policies may be re-oriented to support social innovation initiatives in a broader sense, also in rural areas. The debate on European innovation partnerships may be useful from this point of view as well as the opportunity to integrate different policy tools like FESER, ESF and ERSF.

6 CONCLUSION

In our article we started by analysing the emerging contradiction in the actual economic regime and the impact of the fiscal crisis affecting the State and the welfare system. The reduction in public resources is deeply affecting the provision of services in rural areas where the scale of economy is limited and the provision of services is made complex by the low density of local population and the change of social stratification.

In our discussion the actual crisis seems far to be just temporary but it demands the definition of innovative solutions able to rethink the way of producing and distributing values in the perspective of social sustainability. We have introduced the concept of social farming dealing with the opportunity to mobilise agricultural resources (processes, structures and competencies) in order to fit to traditional as well as emerging social needs in rural areas. Social farming is already developed at European level and differently organised in accordance with different national welfare regimes. In the Italian case social farming is far to be dependent from State intervention and is based on distinctive principles such as subsidiarity, co-production and civic economy. Social farming initiatives are able to co-create public and private goods, social and economic values, as main outcome of a stronger collaboration of public and private stakeholders. Also they offer the opportunity to reshape the economic environment and the relationship among producers/consumers and urban/rural areas according with a new idea of responsibility in the common provision of a good condition of life for most of the local inhabitants. Our analysis has observed that social farming seems to be a promising concept able to re-design innovative services but also new ways of collaboration at local level thanks to a community based production of both economic and social values. Social farming strengths are linked to the possibility to valorise resources that are already available in rural areas and to stress the promotion of services more based on the idea of social justice and less embedded with the paternalistic role of the State.

In conclusion some remarks are needed about the role of the actors involved in social farming and the impact of different policies adopted.

Rural development is more than just economic and it has to be reshaped according with a wider perspective of sustainability, also giving the right attention to the social and health dimension. The rural development policies at EU level are still far from this idea and they should be reframed according with such increasing evidence.

Social un-sustainability is increasingly affecting the quality of the economic processes. When local communities reduce their capability to regenerate themselves and their internal relationships become more vulnerable also to un-fair economic processes based on exploitation of territorial and human resources.

The organisation of innovative solutions in rural areas is becoming steadily more urgent and demanding in terms of methods and pathways. Time for innovation is becoming a scarce resource when the rights of large population strata are under pressure. This is why innovation needs to be related to time for its application.

Research in this perspective has an increasing responsibility in supporting and reducing the lag in the transition pathways. This becomes possible when researchers cooperate with other actors by offering their direct contribution to the definition of innovative solutions. In our perspective the action-research is fruitful even if time consuming. It is able to have a real impact on radical innovation. Along this demand civic universities and researchers are able to make the difference at territorial level acting as third actor among local stakeholders. As a matter of fact, this enhances the possibility to reduce possible conflicts and to give support to innovative solutions also when they are quite far from the common understanding. Our involvement in action research processes started in Italy on social farming in 2003. In 2009 the first regional law was established in Tuscany and today the Italian Parliament is debating on a national law. In the meanwhile social farming initiatives are becoming more common on the national scene creating economic and social values. However, although research was not the only key factor for sure it has been a relevant catalyst of a reaction that could have taken much more time to be explored.

What is becoming clear is that the debate on social services in rural areas opens issues that cannot be addressed only by State intervention. It asks for innovative solutions able to redesign relationships inside the society and to redefine the responsibility of public and private actors and their role the local society but also the possibility to create, at the same time, economic and social values. Social farming initiatives move on the path of EU2020 strategy. It is:

- **Smart**: In the way they mobilize local resources, promoting a retro-innovative use of agriculture by the way of "**grassroots initiatives"** driven by farmers, third sector, public bodies. Social farming initiatives are able to reorganize value creation and distribution by promoting subsidiarity, co-production, civic economy;
- **Sustainable**: By using plants and animals, rural spaces and time organisation, in order to promote **therapy**, **rehabilitation**, **social inclusion**, **education** and **social services** in rural and peri-urban areas, and promoting local agriculture, local markets, reputation;
- **Inclusive**: Stimulating active social inclusion, innovative services, vibrant communities towards **small groups of people** which can live and work together with family farmers and social practitioners on farm. Addressing **diverse needs** for less empowered people (mental disability, physical disability, psychiatric, drugs & alcohol recovery, children, young people, prisoners (ex), long run non occupied, terminal patients, burn out, elderly people).

In order to achieve such results social farming reorganises in a completely different deepens values in the everyday way of operating of the actors involved. Along social innovation processes the ethic of profit and the role of the State are put under debate creating a new sense of possibility. In this perspective once again rural areas seem to offer advanced solutions thanks to the pro-active role of forerunners. It's up to the public bodies to accompany and to facilitate pathways of change where innovation and innovators are fully recognized and accompanied along transition processes able to reshape right ways to support rural change in a wider perspective of sustainability were also the social components are fully taken into consideration.

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RESPONDING TO SCOTLAND'S RURAL HEALTH AND SOCIAL CARE NEEDS WITH INNOVATIVE SOLUTIONS

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ABSTRACT

Demographic ageing is a global phenomenon and issues associated with it are receiving attention from academics and stakeholders alike. In the UK, currently 17.2% of the population is over 65 and predictions state that one in three people will be aged over 60 in 2038 (ONS, 2011). Demographic ageing is not spatially homogenous, urban areas in the UK have lower median ages whilst remote rural areas have the eldest populations [8]. Similar patterns are evident elsewhere (e.g. in mainland Europe and the USA). An increasing number of older people is frequently portrayed as a problem but the situation is not as clear cut. It is well known that most older people live independently and only make notable calls on public services such as the NHS in the final year of life.

This paper aims to: (i) highlight some of the issues identified relating to healthcare, older people and rurality from a Scottish context; (ii) present two case studies (TOPS - Technology to Support Older Peoples' Personal and social interaction and O4O - Older People for Older People) to highlight some of the issues of healthcare provision in rural Scotland and potential solutions that may have applicability in a wider European context. The research comes from an inherently geographical stance, framing the rural as a complex entity within which interactions between people and place are enacted. This work challenges 'fixed' notions of rural places for which services must be delivered in unchanging ways by looking at new models of service provision across rural spaces and places. Local stakeholders – including older people – can contribute to such a research process, making it inherently transdisciplinary by focusing and engaging older rural people in the decision making process.

The first example considers the implementation of eHealth – Information Communication Technologies which are used to play a role in the delivery of health and social care services – which

has been heralded as a potential solution to the provision of health services in rural areas. The Technology to Support Older People's Personal and Social Interaction project (TOPS) is concerned with the social and personal interaction between older people and their health/social care providers and considers how eHealth can play a part in enhancing the life experiences of older people with chronic pain living in rural areas. From this study we will present (i) how older people are currently using eHealth (ii); what aspects of personal and social interaction rural older adults with chronic pain experience and value; and iii) how technology might have a role to play in future delivery of health and social care services.

The second example is the Older People for Older people project (O4O). The project was developed from the concept that place-based health service provision can be tied to community preservation. The O4O project also brought action researchers and citizens together in a process of service co-design, development and delivery for rural older people. It actively engaged rural people and stakeholders to consider new ways of delivering services. Our research has shown that the place embeddedness of remote and rural health care means that bringing together citizens and service decision makers in the design and delivery of services is beneficial.

In conclusion, the paper aims to highlight the ways in which health service delivery changes are likely to be impacted by demographic changes of an increasingly older population in rural Scotland. It will also draw from lessons learnt through the examples which show it is possible to work with communities and stakeholders to plan for changing service provision to address current and future needs.

1 INTRODUCTION

This paper aims to analyse some of the issues identified relating to healthcare delivery, older people and rurality from a Scottish context by presenting two case studies (TOPS – Technology to Support Older Peoples' Personal and social interaction and O4O – Older People for Older People). In doing so, it is hoped that potential solutions that may have applicability in a wider European context. We present this paper from a fundamentally geographical stance, in which rural areas and interactions between people and places within them are viewed as being complex. Our understandings of rural areas are that they are heterogeneous – both within rural areas and between urban and rural areas – and that this has implications for the ways in which services are delivered to different people in different spaces. We argue that local stakeholders - including older people - can contribute to service design and delivery and that nuanced aspects of rural spaces must be better understood to deliver the most effective service delivery options. There are thus a multitude of relationships that make up rural health and health service provision that need to be considered in terms of the place in which they are set.

Worldwide, the OECD estimate that approximately 20% of people live in rural areas [1]. This proportion varies from country to country, but in Scotland it is the same. Most definitions tend to be based on population size, sparsity and distance to service centres. The Scottish Government reported that, in 2010, 18.5% of the population lived in rural areas. Between 2001 and 2010 the remote rural population had grown by 6.2% and the accessible rural population had grown by 12.1% [2]. Most of the growth of the rural population is due to in-migration.

The majority of the global population are urban and live in relatively close proximity to the services and opportunities (employment, recreational and social). They have better accessibility to services and opportunities than their rural counterparts. Health service inaccessibility in rural areas is an internationally shared challenge [3]. However, it is commonly assumed that there should be equivalent access to good health and health care services for who do not live in urban areas [4]. There exist a number of service delivery

issues in rural areas which make the provision of services more challenging than in urban areas, including, for example, the greater distances that must be travelled to physically gain access to a service, sparsity of population, difficult terrain and poor weather conditions and recruitment and retention of health professionals [5]. Accessibility challenges, particularly for health and transport services, are a major concern of rural populations in Scotland [6].

Demographic ageing is a global phenomenon receiving attention from academics and stakeholders alike. In the UK, 17.2% of the population is aged 65 or over and government projections state that one in three people will be aged over 60 in 2038 [7]. Demographic ageing is not spatially homogenous: Urban areas in the UK have the lowest median age whilst remote rural areas have the eldest populations [8]. Similar patterns are evident elsewhere (e.g. in mainland Europe and the USA). In Scotland, the highest proportion of older people live in remote areas and the proportion is predicted to continue to increase for the foreseeable future. People move to rural areas later in mid and (less commonly) later life whilst the outflow of from rural areas, in search of education and job opportunities continues [9]. Those who move into a rural area do not consider how their lives might change in the future and do not think about what their life may be like if they become more reliant on local health and social care services [10]. Those who move into rural areas may be unaware of the differences between urban and rural service provision and may be less accepting of service decline than long-term residents who have already witnessed the centralisation of many services and the decline of others [11]. Older incomers to rural areas who develop a long-term health condition may be less able to access help from family and friends because these people do not live close-by or they have not developed close social networks in their new community. The changing nature of care and the increasing complexity of needs are just some of the challenges that must be met to ensure accessible rural healthcare in remote and rural Scotland [9]. The ways in which services are provided in rural areas may have to change, with new and more innovative approaches being adopted [10].

An increasing number of older people is routinely presented in popular discourse as a ‘problem’. It is assumed that all older people make higher demands on local health services and are a financial ‘burden’ upon society. However, most older people live independently at home and only make notable demands on health services in the final year of life. The relative financial position of retired households across the UK has improved considerably over the last 30 years, largely due to more people receiving income from private pensions (which results in pensioners paying more income tax than before) [12]. Currie et al. [13] show that many older people are reliant upon informal help from friends, family and neighbours to keep them living at home. Such types of informal help means that they do not seek formal help (e.g. from the public sector) but, rather, make other demands upon their community. On the other hand, older rural people also make an important contribution to the voluntary and not-for-profit sectors which play an increasingly important role in the provision of services and community events and activities. Older people are more likely than younger adults to be volunteers [14]. We know that older people are often assets to their communities who bring skills that can help to enhance the local community for the benefit of all the people who live there: I.e. they can add to and create social capital [15].

Health services provision has been critiqued by academics adopting a positivist stance and is described by [16] as following the ‘health services paradigm’. They suggest that, from this perspective, the qualitative and social aspects of services are neglected, particularly in rural areas. They argue that this could result in inequalities in access to health services which can be overlooked and suggest that to fully explore the issue and assess the appropriateness of a type of service for a place, a ‘human/health geography paradigm’ is more appropriate. The nuanced relationships between health, wellbeing, space and place

would be considered more effectively by understanding 'rural' in different ways, including as a socially and culturally constructed phenomenon [17]. This paper frames the rural as a complex entity within which interactions between people and place are enacted.

A human/health geography paradigm, is, we argue, complementary to the 'new rural' paradigm [18] which emphasizes the importance of thinking about rural communities in wider terms than being 'agricultural' and which sees rural areas as having 'unleashed' potential. Local stakeholders - including older people - can contribute to 'sustainable place making' [19] and by focusing upon local stakeholders, the study will highlight some of the diverse forms and types of capital within rural spaces and places and how they are associated with specific demographic groups. This brings a focus on rural places, and rural health service provision, as socially constructed, relational, dynamic and experienced in multiple ways [20]. This work challenges 'fixed' notions of rural places for which services must be delivered in unchanging ways by looking at new models of service provision across rural areas. The interacting and multiple relationships that make up rural health and health service provision need to be considered in terms of the place in which they are set. To examine rural health from this perspective, this paper will describe availability and accessibility to healthcare in rural Scotland. The paper will then focus on two research case studies which both considered innovative solutions for health service delivery challenges in the context of demographic ageing in rural areas. Finally, we will conclude by suggesting aspects to consider when implementing or deploying innovative health service delivery solutions in rural areas.

2 RURAL HEALTH SERVICE PROVISION IN SCOTLAND

Most rural people have very good access to a primary care team (e.g. general practitioners, community nurses) during office hours. For example, [21] showed that although rural people live on average further away from a general practitioner's (GP) practice, they are likely to get seen more quickly by a health professional than in urban areas. Their ability to access any health service (GPs, pharmacies, accident and emergency) out-of-hours may be limited, and it can be more difficult for rural people than urban people to access secondary health services, particularly if they do not have access to a car.

Despite everyone in the UK being entitled to free at point of delivery access to healthcare, via the National Health Service, there is not necessarily equity in terms of receiving treatment. It is less cost-effective to provide the same physical accessibility of health services to everyone. The majority of secondary care services are situated in larger towns and cities. Rural people, particularly those who are remote and living in island settings, can travel considerable distances to access the care they need or may only have access to specialists on the occasions outreach centres or community hospitals hold clinics.

Service in rural areas, particularly in the more remote areas, is always threatened by a number of issues: The first is that of high delivery costs (it costs more to serve a sparsely populated community). Delivery costs are heightened by the current economic crisis. The recruitment and retention of health professionals in remote rural areas is a challenge for service providers in Scotland and elsewhere [22]. An ageing workforce compounds staffing issues because remote rural practice is increasingly unattractive to young health professionals. Many existing health professionals frequently undertake tasks that go beyond their job description, performing activities that in urban areas might be provided by social services and carers. Such out-of-job working by rural health professionals helps to keep older and less-well people living at home, in their communities [21].

Service design, it may be argued, favours meeting the needs of the urban majority population, with policy formulated and implemented by individuals who live and work in an urban context, unaware of the rural issues that should be considered to ensure successful policy delivery irrespective of geographical context [6]. Farmer et al. [23] argue "*there is widespread denial of nuances of rural provision that require different tactics and ideas*", and state that although an explicit rural health policy does exist in Scotland (see [24]) it merely attempts to make urban-based health policies fit in rural areas rather than encouraging policy design from a rural perspective.

Existing research suggests that the many successful policies in rural areas are those which are endogenous in design. This approach allows local communities to be involved in the design or delivery of a policy and to influence decisions relating to funding and resource allocation. This bottom-up approach allows policies to be adapted to suit the unique circumstances of rural areas, and to recognise heterogeneity within them [6]. It is not practical (from financial or time perspectives) for all policy-making to follow an endogenous approach but there are aspects of bottom-up policies that we can learn from. We suggest that the key element to successful service delivery is community engagement, as it allows communication between the community and service providers to be maximised and thus trust and understanding are established, which may assist in needs being met more effectively. However it is not possible for community participation and co-production just to happen.

3 INNOVATIVE SERVICE PLANNING AND DELIVERY

How might co-production of service planning and delivery be approached? Two illustrative examples will now be provided, drawing upon recent research conducted in Scotland. The first example considers the implementation of eHealth - the use of Information Communication Technologies (ICTs) in the delivery of health and social care services - which has been heralded as a potential solution to many of the challenges of providing health services in rural areas. The Technology to Support Older People's Personal and Social Interaction project (TOPS) explored social and personal interaction between older people and their health/social care providers and considered how eHealth can play a part in enhancing the life experiences of older people with chronic pain living in rural areas. We will describe how older rural patients are currently using eHealth technologies, consider what aspects of personal and social interaction rural older adults with chronic pain experience and value and reflect on how technology will have a role to play in future delivery of health and social care services.

The second example draws on findings from the Older People for Older people project (O4O). This project was developed from the perspective that place-based health service provision can be tied to community preservation and considered older people as assets in the design of health services. The O4O project also brought action researchers and citizens together in a process of service co-design, development and delivery for rural older people. It actively engaged rural people and stakeholders to consider new ways of delivering services. O4O highlighted that bringing together citizens and service decision makers in the design and delivery of services is beneficial. The project also helped build evidence about co-production of service design by highlighting successful ways of getting communities to participate as such an approach was a fundamental aspect of the research process.

3.1 Technology to Support Older People's Personal and Social Interaction (TOPS)

The TOPS project focused on older people experiencing chronic pain who lived in rural areas of Scotland and Wales. Chronic pain is defined as continuous, long-term pain lasting for more than 12 weeks and it is estimated to affect 14% of the UK population [25]. It is an interesting condition to consider in rural areas as its prevalence increases with age and the incidence of chronic pain is reportedly higher in rural than urban areas [26]. The prevalence of chronic pain in rural areas is likely to increase as the rural population ages.

Intersections between social isolation, chronic pain, health and social care and new technology are the context for the TOPS project which seeks to examine social and personal interaction between older people and their health and social care providers. Personal social networks contracts as an individual ages [27]. Older people can experience loneliness and depression, particularly if friends and family live at a distance [28]. Maintaining social networks in rural areas is facilitated by personal mobility (achieved by car ownership) which helps overcome difficulties associated with dispersed settlement structure and limited public transport. When personal mobility is compromised (through illness, no longer being able to drive) challenges to maintain social networks are magnified. For many older rural adults with severe chronic pain the only regular in-person social interaction they have is with a health or social care provider who visits them in their home.

Technological developments have been posited as offering innovative and potentially cheaper means of delivering a range of health and social care services (e.g. the UK Government's 3millionlives initiative). The deployment of technology may reduce or negate the need for home visits and consequently reduce opportunities for social interactions between older adults and health and social care providers. This could have a detrimental impact on patient wellbeing.

The TOPS project methodology was designed to explore attitudes towards, use of and acceptance of technology in rural settings, with a particular focus on the experience of adults living with chronic pain. Stage 1 used a postal questionnaire survey to elicit attitudes, opinions and experiences from the membership of Pain Association Scotland [29], a voluntary organisation that provides self-management training for individuals with chronic pain and which addresses the non-medical aspects of living with chronic pain in an attempt to improve the quality of life of pain sufferers. Stage 2 comprised interviews with older adults with chronic pain who received regular home visits from health and/or social care professionals and structured observation of these visits, interviews with professionals who delivered in-person care in the homes of chronic pain patients and interviews with the small numbers of older adults who had completed the online Pathway through Pain programme in Scotland. This approach allowed the experiences of older adults with differing levels of pain severity, impairment and levels of engagement with health care services to be elicited. Stage 2 focused on older adults (aged 60+) to reflect the fact that the incidence of chronic pain increases with age and, to understand the experiences and attitudes of older adults in the context of future health service planning.

Findings from both the questionnaires and interviews suggest that many older people are digitally literate and open to the use of technology as part of their chronic pain care package. This bodes well for Government plans to make eHealth initiatives more ubiquitous.

eHealth: Inclusion and exclusion

Results suggest that eHealth has the potential to both empower or to exclude people. Mechanisms which can enhance accessibility can also promote inclusion. eHealth could empower individuals if their use promoted feelings of independence and enablement in the

user. However some of those interviewed who had participated in an eHealth programme were not able to retain access to it at the end of the programme. There is therefore the potential that people could be left worse off, feeling 'dis-enabled', if they do not retain access to something they think has been of benefit to them.

Not everyone is a suitable user of eHealth technologies

Females were found to be less happy to accept the use of technology as a formal element of their care in the future than men, this may be because women value social interactions more than men. Men may be more amenable to the use of eHealth because they are not concerned about the decreased opportunities for social interactions. Our findings also suggest that eHealth users need to be motivated and willing to learn, suggesting that not all personality types are likely to benefit equally from using eHealth technologies. Chronic pain is a condition that can create challenges to using the devices used in eHealth.

The digital divide and challenges in universal deployment of eHealth technologies

Scotland is not unusual in a global context in having some areas with excellent digital connectivity and other areas with very poor digital infrastructure – the urban-rural digital divide. Unless widespread improvements to connectivity in many rural areas are made soon there is a risk that rural patients will be excluded from the benefits eHealth technologies offer simply because they cannot be used in all homes. Service planners need to take note of this. Rural patients, who potentially have the most to gain from the improved access to health care that eHealth offers may be further excluded if the use of eHealth to manage conditions such as chronic pain becomes more widespread.

Ehealth - Stand-alone or supplementary?

Findings from both stages of the research suggest that eHealth is currently being used to supplement existing care. Many questions about future use of home-based technology in care remain unanswered. However we posit that as a patient's condition deteriorates, eHealth can only be used to supplement other healthcare options (such as in-person visits).

Conclusion

This study highlights that older people with chronic pain are broadly open to eHealth, but it is primarily accepted as having a supplementary role and it is unlikely it would replace more traditional modes of care, particularly when an individual's condition deteriorates. Differences exist between groups about how accepting they are of using eHealth solutions in the future (more accepting groups including those who are male, older, living alone, already in receipt of formal care, whilst females, younger people, those living with others, and those who are not in receipt of formal care are less accepting). We predict that acceptance is likely to increase as older populations in the future have more experience of using technology in everyday life. Currently those who do use it, are on the whole positive about it, but crucially they view it as being supplementary to the care they receive. The results suggest that these opinions are likely to change if eHealth is perceived to be replacing in-person visits.

eHealth has been heralded as a cost efficient solution to the service delivery issues of providing care in rural communities. However before any widespread deployment of eHealth is undertaken, it is imperative to understand issues that people might have using and accessing eHealth initiatives. People with the most severe cases of chronic pain, are unlikely to be able to use eHealth initiatives to substitute some in-person visits. Thus eHealth should be considered as being part of a suite of responses to provide more options to patients, which has the potential to increase accessibility to people - particularly in rural areas - who

may have trouble accessing mainstream services, but it should not be considered to be the answer for everyone.

Further, eHealth has the potential to assist with both the management of some health conditions (in this paper those relating to chronic pain), and to assist with tackling issues of service provision and accessibility to services for an increasingly ageing population in more remote and rural communities. However we suggest that for eHealth roll out to be a success it will be important for patients to feel that they have been individually considered, and suggest any roll out begins by supplementing, not replacing more traditional in-person visits until the patient, when feeling comfortable with it desires it to replace visits. Before eHealth is "rolled out" it is imperative that greater understanding is gained about who eHealth is best for and at what stage of their illness it will have the most benefit.

3.2 The Older People for Older People (O4O) project

The O4O project worked with remote and rural people to understand whether social enterprise type organisations could be created in remote and rural areas to deliver basic health and health improving services to older people. The project can thus be described as engaging communities in a process of co-production of services. The O4O project regarded older people as assets who could help to keep communities sustained and vibrant by providing a range of basic helping services that contribute to maintaining other older people living independently in their communities for as long as possible. The approach taken was one in which action research principles were employed, with researchers going out into the community to work with them to develop services that meet the needs identified by the community and organisations that are run in locally-sensitive ways. O4O sought to support communities in developing types of social organisation that suit them; for example, volunteering organisations, timebanks, co-operatives or social enterprises. A key goal was facilitating development using resources that already exist within communities, their related networks and different agencies.

O4O was a three year project (2008-2011) led by UHI (Highlands of Scotland) and included partners in Northern Ireland, Luleå in Sweden, North Karelia and Kainuu in Finland, and Dumfries & Galloway in Scotland. Each of these countries and areas has a different third sector structure, variety of civil society actors, and their own culture of participation and volunteering. Drawing on and learning from the experiences, models and knowledge in the partner countries allowed us to assess the effect of the different policy contexts on harnessing the collective capacities of older people.

The issues previously highlighted in this paper, those of demographic ageing and rural health service provision, were a main driver of the project. The O4O project sought to contribute to sustainability issues relating to issues of governance, the enterprise, and the communities, framed in the context of rural health service restructuring and community care initiatives, which are inter-linked with different aspects of sustainability. Sustainability in governance refers to citizens' engagement (e.g. community participation, involvement, influence). The sustainability of communities relied on bottom-up engagement. Enterprise activities were based on needs identified by the communities themselves, and the participants needed to be active in their efforts of recruiting and retaining participants, so that the success of activities is dependent on a steady supply of volunteers, not project funding. Similarly, the evaluation of the enterprise activity sought to encourage local ownership. Ultimately, O4O hoped to contribute to the cohesiveness of the localities.

Project managers in each country were used to mentor communities and gathered information of the process of social entrepreneurial development through an action-research

process. Organisations were developed in the selected communities which were felt to meet the needs of that community. The project identified a 5-stage process:

Stage 1 – initiating community engagement
Stage 2 – needs identification
Stage 3 – building community skills
Stage 4 – establishing the social enterprise
Stage 5 – sustaining the social enterprise.

In Scotland, O4O focused on four communities in the Scottish Highlands. In Tongue, Transport for Tongue (T4T) was developed which included informal lift-giving, volunteer drivers, a community car scheme and maintenance and hire of a donated minibus. In Assynt, the Assynt Centre which had been run by the local authority and provided day care services, residential respite and a lunch club, closed down but the local authority gave money to the community to make alternative provision, this was used to establish the Community Care Assynt. The Centre has developed as a hub offering a range of opportunities for social interaction, peer support and development of social networks. In South West Ross, O4O worked with a pre-existing social enterprise that provides a range of older people's services, e.g. a neighbourly helping scheme to support older people in their homes. In Arderseir, a 'first stage' project aimed to develop social capital in the community. An oral history project was conducted which involved a group of older people who interviewed other older people about their early memories of the area. The community characteristics of each of the localities differ in terms of their histories, backgrounds, and experiences of community initiatives and projects, so it was essential the O4O approach reflected this.

At the end of the project a project report was made available on the project website (for more detail [30]). A number of key messages emerged across the O4O countries:

- Structure is needed to make community service delivery happen.
- Policy and service delivery motivations for co-production must be transparent.
- Communities require ways of identifying need and linking these to locally appropriate service provision models that combine community goals and generate revenue.
- Policies supporting social enterprise seem to be disconnected from communities.
- It is important to decrease or remove bureaucracy from the local level.
- New structures are needed to make social enterprises work as service providers for rural areas.

There were also a number of cultural differences between the O4O countries. Variations in the definition of older exist between partner countries. A volunteering culture was found to exist across all the countries but was found to be strongest in Scotland and weakest in Greenland. It was also found that older people could be spilt into the 'younger old' – those who were still active in their communities – and the 'older old' – those who were in need of services -.

O4O also found two models of social enterprise occurred. Those who could be described as being 'Nordic' usually involved private/voluntary sector employers who had a workforce with around a third would find it difficult to otherwise get a job e.g. due to ill-health, long-term unemployment, homelessness. The second model was the 'Celtic' model in which social enterprises had social objectives, they were embedded into the community and profits were returned back to the community. In general, it was found that social enterprises that were more business-minded were more likely to succeed.

Recommendations for the future included:

1. Communities should be involved in the delivery of older people's services.
2. Policy should commit to service co-production with communities.
3. Structures need to be enhanced that empower communities to engage with service co-production.
4. Older people's needs should be fully integrated into policy-making and public sector decision-making.

4 CONCLUSION

In conclusion, the paper has aimed to highlight the ways in which health service delivery changes are likely to be impacted by demographic changes of an increasingly older population in rural Scotland, and to provide innovative examples of ways these can be overcome – firstly by considering the role of eHealth (TOPS) and secondly by encouraging the development of co-production of service design involving older people from rural communities (O4O). These examples highlight that in order to deliver effective service provision in rural areas, decision-makers need to consider this provision in the context of demographic change. Further, we suggest that communities and stakeholders need to plan changing service provision together to adequately address current and future needs. Some solutions, such as eHealth and social enterprises may have transferable principles but their suitability for implementation in diverse areas may be different.

It is important to think not only of trying to enhance what is already there, but also to implement more innovative solutions which can be used to develop and support service delivery. In this paper we have used examples to illustrate potential solutions which have highlighted that one of the key ways in aiding pressure to health and social service delivery in rural areas is for us to be able to support older people in their homes more effectively. Other examples include making models of health service provision in rural areas more sustainable, and tackling other issues which threaten rural community sustainability such as the trend for younger people to leave rural areas.

This paper has highlighted that rural areas and the health and social service delivery in them is nuanced, and thus the challenges they present, and the potential opportunities to overcome them will be experienced differently. Therefore any potential solutions that may be heralded as 'the' solution to rural health service provision and delivery should be approached with caution and need to be considered in the context of different people in diverse communities.

Acknowledgements

The TOPS research described here is supported by the award made by the RCUK Digital Economy programme to the dot.rural Digital Economy Hub; award reference: EP/G066051/1. O4O was funded by the European Union Northern Periphery Programme with support from organisations including the Scottish Government, Highlands & Islands Enterprise and the Highland Council. Thanks to all the researchers involved in both projects without whom this paper wouldn't be possible.

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COMMUNAL NETWORKING FOR SHAPING HEALTH CARE IN RURAL AREAS – EXPERIENCES FROM THE MODEL PROJECT "ZUKUNFTSREGIONEN GESUNDHEIT"

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ABSTRACT

Life takes place in a community. It is therefore appropriate to design and organize the education system, infrastructure and health on a regional level. By putting a focus on the regional level the local needs and distinctions can be considered more specifically. Already now many communities are confronted with the challenge of providing health services accessible for everyone: A long-living but decreasing society, problems at the interfaces between different sectors of the health care system and especially the shortage of skilled labour in the medical and care field especially hit rural areas. The disparities between urban and rural areas are an aggravating factor. As Lower Saxony is a territorial state and most of the communities are rural regions they have to face the above described challenges. For this reason at the end of 2010 the Ministry of Health in cooperation with the Association of Statutory Health Insurance of Physicians and the AOK - Health Insurance Company decided to initiate the model project "Zukunftsregionen Gesundheit".

With large broad participation at regional and state level innovative approaches in health care should be developed and put into praxis. The aims of the project are: To improve quality and efficiency of the health care system, to improve medical care, to strengthen health promotion and prevention and to optimise healthcare for chronically ill persons and people in need of care.

In this three year pilot project all relevant partners are involved in discussions about a safe demographically aligned health system and the need for a more active role of the community is met. In three rural model districts (Emsland, Heidekreis and Wolfenbüttel) structures were established, which optimise communication between the players of the regional health system and subsequently help to develop multi-sectoral approaches. In every region steering groups were established with partners from local hospitals, physicians, health insurances, care providers, local administration, self-help and others. They manage the process and discuss project applications from the working teams. Support from state level is guaranteed by a task force with all acting partners of Lower Saxony's health system. First results of the evaluation show, that the involved players appreciate the established structures. In their opinion the structures help to communicate cross-sectorally and in a concerted manner to develop cross-sectoral approaches.

From the beginning of 2014 the experiences of this project are spread to all communities in Lower Saxony. Every region will get the chance to establish structures that help to work more cross-sectoral and to adjust the regional health system to the needs of the population. In this way the communities of Lower Saxony can respond to the described challenges today and in the future.

1 INTRODUCTION

The German health care system is facing different challenges at present which call for a change of existing structures [1, 2]. The demographic change, causing the change of the age pyramid and an increased morbidity, is one central aspect to be considered by the health care system [1, 2]. Germany's health care system is divided into different segments for ambulant and stationary care, causing insufficient cooperation between the professionals, which underlines the necessity to initiate a structural change and rethinking [2, 3]. Associated with the demographic change there are growing differences between the urban and rural areas concerning the securing of the local health care [2]. Especially rural areas are struggling to ensure the accessibility of health services for everyone [2]. According to the federal medical association (KBV) the health industry in rural areas is not interesting for health professionals e.g. due to the deficient infrastructure - in terms of education, public transport and occupational opportunities for their family members [4]. The need for a more intensified cross-sectorally health care, focused on the regional level, is becoming clear [2]. This requires a more intensive cooperation of the health professionals, so that existing competences can be effectively used to shape the regional health care. The district (Landkreis) as the competent administration for the public health surveillance and planning is particularly important [5, 6]. The district can offer a platform to initiate and shape cooperation between professionals and to create cross-sectoral approaches. Moreover, it provides the chance to cooperate with professionals from other sectors, because the district is also responsible for mobility and the infrastructure within the district and municipalities are responsible for all affairs of the local community under the Basic Law [7, 8].

Many regions in Germany have reacted to the described challenges. Nationwide there are efforts to ensure, or rather optimise, regional health care initiating cross-sectoral cooperation. Many rural regions are developing approaches for a regional health care. These initiatives are now commonly called health regions within Germany. Health services research and elaborating concepts, which contribute to secure an available health care, are central fields of action in a health region [9]. Moreover, the promotion of innovations and the innovation management are associated with the establishment of a health region [10]. There is no standardised definition of the term health region and plenty of understandings and definitions can be identified in practice [11]. However, a definition, which summarises all the different understandings of a health region was phrased by W. George as follows: "*A health region can be described as a geographic cluster with a target-oriented merging of organizations and persons, who cooperate in order to develop new and coordinated services, and quality activities. They can be focused on the following fields:*

- *Patient care*
- *Health economy*
- *Health literacy and health research*
- *Tourism*

Beside the cooperating players also the citizens and patients should profit from the health region" [11][12].

[12] The definition of the term health region is a german translation of „Gesundheitsregionen": „Als Gesundheitsregion wird ein geografisch benanntes Cluster bezeichnet, in dem es zu einem zielgeleiteten Zusammenschluss von Organisationen und Personen kommt, die zugunsten eines neuen, abgestimmten Leistungs-, Entwicklungs- und Qualitätsgeschehens miteinander kooperieren. Sie können in den folgenden Bereichen angesiedelt sein:

- Patientenversorgung
- Gesundheitswirtschaft
- Gesundheitsrelevante Bildung und Forschung
- Tourismus

Neben den kooperierenden Akteuren sollen auch die Bürger und Gäste von der Gesundheitsregion profitieren" [11].

Looking at the diverse nationwide activities in health regions it becomes obvious that cooperation can promote the implementation of cross-sectoral projects and help to handle the often discussed problems, like shortage of physicians in rural areas [9]. The result of cooperation and networking among the different players is the concentration of competences leading to the optimisation of the quality of supply and the economic efficiency of health care, reducing its costs [12].

Responding to the described challenges within Germany the model project "Zukunftsregionen Gesundheit – kommunale Gesundheitslandschaften" and the follow-up project "Gesundheitsregionen Niedersachsen" was initiated within Lower Saxony. Through the establishment of health regions a focus should be put on the administrative district as a planning authority for public health services and through the coordination of the administrative district new cooperation and communication structures as well as new approaches of health care should be developed with the regional players [6].

The objective of the present paper is to describe an option of communal networking for shaping health care in rural areas. Therefore the structure and organisation of the model project "Zukunftsregionen Gesundheit" will be described. Further on first results from the practical perspective should be presented and critically discussed. Finally the conclusion seizes important aspects for the establishment of a health region.

2 MODEL PROJECT ZUKUNFTSREGIONEN GESUNDHEIT

2.1 Selection of the model districts and project aims

At the end of 2010, the Ministry for social affairs, health and equality of Lower Saxony (MS) decided to initiate the model project "Zukunftsregionen Gesundheit" in cooperation with the Association of Statutory Health Insurance of Physicians (KVN) and the AOK – Health Insurance Company (AOK). The aim of this project was to improve the rural provision of health care, involving the regional level in order to take local needs and characteristics into account. The need for a more intensive cross-sectoral regional health care was expressed in a former government declaration. The project duration was set to three years. The Association of Statutory Health Insurance of Physicians and the AOK – Health Insurance Company each funded the project with 150000 Euro p.a.. These funds were to be used to establish structures and projects within the three model districts. The process management as well as the evaluation was funded through the Ministry of social affairs, health and equality and both tasks were assigned to The Association for Health Promotion and Academy for Social Medicine Lower Saxony.

The model districts were chosen by the main cooperation partners. In the selection process all districts of Lower Saxony were analysed on the basis of specific criteria and the project aims. The market shares of the involved health insurances, already established structures, the amount of general practitioners (gp) and the share of chronically ill persons were taken into account. The main criteria for the selection were the market shares of the involved health insurances as well as the already existing structures as these criteria may help to successfully realise cross-sectoral approaches within the districts. As a result of this analysis the districts Emsland, Heidekreis and Wolfenbüttel were identified as particularly suited.

The aims of the project were:

- to improve quality and efficiency of the health care system
- to secure the medical health care against the backdrop of the demographic change

- to strengthen health promotion and prevention and avoid the development of chronic diseases
- to improve the healthcare for chronically ill persons and people in need of care.

2.2 Structure and organisation of the project

In this three year pilot project, all relevant partners were involved in discussions about the securing of a demographically aligned health system and the need for a more active role of the community in shaping the local health system. With large participation at regional and state level innovative approaches in health care could be developed and put into praxis.

The project structure included a task force on the state level where all participating partners of Lower Saxony`s health system were represented. Within the districts administrators, community head associations, the ministries of Lower Saxony, health insurances, the Association of Statutory Health Insurance of Physicians and Dentists, the Hospital Federation, Institutions of welfare work and the municipal umbrella organisations, the Association for Health Promotion and Academy for Social Medicine Lower Saxony as well as other organisations of the health system formed part of the panel. Their tasks were in part public relations as well as aspects concerning the funding. Within every region a steering group was established with partners from local hospitals, physicians, health insurances, care providers, the local administration, self-help groups and others. They managed the process and discussed project applications from the working teams. On average five working teams were established in each model district [6]. The following Figure 1 shows the organisation of the project:

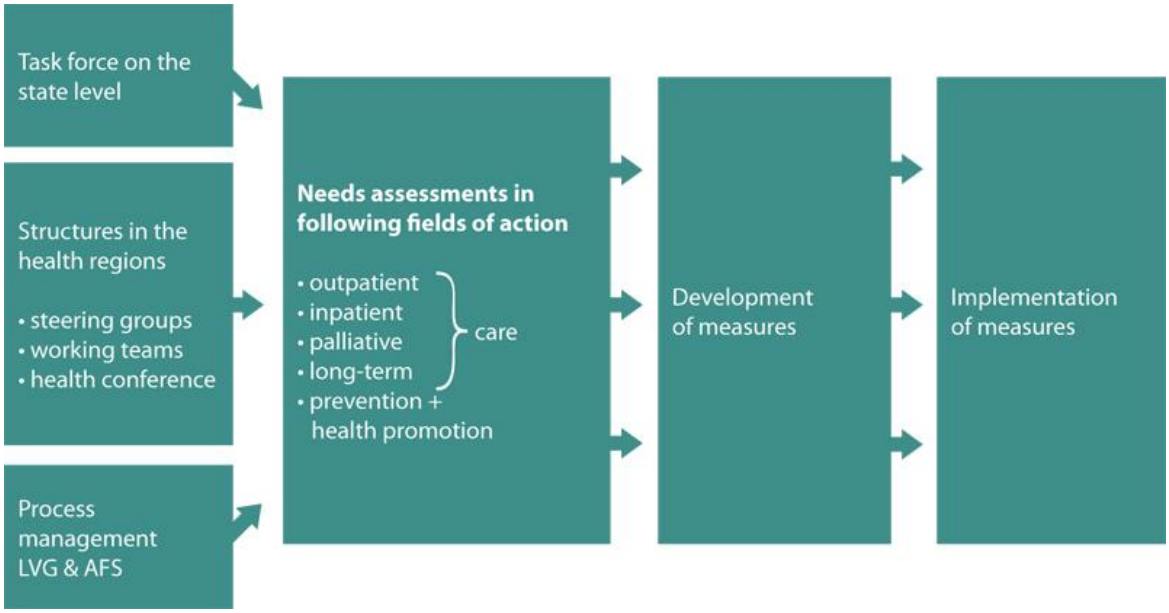

Figure 1: Process and organisational structure of “Zukunftsregionen Gesundheit” [6]

Characteristic of the project is the participation of all players within the field of health care; the focus was on the regional level and so health care was shaped and discussed on that level.

The project management and coordination was the responsibility of the respective districts. All regions carried out needs assessments and established structures for an annual regional health conference. In this context the health conferences can be understood as a meeting where citizens and stakeholders of the health system had the opportunity to participate, to exchange views and to provide information about the work status. Another task

for each region was to develop measures to ensure medical coverage within their region. In addition, networking projects should be initiated for a better coordination of care between different facilities and areas. Existing projects should be taken into account to prevent unnecessary effort and initiatives [6].

The process sequences in the three model districts were similar (s. Figure 2). The working teams developed project applications, which were examined by the steering group and after a positive feedback these were realised by the working teams. For a successful implementation process many regional players were involved. The task force from the state level supported the processes on the regional level on demand [6].

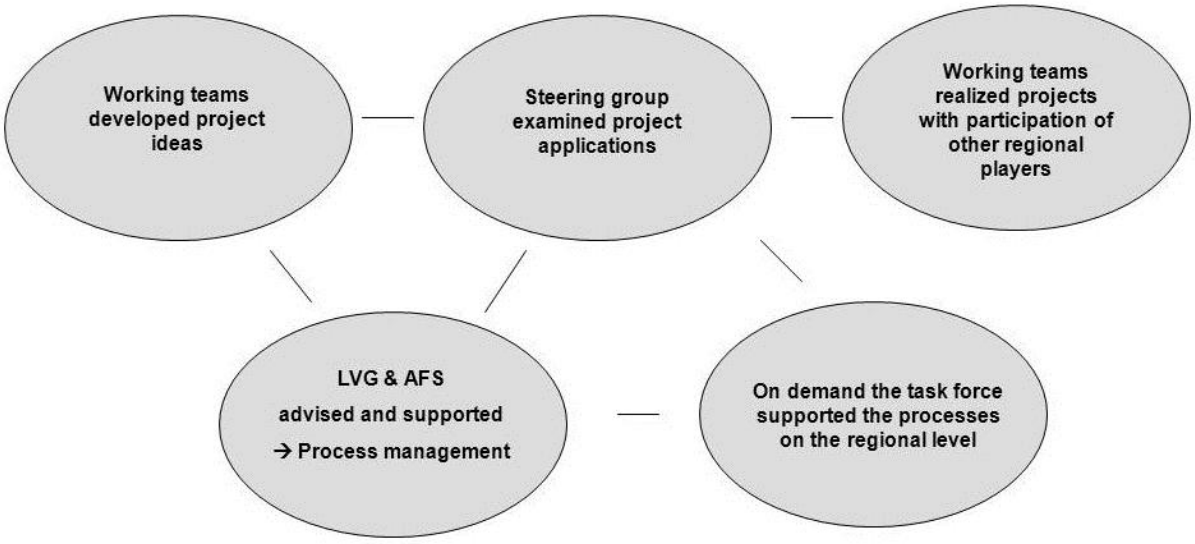

Figure 2: Process sequences in the three health regions [6]

The communication structure within the project was more complex. At the regional level the exchange took place between the members of the local steering groups, working teams, the task force and other committees (e.g. county committee, various networks). Similarly, the exchange between the LVG & AFS, the regions and the task force was warranted during the whole project. Quarterly meetings between the project coordinators and main cooperation partners (MS, AOK and KVN) were organized by the LVG & AFS. Thus, a framework was established that allowed the coordinators and main cooperation partners a supra-regional exchange in order to create transparency about the processes in the regions and on the state level as well as to raise awareness of the requirements and needs of the project stakeholders. All in all these meetings and activities had the goal to strengthen the cooperation. During the meetings of the task force, the project states were discussed and possibilities for support of the model districts clarified.

3 RESULTS FROM THE PRACTICAL PERSPECTIVE

In this chapter first results of the project are described from a practical perspective. They are differentiated according to structures, processes and outcomes. The experience of the process management as well as the results of project related elaborations are included in this presentation. At this point the result monitoring is to be understood as an intermediate status. The evaluation report will processed the results systematically. The report is expected

to be completed in May of 2014. Therefore, only a limited representation of the results can be given at this point.

Structures

During the pilot project the aim was to initiate a structural development process in which the regional level is increasingly perceived as a planning and decision-making body within the health services. With the establishment of regional steering groups and the anchoring of structures and the coordination at the district office this objective was taken into account. Due to these established structures plenty of activities could be initiated and implemented. The project experience showed that the creation of regulatory and legal frameworks at state level as well as the clear order to the district administration as a coordinating and controlling function, contributed significantly to the success of the development process. The participation of (political) decision makers from the involved institutions at both state and regional level supported the development process as well.

The involvement of existing bodies in the establishment of working groups has been positive. By integrating the development process in the existing structures of the district, e. g. through the integration of existing bodies such as the social psychiatric composite or care conference, the aspect of sustainability was taken into account. The construction of double structures was avoided and at the same time resources of the involved actors can be targeted without the double workload of them. The experience gained during the three year model project showed that networking with local institutions and the cooperation with e.g. nationally active organisations was advantageous for the implementation of interdisciplinary projects. Thereby the necessary cross-sectoral cooperation could be strengthened and plenty of different impulses were gathered for shaping the health care.

In order to let the municipalities fulfil their task as a coordinating and planning body as well as to fulfil the requirements, a coordinating body is needed in the district administration. The implementation of the coordinating body at the district has proven to be beneficial. Firstly, neutrality was ensured by the coordination. Secondly, by the local political connections a special importance was attached to the process and associated with that a higher assertiveness for the development process was given.

Processes

For the process design factors which relate directly to the stakeholders are of primary importance: Especially their willingness, ability to cooperate and the design of collaborative relationships are essential for a positive process design. As the project was positioned at the regional level many participants already knew each other through previous collaborations. Thus, relationships and trust relationships were already established previously. Positive collaborative relationships facilitated cooperation in such a development process. The design and creation of appropriate communication structures promoted the establishment of trust and at the same time ensured transparency in the process. The establishment of regular meetings between the project coordinators and main cooperation partners provided another measure to ensure fruitful cooperation. In addition, the expertise and social skills of the participants are factors that promoted the development process. Regarding the staffing of the coordinating body and other positions with coordination and management tasks, project management skills were of immense importance. Project management skills and expertise can be promoted by trainings, this has been confirmed as part of the project period.

In addition to the personal also organisational aspects have been found, which can be conducive or obstructive for the process. In retrospect it can be seen that the design of the

project start is largely important for further processes and structure formation. Thus a reasonable period for the planning of operations and needs assessments should be given.

Closely related to the process design is the clear description of roles and responsibilities for the project participants. The project experience made obvious that the definition of roles and job descriptions helped to increase the degree of transparency in the process.

The allocation and use of work materials, e.g. application forms or hand-outs, were perceived by the project participants as beneficial. Likewise, it was advisable to think about sustainability of projects and developments from the outset: The model project showed that with the establishment of a permanent coordinating body settled at the district administration sustainability could be ensured. After expiration of the project term each model region continues the activities. Further on the definition of district specific health aims contributed a sustainable development process.

Outcomes

A big variation of topics was addressed with the realised projects. Associated with the project, chances were given to initiate and implement activities, which not necessarily resulted in a project application. In addition, through the "knowing each other" and the establishment of communication structures, measures could be implemented which could not be implemented before the start of the project. One example is the realisation of the 24h GP service at the clinic Wolfenbüttel. Furthermore fields of action received attention, which were previously mostly ignored. Through the political and media attention various topics got promoted and not yet involved stakeholders could be involved in the development. The high relevance of the project both at regional and state level conduced to ensure a constancy of participation. During the project around 38 projects have been implemented in the three model regions. Many healthcare stakeholders were involved and cross-sectoral collaboration was initiated.

4 DISCUSSION

Looking at the present research concerning health regions it is clear that little seems to be known about beneficial and inhibiting factors contributing to their success [10]. Against this backdrop and the current discussions about health care structures particularly in rural areas, e.g. the cross-sectoral care and cooperation [2], the need for research on health regions as part of the health care structure research is obvious. The pending project-related evaluation report of the pilot project “Zukunftsregionen Gesundheit” can make an important contribution to this body of knowledge.

The initiatives in practice show that there is no uniform use of terminology. As described above, various approaches can be subsumed under the term health regions. Similarly, there is no generally accepted term used for the regional steering committees. These are often referred to as a health conference or steering group, and also the design varies regionally. Therefore, comparisons of health regions and their operating conditions always need to be considered in the context of regional conditions. Due to their different characteristics comparisons are limited. It is obvious in many initiatives that the involvement and direct participation of the political level, both regionally and nationally, represents performance-influencing factors and promotes a structural development process. Likewise, the participation of decision-makers of involved institutions, e.g. health insurance companies, hospitals and the medical profession is a significant component [13].

The integration of existing bodies or the foundation of new structures must be critically discussed. Experiences have shown that it is advisable to include existing bodies, such as existing skills, which can be incorporated into the process, and the structure of duplication can be avoided. Whenever possible a strategy and structural fit should exist. In other words objectives, strategies, structures and performance capabilities of the involved parties should be compatible with the bodies which should be integrated and the bodies of the health region [14; 15; 16]. In addition, a discussion is necessary as to whether the opening of existing committees for further interested parties is reasonable and feasible. But this always depends on the local conditions, so that a general recommendation cannot be expressed here.

Similar the settlement of the coordination body within a specific department (e.g. public health department, educational centre or regional development) should be discussed and decided taking the starting conditions within the district into account. These can be different, e.g. in terms of job descriptions of the different areas and personnel and professional resources.

Looking at the results in terms of the developed processes it is critical to note that knowing each other cannot only be a beneficial aspect for the developments. In particular, when unresolved conflicts have arisen from previous collaborations, these can be transferred to emerging collaborations with uninvolved third parties under certain circumstances. This should be taken into account in the development process of health regions.

It also showed that for the initial phase in the model districts sufficient time should be allowed. The amount of time for determining objectives, planning and a needs assessment must be discussed in the context of initial conditions in the districts. The initial conditions can be related to existing structures and cooperation between the departments of the district administration or bodies to be involved. Similarly, the establishment of a public health reporting system is different in every municipality. For the analysis of needs within the district and to be able to align efforts and interventions to the regional requirements, the use of existing data of the public health report, as well as data on medical care coverage of physicians' associations should be considered. Extra performed data collection by the project participants should be carefully considered and carried out in a goal-oriented way.

Within the three model regions the patient and user perspective was integrated through needs assessments in some implemented projects. Experience has shown that this perspective needs to be taken into account even stronger than previously considered. With the annual health conferences the opportunity to inform about the project process should be given to all interested parties. In future further alternatives should be used to inform about the development process and to give participation opportunities for citizens. A health region must be experienced by all persons who live there, so that the health region can develop sustainably [11].

5 CONCLUSION

Overall, the project gave the regions the opportunity to reconsider the needs of the individual service areas and to approach the development of a sustainable health care concept with the participation of all relevant actors.

The continuation of the established structures in the model regions can be seen as a success of the pilot project and as an impetus for the establishment and development of health regions within all municipalities of Lower Saxony according to the experiences made within the three model regions. For an assessment of sustainability, however, a longer project period should be considered. Thus, the further development of the regions remains to be seen. A statement about the actual change in quality of care and the improvement of the

efficiency of the health care system cannot be made at this time due to the short project period. The project experience showed that local authorities and stakeholders were sensitised of the need for coordination and organisation of health services and they realised these tasks.

For the permanent establishment of a health region, the involvement of all the different departments of regional interests in the development process towards a health region is of central importance. In addition, the citizens' needs should be included intensely and considered in the development process [11]. Stakeholders involved should be aware of these local needs and plan activities accordingly so that the region is perceived by all members of society as a health region.

The experience gained from the pilot project and other practical experience in health regions have shown that health is intertwined with many other fields, such as mobility, education and economy. With the involvement of the regional level as a moderator and coordinator of the structural development process, cooperation between the different fields can be initiated. Moreover these structures contribute the urgently required cross-sectoral health care long-term. With the pilot project the need of a localisation of responsibility for a coordinated and cross-sectoral health care was taken.

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TARGETING CHALLENGES IN RURAL EMERGENCY CARE

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ABSTRACT

Provision of healthcare in rural and urban areas differs considerably and this difference becomes apparent especially in emergency situations. In Scotland about one million people live in rural areas, where it can take a considerable time for an ambulance crew to arrive on scene. To care for patients in these rural areas whilst help is en-route, the Scottish Ambulance Service operates an innovative volunteer first responder scheme. We present the MIME (Managing Information in Medical Emergencies)[13] project, which aims at supporting Community First Responders when they respond to emergencies.

Employing a mobile device with novel lightweight sensors, MIME enables Community First Responders to capture a greater volume of physiological patient data, giving them a better awareness of a patient's medical status so they can deliver more effective care. On basis of the captured data a textual handover report is produced using Natural Language Generation that can be passed to the arriving ambulance crew to give a quick summary of the situation and can accompany the patient to inform later stages of care. We will showcase how the MIME project targets health care issues in rural areas using natural language processing and novel technology to enhance rural resilience.

1 INTRODUCTION

Rural patients' experience of healthcare differs from that of urban patients. It is, for example, more difficult in many cases for the rural population to access appropriate health services locally: For example long distance travel for routine check-ups and other medical appointments present obstacles to them [1]. Further, it is challenging to recruit and retain healthcare staff in rural areas [2]. The difference between rural and urban areas becomes particularly apparent in time-critical medical emergencies. Calling help in case of an emergency can be hindered by poor mobile network coverage. Also, the arrival of help can further be delayed due to the distance from care, poor transport networks and inclement weather conditions.

[13] http://www.dotrural.ac.uk/mime

About one million people live in remote or rural areas in Scotland, where it can take a considerable time for an ambulance crew to arrive on scene. To care for patients in these areas whilst help is en-route, the Scottish Ambulance Service operates an innovative first responder scheme. Volunteers from local communities, Community First Responders (CFRs), are sent to the emergency to assess patients, perform potentially life-saving first aid procedures and record medical observations before the arrival of an ambulance. These data are then handed over to the ambulance team upon arrival. Because of their time-critical nature, such handover reports are often verbal and hence maybe incomplete or misunderstood.

The MIME (Managing Information in Medical Emergencies) project is developing technology to support Community First Responders when they respond to patients [3]. Employing a mobile device with novel lightweight sensors, we aim to enable CFRs to capture a greater volume of physiological patient data, giving them a better awareness of a patient's medical status so they can deliver more effective care. Our system will also provide some basic suggestions based upon the patient's clinical condition. One focus of MIME is the production of a textual handover report using Natural Language Generation that can be passed to the arriving ambulance crew to give a quick summary of the situation and can accompany the patient to inform later stages of care. Our paper will showcase how the MIME project addresses health care issues in rural areas using natural language processing and novel technology to enhance rural resilience.

2 DEMOGRAPHIC CHANGE AND HEALTHCARE ISSUES IN RURAL SCOTLAND

Like in most European countries, Scotland's population is ageing as a result of an increasing life expectancy and a relatively low birth rate. At the end of 2010 the Office of the Chief Economic Adviser of the Scottish government published a report on the demographic change in Scotland [4]. This report showed that since the year 2003 more people in Scotland are at a pensionable age (60 years for women and 65 for men) than those in the group of under 16 year olds, and that the shift in balance between old and young people is continuing. By 2033 a 50% increase in over 60 year olds has been projected. Due to an age related migration (e.g. the age group of 16 to 24 years old showed a net out-migration from rural and remote areas of 6.1% in 2007 and 2008), there is a clear difference in Scotland's ageing population between urban and rural areas. The report further showed that in several rural communities 21% of the population are over 60 years old. Other European countries like Germany or Italy face a more severe situation, but the effect of this worsening dependency ratio comparing the number of those of working age with the population of dependants potentially increases demands on public services associated with reduced tax revenues to fund this increased demand.

Provision of healthcare for rural areas is different from healthcare provision in urban areas. A report on the remote and rural workforce [5] shows that the pattern of disease is similar in rural and urban areas, however, other factors present challenges for rural healthcare providers in Scotland. For example the number of accidents on roads per head of population is higher in remote and rural areas and the overall number of accidents per head of population outnumbers those in urban areas due to incidents related to activities that are specific to rural areas, such as climbing, farming, fishing and diving for example. At the same time the suicide rate is smaller in urban areas [6], as is the incidence of alcohol related disease [5]. The report goes on to state that it is a challenge in rural areas to recruit and retain health care service personal and that due to low caseloads there is a risk that skills will decay in the rural workforce, and the maintenance of expertise thus poses a bigger challenge

in rural areas. The demographic change over the next years, with its increase of older people and decrease of people of working age especially in rural areas, will impact upon health patterns in Scotland and have a significant impact on future healthcare services.

One of the main functions of the Scottish Ambulance Service (SAS) is response to accidents and emergencies. In remote and rural areas, however, this presents huge challenges, due to the dispersed population across a wide geographical area that must be covered and the special circumstance that some of these areas include islands. In order to tackle these challenges the SAS has modernised its workforce (i.e. new air ambulances, digital mapping technology, automated vehicle location systems). Another concept sustaining local healthcare in remote and rural areas is 'Community Resilience' which describes the effort of communities to facilitate their own healthcare by collective and collaborative response, using volunteers and informal carers and promoting self care [5]. One such creative community emergency approach is the SAS First Responder Scheme.

3 COMMUNITY FIRST RESPONDER SCHEMES

Community First Responders (CFRs) are volunteers who respond to emergency calls within rural communities or areas that are difficult for ambulances to reach within the target response time – roughly 30 minutes [7]. In general CFRs are lay people, although some may be healthcare personal, recruited from their local communities. They receive a basic medical training and the necessary equipment to deal with a range of emergencies and accidents while they are awaiting the arrival of an ambulance crew. It is their task to attend the patient during this time and record their observations to report back to the arriving ambulance team. From time to time they may also sample the patient's physiological measurements, such as heart and breathing rate, which are also supposed to be recorded.

There are a multitude of challenges to delivering care in an emergency situation in a remote or rural area which make it different from care taking place in the controlled environment of an emergency department or a hospital ward. Emergency situations are inherently unpredictable and the actual clinical condition of a patient may be different (better or worse) from that conveyed in the original call for help. It may be difficult to access and assess the patient in order to ascertain the full extent of their injuries or medical illness. The situation may well represent a life-threatening emergency, where swift appropriate action is needed. The type of calls assigned to CFRs vary considerably. The CFRs may be relatively inexperienced and many rural emergencies take place even outside the range of mobile communication. Further, environmental factors such as adverse weather conditions and nearby dangers may affect what can be achieved.

At the time of handover to the arriving ambulance team the CFRs should have created a record of their observations and actions on a paper patient report form. In practice, however, this rarely occurs because often CFRs do not have enough time to complete the paperwork when they are with the patients. Physiological measurements are sometimes even written in ink on the back of a protective glove, and are rarely passed on in any systematic way. Often a verbal handover is performed and the patient's report form is filled in later. This can lead to misunderstandings or omissions of important facts.

4 THE MIME PROJECT

The cross-disciplinary MIME (Managing Information in Medical Emergencies) project, in collaboration with the Scottish Ambulance Service, is developing technology to support CFRs when they respond to patients [4]. The project aims to enable CFRs to capture a far greater volume of physiological patient data such as heart and breathing rate and by doing so, MIME intents to give CFRs a better awareness of a patient's medical status so that they can deliver timely and appropriate care. Further, the project's purpose is to give ambulance clinicians an enhanced awareness of the nature of the medical emergency they are arriving at and to give ambulance services an enhanced patient record for the purposes of audit and training.

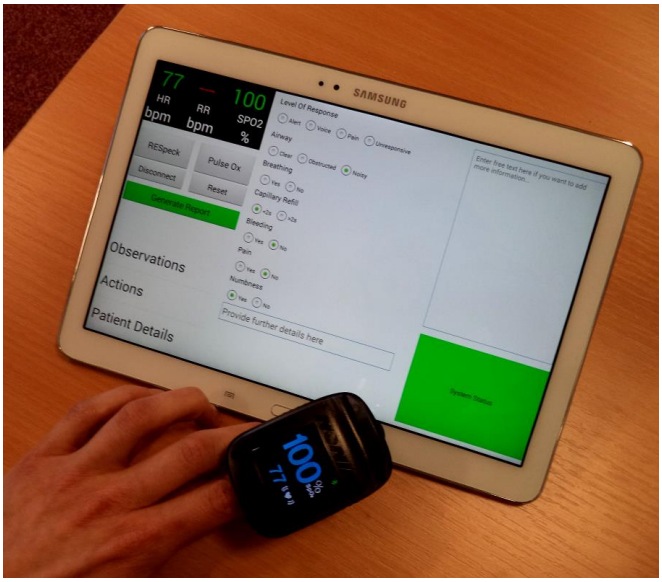

Figure 1: MIME prototype with Nonin 3230 Pulseoximeter sensor

There are several important components of the research work in MIME. One is the use of novel lightweight wireless medical sensors that are simple and quick to apply, another is the use of novel software that takes these inherently complex sensor data, along with some other information inputted by the user (e.g. patient age, visual observations, actions performed) on a tablet computer, and presents it very simply. The latter spans from the development of an easy to use interface that supports CFRs even in stressful situations, to the employment of Natural Language Generation to produce a textual handover report [8].

Natural Language Generation (NLG) is used to transform a large amount of information into readable text. An often cited example is the generation of weather forecast reports from meteorological data [9]. Applications of NLG which have been investigated in the medical domain have also been manifold, including a range of approaches to informing patients and supporting decision making. A number of systems address the problem of presenting medical information to patients in a form that they will understand (e.g. STOP [10], PILLS [11], MIGRANE [12]). Other systems aim to summarise information in order to support medical decision-making (e.g. TOPAZ [13] or Suregen [14]). In the case of MIME, the challenge is similar to that of Babytalk BT-Nurse [15], to summarise large amounts of sensor data, in the context of carer observations and actions, into a coherent handover report that can be retrieved at any time to support quick decision making by the reader. This generated handover report can be passed to an arriving paramedic to give them a quick summary of the situation and can accompany the patient to inform later stages of care.

The new method of using sensors to capture physiological data continuously introduces the problem that irrelevant information needs to be suppressed in order not to

overload the paramedics with data and therefore hinder information interpretation. We are currently working with two sensors, the Nonin 3230 Pulseoximeter[14] and a RESpeck [16] breathing rate sensor, that together provide measurements of the patient's respiratory rate, heart rate and blood oxygen saturation at intervals of 5 seconds. The generated reports must provide a quick overview of the situation but at the same time be sufficiently comprehensive. The presentation must also be transparent – it is vital that the format enhances the readability.

In a user-centered development process we developed scenarios and asked paramedics to write handover reports for these scenarios. Then we analysed the scenarios and decided upon a general structure for the handover reports. Our reports are structured into five main sections – see Figure 2 for an example. After the demographic description of the casualty (i.e. age and gender) and incident details (these can be entered by the responder whenever they have an opportunity), two sections of generated text follow, the initial assessment section and the treatments and findings section. The initial assessment contains information on the patient gathered by the CFRs just after the sensors are applied and also any observations made during the first minute after the application of the sensors. The treatment and findings section is a report on the observations and actions of the CFRs while they attended the casualty and waited for the ambulance to arrive. This includes a paragraph that sums up the condition of the patient at the time of handover.

HANDOVER REPORT

TIME OF STARTUP: 10:31:00
TIME OF HANDOVER: 10:43:00

CASUALTY
Casualty is 54 year old, male.

INCIDENT DETAILS
Man is experiencing severe chest pain in his rural home. His wife calls 999 at 10:23 as she thinks her husband is having a heart attack. he has experienced angina periodically for around five years

INITIAL ASSESSMENT
On examination the casualty's airway was open, his skin was pale, his capillary refill was slow and he had pain in his chest. His pulse rate was 100 beats per minute, he was breathing at 18 breaths per minute and his blood oxygen saturation was 92%.

TREATMENT AND FINDINGS
At 10:32 high flow oxygen was applied and he took his GTN spray. Then SpO2 rapidly increased to 96%. However, after that SpO2 remained constant around 95% for 10 minutes.

At 10:35 he was feeling faint.

At 10:35 the casualty was moved.

At 10:38 he had pain in his chest.

At 10:38 he was vomiting.

After treatment HR has remained fairly constant around 109 bpm for 11 minutes, RR has remained constant around 22 bpm for 2 minutes and SpO2 has remained constant around 95% for 10 minutes.

MEDICATION, ALLERGIES AND PAST MEDICAL HISTORY

Figure 2: Example of a generated handover report

[14] http://www.nonin.com/OEMSolutions/Nonin_3230_Bluetooth_SMART

5 CONCLUSIONS

Due to the demographic change in Scotland we are faced with the challenge of an aging population in rural Scotland. Falling numbers of people of working age will impact upon health patterns in Scotland and future healthcare services. The term 'Community resilience' has been coined to describe collective and collaborative response within communities to promote independence and is seen as the key to sustain local healthcare in remote communities. The aim is to facilitate communities to look after themselves, encouraging self-care as well as using volunteers and informal carers.

One initiative promoting Community resilience is the Community First Responder scheme operated by the Scottish Ambulance Service, which currently involves more than 1000 volunteers all over Scotland in remote and rural areas. The task of providing healthcare in accident and emergency situations in rural areas is however extremely challenging due to a number of factors. That Community first responders are in general lay persons who may be relatively inexperienced further adds to the challenges. Volunteer First Responder Schemes internationally face the problem of a high drop out rate of volunteers as a result of stress after they have dealt with major emergencies.

The MIME project aims to support the task of Community First Responders by enabling them to capture a greater volume of physiological patient data as well as giving them a better awareness of a patient's medical status so they can deliver more effective care. We aim to improve the process of handover between First Responder and arriving ambulance crew using Natural Language Generation to generate handover reports. A first prototype has been developed and is under evaluation. In an initial evaluation of the NLG system we sought to assess how our reports would be received in comparison with the current situation – either short verbal reports or paper report forms – and also in comparison with what might be regarded as a "gold standard" report produced by an expert (paramedic). We were able to show that the generated reports produced by the MIME system appear to improve on the current practice of verbal handover. We also collected data from real emergency ambulance callouts by having a researcher join ambulance crews for their normal activity, which is used to modify the NLG system (e.g. in order to allow for more reliable handling of noise).

Currently, we carry out a more in-depth evaluation of a refined version of the NLG system. Basic decision support has been implemented in the first prototype which will now be tested with CFRs in user studies and we also explore the use of Empathic Conversational Agents to encourage First Responders with targeted support messages [17]. CFRs are used widely and are an important addition to the care provided by the Scottish Ambulance Service. We hope that MIME can contribute to community resiliency by improving CFRs work practices.

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LIGHTS AND SHADOWS OF SOCIAL SERVICES IN SPANISH RURAL AREAS

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ABSTRACT

The objective of this research is to address social policies in Spanish rural areas; social actors involved were on one hand professionals (social services and other areas) and on the other hand the inhabitants, to discern the actions undertaken to improve the current situation of the Spanish countryside.

This article aims to determine the coverage of social services and establishes the valuation that rural inhabitants make about that. Therefore we try to show the strengths and weaknesses to enhance the former and minimize the latter.

We identify the barriers posed to the territory when implementing social policies as well as on the institutional framework of social services.

The interviews have shown two novel indicators that help or hinder social policies: "The Castilian character" and inter- and intra-municipal disputes. They also report results that we did not expect as the contrast between the speech of citizens and professionals of Social Services, the lack of enthusiasm of the professionals on the future social context in which they work or terminological inexactitude of citizens in relation to social services.

The solution to rural areas does not go through the gradual increase of one service after the other independently. However a proper coordination of these services will achieve an efficient improvement, optimizing existing resources, avoiding overlap of activities and providing rural areas a better coverage at all levels. Socio-economic policies must also take into account the intrinsic reality of each area, but a priori, not a posteriori as it often happens.

The Spanish inhabitants, according to the different characteristics of the habitat where they live, have access to the use of different services. Social Services must perform the necessary measures and actions to promote equal opportunities for all citizens, paying special attention to the disadvantaged for personal, economic, cultural, family, social and territorial reasons.

In this future social professionals must play a crucial role and only then they will honour their surname: SOCIAL.

1 INTRODUCTION

The main determinants of Spanish rural areas in the early twenty-first century are depopulation, the dispersion of municipalities and organisations of population, a poor communication network and the heterogeneity of the territory [1]. Taking into account these factors is essential to the planning of social policies or to undertake any activity or more specific projects. Other subjective indicators identified in several works are the typical Castilian character and inter- and intra-municipal disputes that block the development of

many projects or impede the proper functioning of some services, hindering coordination that is essential especially when resources are scarce.

The characterisation of Spain, and more specifically its rural areas, presents a number of difficulties for the government in providing basic services coverage to such a geographically dispersed population. It would be extremely difficult to provide each municipality with basic social services settled in their territory: This relates mainly to health, education and social services.

Social services in rural areas are an important subject to be investigated due to the following factors:

- Growing relevance of Social Services with input from European funds and programs.
- New effect of terms like rural development, sustainable development, new rurality, indicating a new rural emergency that must be addressed from multiple fields, including social policy.
- Lack of research on this subject.

The social, educational and health services are critical to the quality of life of the inhabitants of any region. The smallest municipalities of the Spanish countryside face greater difficulties in accessing them, mainly due to transport related issues. A good accessibility is necessary for children to attend schools located in other municipalities, for patients travelling to health centres with specialized services, or for any citizen to make an administrative procedure with the social worker. Considering the aging population in rural areas in Spain, poor transport infrastructure with reduced schedules and routes, and the inability of many elderly to scroll due to a lack of transport services or the inability to drive, we found a population for which equality of opportunities is an utopia.

Precisely one of the main objectives of social services is to promote equality of opportunities and therefore in rural areas there is a great way to go.

In this paper we try to answer certain questions related to the situation described:

- What are the main needs of Spanish rural areas today?
- Are there uniform rural areas and, therefore, can the same or similar social policies be designed throughout the country?
- Can we talk about equal opportunities in rural and urban environments in Spain?
- What role should social services play in the social sustainability of rural areas?
- What should be the lines of social intervention to improve the situation of Spanish rural areas?
- Does the rural population feel satisfied with the coverage of social services?

We are also going to delve into a particular region, Castilla y León, significant for its large geographical dispersion, its aging population and a low population density.

2 NEEDS OF RURAL AREAS IN SPAIN

In line with the idea of economic colonisation of our symbolic imagery of Bourdieu [2] and Latouche [3], the possibilities of social sustainability are closely linked to economic sustainability.

The new Law for Sustainable Development of Rural Areas from 2007 [4], pays special attention to young people, women and the elderly.

We talk about rural areas in Spain as a homogeneous context and actually it is not. We found very different rural habitats and among them scattered small municipalities in North-eastern peninsular parts and large municipalities in the South.

Following Camarero [5], we distinguish five models of rurality:

- Disconnected Rurality: Where relations between the rural populations are low and the population is aging.
- Dense Rurality: Rural areas where the population has grown rapidly with the arrival of new residents and has a social landscape that predominates the productive force.
- The Transition Rurality: Mainly in the North of the peninsula, showing some of the features of rurality decline but less depths.
- Local Rurality: Focus on the environment of Andalusia and Extremadura, showing an overview of relative demographic balance in the context of the larger nuclei and more self-sufficiency.
- Liquid Rurality: Present in Mediterranean coastal areas in the North of the Ebro valley and the Madrid region, forming a highly dynamic rural area where the heterogeneity of the social composition of the social processes are very dynamic.

A closer look to the characteristics of this typology of rural areas in Spain reveals that there are big differences between them. One important factor when seeking for adequate public politics is the context. The Spanish inhabitants, according to the various characteristics of the habitat where they live, have access to different services.

"*There are two realities, one is (the) small villages (which) have no shop or sometimes both are header region where services are concentrated in the area, with less agriculture and trade. They are very different*" (Cooperative representative).

Therefore, the place of residence determines the standard of living. The pragmatic evidence materialises in great detail in a study of the Argentaria Foundation [6]. Social services, along with other organisations and institutions must undertake measures to promote equal opportunities for all citizens, with special attention to the most disadvantaged by personal, economic, cultural, social, territorial and family reasons.

3 RESULTS AND DISCUSSIONS

3.1 The answers of social services

In Spain there is a structural difference between urban and rural basic social services. They have separate units, while the former depend on the municipalities; the latter depend on the provincial councils. Social policies and rural development are not designed globally but sectorial interventions have been made and there has been no feedback.

The term public policy comes from Polis (city) and shows that from its beginnings it was designed for cities. The urban centre shows a restrictive policy with urban focus, and today the development of social service coverage still meets typically urban designs. In rural areas it is necessary to adapt to the needs and characteristics of this context.

Importantly, some of the social needs are covered by the associations and non-profit organizations both in rural and urban habitats. However, the Spanish countryside has a less associative movement, relational greater poverty and a lower social participation by environmental constraints. For example, a person with disabilities living in a rural area is subject to multi-exclusion, first by the disability and secondly by residing in a rural area. These two factors are not added but multiplied since the interaction with the environment is

further complicated by structural barriers. Also access to basic social goods like health, education, employment, housing, transportation, social services, leisure etc. is more complicated than in urban areas.

- Social sustainability has three major threats in rural areas [5]:
- Demographic Imbalances
- Gender inequalities
- Differences in access to mobility

These three elements are interrelated and representing a great social and political challenge. Social services should contribute to social sustainability and implement public policies to eliminate these barriers. The interviews show that many of the interventions are limited to individual and specific attention and more related to bureaucratic interventions than to structural issues.

Many studies provide guidance on the importance of social sustainability for the future of rural areas, then, is necessary to work on these three threats described. Social services can (and should) help to mitigate these threats, but their protocols and the territorial coverage impede involvement in actions to improve the demographic imbalances and increase mobility difficulties (many users must travel dozens of kilometres to access social services). In contrast, most other interventions aimed at reducing gender inequalities. Therefore, we can conclude that rural citizens face a tripod that hinders social sustainability and social services do not contribute enough to promote social sustainability.

The depopulation is closely linked to the difficulties of access to employment with suitable characteristics, but also the lack of services for quality of life, preventing equal opportunities between rural and urban, which affects so differential women [7].

As a result, rural citizens, in addition to the structural problems, have social services which instead of promoting equal opportunities, in some respects, impede them:

> "*The much hyped equal opportunities remain a panacea for people in small towns in Castilla y León. The almighty (at least theoretically) welfare state has shown over time that its bases were cracked and expectations of universal coverage have been impossible to meet*" [8].

3.2 The case of Castilla y León

We present research data from Castilla y León (which corresponds to the model of Disconnected Rurality).

For the implementation of the study we relied on a qualitative methodology: Eleven in-depth interviews and two focus groups were carried out. Interviews were conducted with four rural CEAS professionals (social workers and community cheerleaders), two social workers (one law degree without training of Social Work) of the MEC (Educative Team Psicopedagogy) and five social workers from Health Centres in the province.

Before offering some of the results we will make a brief demographic description of this region. While municipalities with less than 2000 inhabitants have grown in Spain since 2000, Castilla y León has lost population. Smaller towns grow less than the average for its size, in a situation of double retirement: The public policy responds to the citizenship with a decision to leave the smaller towns, with a greater comparative disadvantage for women and the youth.

The relationship between demographic recession and municipality size is clear: Villages in Castilla y León with less than 100 inhabitants are the most affected in Spain, 12% from 2000 [7].

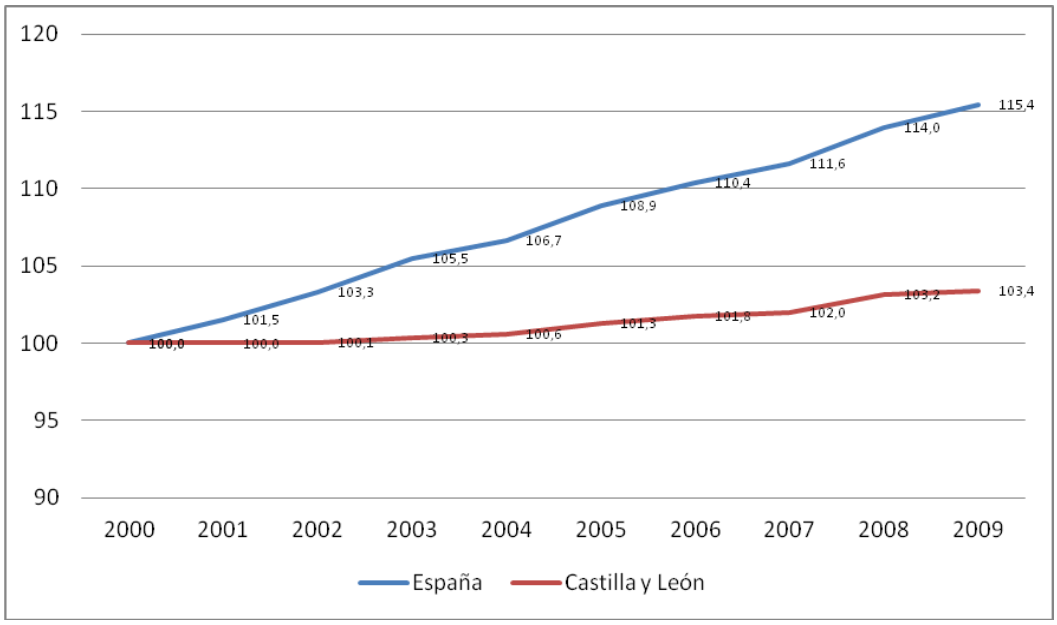

Figure 1: Evolution of the rural population in the period 2000-2009 in Spain and Castilla y León (2000 = 100) (Source: [7])

The data reflect the population of municipalities with less than 2000 inhabitants in Castilla y León has decreased by 4.0% compared to the national growth of 9.3% (s. Fig. 2). The population in rural areas increased since 2000 in thirteen regions, and reduced in Castilla y León, Extremadura, Asturias and Galicia.

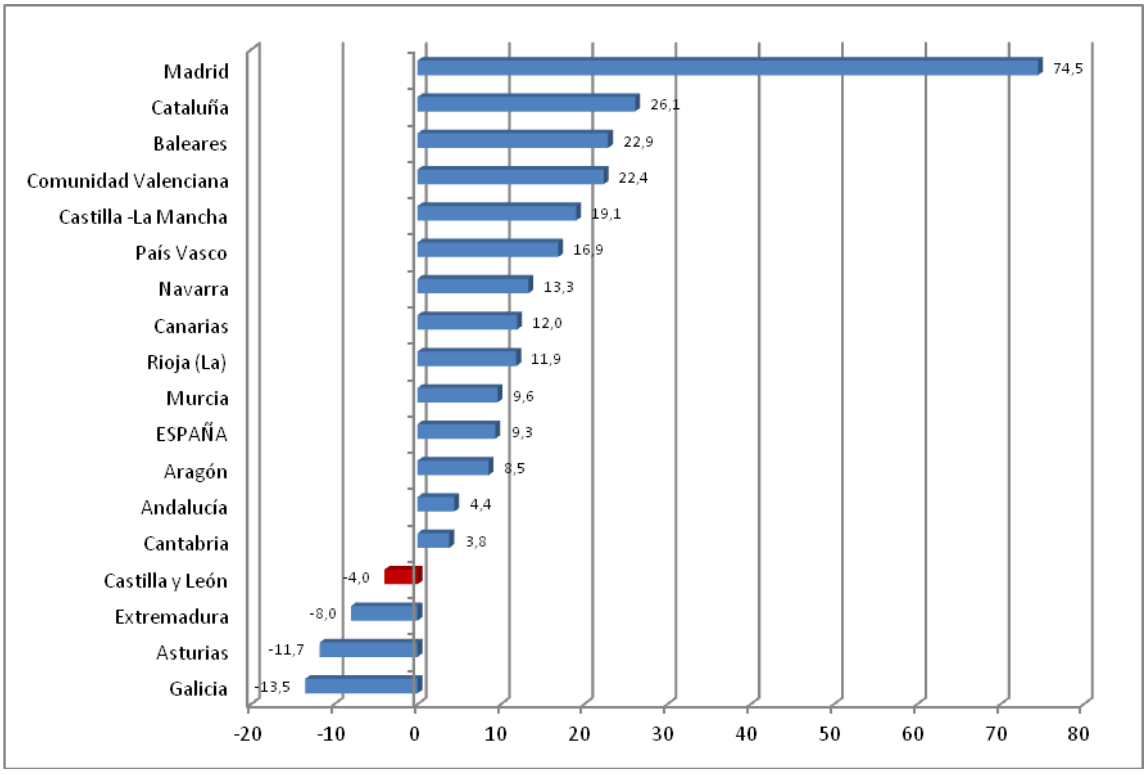

Figure 2: Population growth in the municipalities of ≤ 2.000 inhabitants according regions, 2000-2009 (Percentages) (Source: [7])

Following this contextualisation we list the results:

1. Rural citizens of Castilla y León do not feel protected by the coverage of Social Services and consider it distant due to ignorance of their functions, location and closer links with the city, especially municipalities closest to it.

2. There is an opposition between the belief of social workers that rural citizens have sufficient details about their work and their work schedules, and the forceful speech of rural inhabitants as nonusers of Social Services, who do not know these aspects.

"*I know that sometimes the social worker comes to the centre, but I do not have a schedule (about the working hours), (he/she) comes when needed, but is not a lot.*" Doctor

"*The social worker ever comes to CRA*[15] *but (we) have little contact with her.*" Teacher

3. We proved a remarkable critical attitude to the social policies of the interviewed professionals and the open manifestation of their ignorance in some cases. How can someone be a social worker and not know the lines that revolve around social policies?

4. Practitioners not directly linked to the Social Services showed a much more connected and inclusive discourse than rural social workers.

5. The terminological inexactitude is very strong among the rural population of Castilla y León.

6. Lack of enthusiasm for the future of rural society on behalf of social professionals interviewed in which they should be protagonists, according to some answers they rather seem to be "spectators".

7. There is a clear contrast between the discourses of the interviewed social workers (except for social workers of EOPS), who think that rural inhabitants of Castilla y León know their schedules and functions, while the focus groups indicate the opposite.

8. There are problematic acting barriers in social work professionals: Their areas of social action are too far, lack of interagency coordination and lack of time to delve into the different areas. One example is the fact that many professionals do not know the number of municipalities covered by their scope.

9. Regarding the interdisciplinary coordination we can say that there is teamwork both in the CEAS and in the MEC (Ministry of Education) Psicopedagogy Teams and Health Centers, with the collaboration of different professionals.

10. There are some indicators that do not appear in many studies, but which can decide the success or failure of any initiative: We refer to the Castilian character which was made manifest as a brake on the two interviews and discussion groups. The main problems of this region in the early twenty-first century are depopulation, the dispersion of municipalities and organizations of population, poor communication network and the heterogeneity of its territory [9], [10].

It is fundamental and essential to know the context for planning broad social policies or any activity or project. Our research which sought to understand the perception of rural citizens of Castilla y León about Social Services, has led us to conclude that they do not have a great popularity and recognition among the population. The explanatory factors for this include the ignorance of the socio-structural context (which has been outspoken in interviews) and a lack of involvement and awareness in rural areas (reflected in the focus groups).

[15] Grouped Rural School

4 CONCLUSIONS

The report shows that there are needs not covered for the Spanish inhabitants of rural areas in general and in particular needs in Castilla y León. These needs can be grouped into four groups [7]:

1. Need to define a set of quality of life indicators to measure social cohesion.
2. Maps should define the needs, resources, services and a territorial base.
3. Need for specific policies for women and young people, ensuring equal opportunities in the labour market and avoid "relocation", which is a serious loss of talent, the most valuable in the information society and employment of knowledge resources. Among such interventions should be return policies targeted to migrants and policies that promote access to housing, with a specific application in rural area.
4. Need for policies to reconcile work and family life, with special emphasis on rural areas and with comparable quality and conditions of access to urban areas.

To ensure the social sustainability of rural areas in Spain, it is necessary to design and implement public policies to promote satisfaction and the roots of the local population:

- Conquest of "quality of life" as an increasingly important objective for future generations.
- The perception of comparative advantage in relation to the urban environment, while at present the social perception of the rural population is disadvantaged.
- Mobility and quality services. In a globalised world, the distance between the demands and needs experience and the reality in rural areas is exaggerated. The dispersion of population and employment and the relocation of services require constant travel and is expensive. This issue must be addressed by public policies, both with reductions in the cost of individual mobility as well as a guarantee of public transportation systems.

Social sustainability requires the construction of dynamic social networks to strengthen the social and economic fabric of the territories. We must promote complementarity between rural and urban areas. The local and the global overlap, resulting in a new space: The glocal [11].

The rural world unfolds between proximity and remoteness. Local services and care for older people, representing two core areas of intervention, have acquired a clear priority. This will fulfil the objectives of the Law of Personal Autonomy and Care for Dependency and loneliness and social isolation, key facts in the social exclusion of rural citizens. Proximity is treated it in two ways: As a direct care for people, and thus close and adequate to everyday contexts, and as a tool to support the retention and fixation of the population in its usual environment, promoting independence in daily activities and social integration, which undoubtedly leads to an improved quality of life. Our research shows that this proximity of social services is not perceived by rural residents.

One consideration: You cannot simply apply the organisational patterns of urban services to rural areas, where the features should be: The integration of sectorial policies, the multifunctionality of resources and mainstream projects.

Finally we propose a series of lines of intervention that will undoubtedly improve the coverage of rural people with social services in Castilla y León and Spain:

- Reduction of social action areas.
- Support for the organisation of regional institutional fabric.
- Support for the organisation of local social fabric.
- Campaigns for the attraction and integration of immigrants (job boards).
- Local development programs and promotion of new employment.

- Greater involvement of social professionals to rural areas that must necessarily pass through knowledge of the pillars on which it is based.
- Coordination among institutions to leverage all available resources and not superimpose performances.
- Matching the territorial division of the areas of CEAS, the MEC Psycho Equipments, NIHM professionals, commonwealths, etc..
- Increased concern of public institutions to maintain and improve the situation of rural areas through technical, political and economic support.

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DEMOGRAPHIC CHANGE AND MARGINALIZATION OF SOCIAL GROUPS ON THE LABOUR MARKET: ANY GOOD PROSPECTS FOR CZECH RURAL REGIONS?

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ABSTRACT

The presented study intends to map and analyse ongoing processes in the regions of the Czech Republic while emphasizing the position of rural areas. It aims to reveal their trends, as well as their differentiation with respect to the categories of regions and their geographical location. It addresses the issues like ageing, population change, dependency burden, and more importantly the situation on the labour markets by characterizing development of unemployment rates as well as the marginalization of chosen social groups of unemployed under the influence of the last economic crisis.

The results support the intention of developing more regionally suiting strategies to mitigate and reverse the identified changes. Moreover, the position of rural areas is not straightforward, as the ongoing trends are much more dependent on the other factors and the rurality is only additional to them. The hot spots of a negative development were found on national borders as well as in the old industrial districts. The paper concludes with suggestions for the creation of development strategies that would be able to face the most emerging issue arisen from the cumulative trend of increased youth unemployment and out-migration that enhance further depopulation and the loss of human and social capital.

1 INTRODUCTION

The EU agenda for rural development policy is under the process of dynamic changes. It must give appropriate responses to questions concerning the mitigation of negative trends (e.g. impact of depopulation, ageing and a decline of agriculture on rural employment) and the utilization of existing development potential while facing and respecting great heterogeneity not only among the Member States but most importantly at the regional level within them. Therefore, all processes need to be interpreted and compared in an appropriate regional scale and with respect to a regional fabric. Among the most pronounced threats for rural futures ageing, an increasing dependency burden, depopulation and an increasing marginalization of selected social groups on labour markets may be considered. These all affect the overall picture of quality of life in rural areas as well as their development potential.

1.1 Background

It is already common knowledge that the rural population is an ageing population [11]. This is the result of out-migration of young people, in-migration of elder people and changes in traditional rural families. It generates a two-fold problem, and so – the increased demand for specific services, such as social, health and public services [2] that would serve the elder population, and an increased cost of provision for existing services due to a shortage of demand from specific groups of consumers. In the case that the population dependent on the provided services increases, it also leads to a further decline in the local quality of life [5] that would call for some policy action. However, actions should not be taken only to mitigate negative trends but it is also important to start the reversal of ongoing processes. The example may be the support of migration of young families into rural areas in order to sustain their viability [8].

The strategy of improving inflow of young families seems to be helpful for the slowdown of rural depopulation by the prospective improvement of low birth rates, that is another negative attribute of development of rural areas. However, since the 1970s and in the past 15 years in the Czech Republic [8], it seems that rural areas have been able to overcome rural exodus and there has been a noticed population turnaround [6], being characterized by the increase of inflows into rural areas and the overall increase of rural population in comparison with population developments in urban areas. It is important to notice that the migration is changing its direction in the last decades, what is enhanced by the fact that it is a very selective issue [8, 11]. It is both age and social status dependent. It has two flows, on one hand the young and active people moving out to cities in different stages of their life (education, work) and on the other the elder people who decide to spend their retirement in the countryside moving in. People are more often willing to pay so-called social costs of living in the rural areas [10] what explains the overall change of attitudes towards the life in rural areas.

Furthermore, the migration process considerably affects the rural labour market [4]. Newcomers are those who usually boost the local job market by also boosting the rural economy. This contribution needs to be weighed against the number of job losses as a result of displacement of local people by in-migrants. Nevertheless, we may consider migration to be a catalyst in rural regeneration, both in its economic aspects as well as its role in sustaining vitality of rural areas through population growth.

Population growth correlates with employment growth and vice versa [3]. Those regions that are able to create and guarantee employment direct in place or provide opportunities to make employment outside the area reachable for their citizens, have better prospects to sustain a satisfactory level of population and may even enhance their development by attracting newcomers. Moreover, the impact of population growth may be understood firstly as the increased demand for services and secondly as the increased supply of labour that inevitably leaves an impact on local economy [1]. Therefore, by creating a stimulative economic and social environment in rural areas, we may further enhance the process of rural regeneration and keep the positive development prospects of rural areas.

1.2 Objectives

As it was previously mentioned, ongoing processes are not evenly distributed [e.g. 5, 8, 11]. What need to be considered in policy planning as well as in interpretations are regional endowments. Another important feature of policy planning is to assess regional dynamics of selected issues as it has already been proved that national numbers are too vague [9]. Regional dynamics reveal the existing polarization of development, either with respect to the

dichotomy rural-urban but more presently also within “rural”, showing different development patterns in suburban and remote rural areas. With respect to this, we may even expect that the development of some rural areas will overcome in positive terms the development of some urban areas. However, by ignoring the intra-rural heterogeneity and applying rural policy flatly, this may create some real threats for rural futures.

Concerning the problems stated above and with respect to spatial development inequalities, we intend to answer the following questions:

1. What is the direction of change in ongoing processes of ageing, population development, dependency burden, unemployment rate and marginalization of social groups on labour market in Czech regions?
2. Do in the Czech Republic exist any spots with cumulative negative trends in all observed processes?
3. Does the rurality really matter in the development and the magnitude of change in the ongoing development? If not, what else may matter?

1.3 Methodology

For the purpose of the intended analyses, we make use of cartograms to visualize categories of regions and other observed processes. By the use of maps we are able to interpret results not only with respect to different categories of regions but also with respect to their geographical location (either centred or peripheral).

Categories of regions are made on LAU 1 level (districts in Czech Republic) and according to the OECD classification [7]. This method divides them into three categories: predominantly rural (PR), intermediate (IN) and predominantly urban (PU).

We assess the observed processes on the base of chosen indicators:

- Ageing is being assessed as the increase in the share of population aged 65+ on total population during the chosen time period. This phenomenon reflects the increased pressure on the public sector in provision of basic health and social services.
- Population development is assessed on the basis of change in natural population growth and migration change and the absolute difference between these two flows that distinguishes areas either with population growth or population decline.
- Dependency burden is calculated as the share of sum population aged 0-14 and 65+ on the active age population (15-64). This indicator reflects the social pressure on the active population as well as the demographic pressure on the labour market.
- Unemployment rate describes the situation on labour markets as well as it reflects the vulnerability of regional economies to the economic crisis. Therefore we assess the change between years 2008 and 2011.
- Marginalized social groups on labour markets. We assess unemployed people with low education, unemployed women and age-dependent unemployment. These are the groups that are most vulnerable in economic crises and most disadvantaged in searching new job positions due to both their low or outdated skills and work experiences, the combined role of home and care keepers or a limited willingness to adjust to new working techniques and habits.

Data are obtained from the Czech Statistic Office (CSO) and the Ministry of Labour and Social Affairs. For the processes of ageing, population change and dependency burden we operate with the change between 2001 and 2011. For the labour market change assessment

we intend to reveal the effects of economic crisis, and so we mainly focus on years 2008 and 2011.

2 RESULTS AND DISCUSSION

2.1 Regional projection of ageing

The map in Figure 1 clearly illustrates the trend of ageing between the years 2001 and 2011 in LAU1 regions of the Czech Republic (except districts close to the capital). We may notice some regional trends when the speed of change is differentiated, especially with respect to the vertical geographical position (Prague and Brno). Within the categories of predominantly rural, intermediate and predominantly urban regions, the share of the population aged 65+ goes remarkably high in districts located on borders, especially in districts on the Slovak borders and those structurally most affected districts (old industrial districts).

According to the information displayed in Table 1, the ageing is considerably influenced also by the decrease of young people (0-14). Additionally, intermediate regions account for more than 60% of the increased ageing. We may also observe that the ageing is slightly lower in predominantly rural regions. However, we need to keep in mind that the overall population change in these areas is negative as the only one within categories of classified regions (-2,92%).

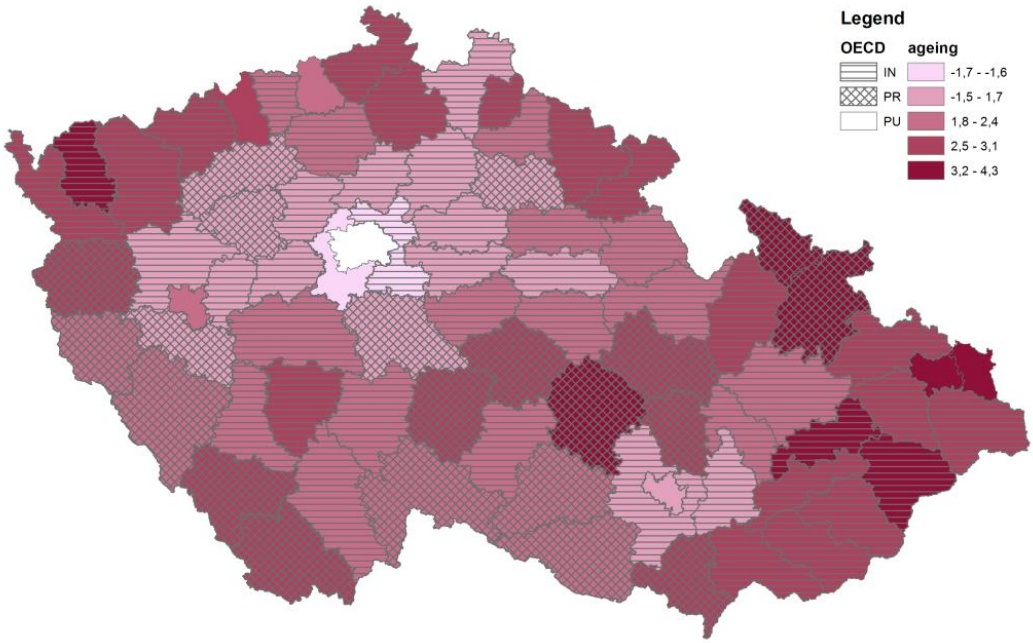

Figure 1: Percentual point change of the share of population aged 65+ on total population between 2001 and 2011, by LAU 1 regions

Table 1: Change in number of persons in age categories and contribution to ageing, by typological LAU 1 regions

		Change in number of persons (%)			Contribution to ageing by OECD regions
		Age classes			
	Change of total population*	0-14	15-64	65+	
Predominantly urban	4,25%	-8,01%	2,79%	23,68%	19,88%
Intermediate	1,67%	-9,77%	0,79%	17,93%	60,20%
Predominantly rural	-2,92%	-16,53%	-3,25%	14,15%	14,43%
Praha	8,53%	-1,97%	10,43%	6,83%	5,49%
CZ	2,02%	-10,03%	1,48%	16,61%	

**according to the census information there are some missing values for all age categories*

2.2 Regional population projections

The overall change of the population in the Czech Republic was positive (2,02%). As the map in Figure 2 shows, the population increase is the most pronounced in the proximity and on the development axis of Prague and Brno and regionally important districts, such as České Budějovice and Český Krumlov in the southern part. On the other hand, the districts on regional borders are characterized by the decline or relative stagnation of population as well as old industrial districts and districts on national borders. Together with the increase of the population aged 65+, these districts are under the serious threat of further decline due to multiple negative trends.

Table 2 displays the population growth with respect to its two main components, the natural population growth (N) and the net migration (M). According to all categories of regions, positive net migration is an important factor for all of them. We may notice the positive trend in the increase of population which resulted from a combined natural population growth and a positive net migration (21 to 2). This trend is most noticeable in intermediate regions. The positive change is also visible on the increased number of growing regions, especially in the intermediate (24 to 9) and predominantly rural category (8 to 3). On the other hand, more often the negative population growth is led by a net migration that cannot exceed the lower birth rates in 2011 by comparing it with year 2001. According to population decline components, negative net migration is the key determinant, combined either with negative natural growth or natural growth that cannot exceed the out-migration.

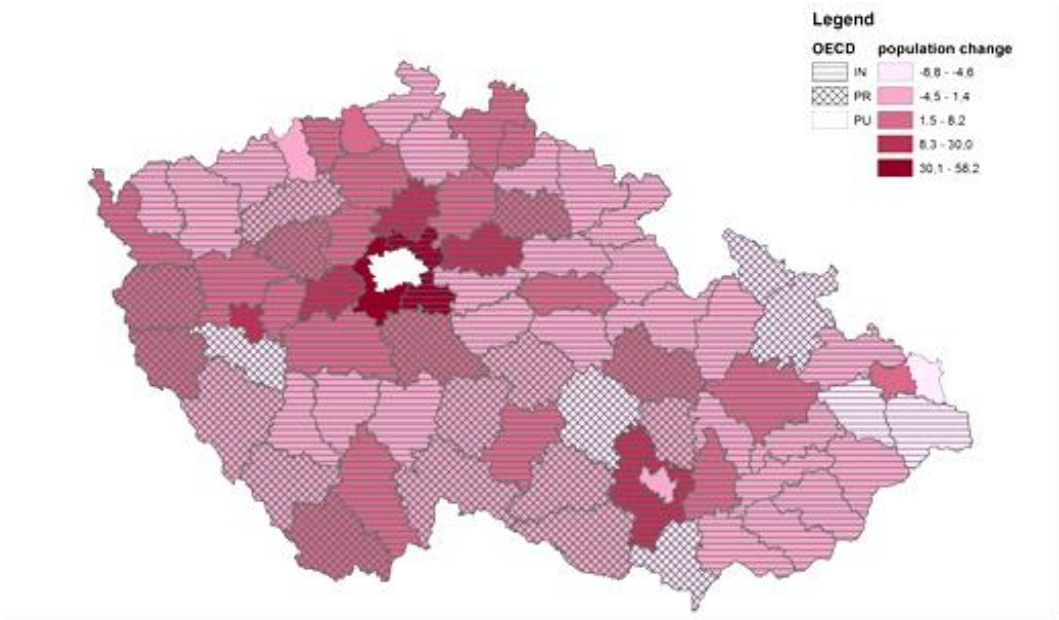

Figure 2: Population change between 2001 and 2011 (in %), by LAU 1 regions

Table 2: Components of population change in 2001 and 2011, by typological LAU 1 regions

	Positive change			Negative change		
2001	**N+M+**	**N+M-**	**N-M+**	**N-M-**	**N-M+**	**N+M-**
Predominantly urban	0	0	0	5	1	1
Intermediate	1	0	8	20	0	19
Predominantly rural	1	0	2	7	2	9
Praha	0	0	0	1	0	0
Total	**2**	**0**	**10**	**33**	**3**	**29**
2011						
Predominantly urban	1	0	1	2	1	2
Intermediate	17	0	7	14	4	6
Predominantly rural	2	0	6	8	4	1
Praha	1	0	0	0	0	0
Total	**21**	**0**	**14**	**24**	**9**	**9**

2.3 Regional projection of change in dependency burden

In the majority of the LAU 1 regions, the increase of the dependency burden between 2001 and 2011 was noticed (cf. Map in Figure 3), with an exception of some predominantly rural regions. The highest values were recorded in all types of regions, especially those located on national borders. The speed of change may be affected by the fact that the increased dependency burden (combination of young-age dependency and old-age dependency) is enhanced by the overall ageing in these regions and either of existing population growth or decline. Those regions with negative or stable population growth that face the increased dependency burden (e.g. Jeseník, Karviná) give the clear signal of worsened development prospects, especially related to the quality of life of the active age population that is facing much higher social pressure than in those regions where the population growth may be naturally translated into the increase of the dependency burden.

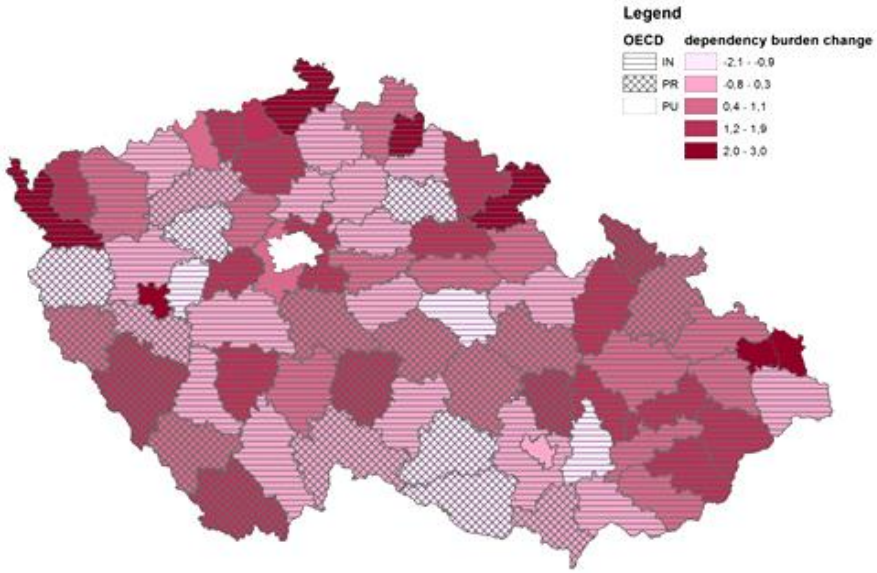

Figure 3: Percentual point change between 2001 and 2011 in dependency burden, by LAU 1 regions

For a better explanation of the character of change of the social burden in the regional context, Table 3 provides the information on the change with respect to age categories (young-age and old-age dependency) and the overall cumulative change between 2001 and 2011. We may draw attention to the fact that the dependency burden on the active-age population is increasing in all categories of regions, only with Prague as an exception. The

cause is mainly the increased old-age dependency rate that is observable within all categories, however in the category of predominantly rural regions followed by the highest decrease of the young-age dependency rate, possibly explained by lower birth rates and ageing of population. Therefore, the situation in predominantly rural regions may be even worsened in the future, characterised by the increased demand on the public sector and an empowered demographic labour pressure.

Table 3: Dependency burden components in 2001 and 2011, by typological LAU 1 regions

2001	Young-age dependency	Old-age dependency	Dependency burden
Predominantly urban	22,45%	19,14%	41,59%
Intermediate	23,68%	19,35%	43,03%
Predominantly rural	24,45%	19,19%	43,64%
Praha	19,05%	22,88%	41,93%
Total	23,11%	19,70%	42,81%
2011			
Predominantly urban	20,09%	23,03%	43,12%
Intermediate	21,20%	22,64%	43,84%
Predominantly rural	21,10%	22,64%	43,74%
Praha	16,91%	22,13%	39,04%
Total	20,49%	22,63%	43,12%

2.4 Regional projection of labour markets

An important factor affecting the labour market development in recent decade was the economic crisis with most noticeable impacts in 2009. Figure 4 presents unemployment rates in categories of regions being represented by a demarcation line according to their degree of rurality[16]. Changes between the years 2008 and 2004 led to an overall decline in the interregional as well as intraregional[17] dispersion of unemployment rates. We can see that in 2008 the maximum values decreased to the rate of 13,1%. However, the peak of the economic crisis in 2009 left an impact on the labour market, moving unemployment rates in all categories of regions higher by on average 3,6 percentual points. The situation did not change significantly in 2011, with only a slight decline of unemployment rates in almost all districts what indicates the starting economic regeneration. However, more important is to look at different categories of excluded groups on the labour market to understand their prospects in changing and challenging economic environment.

[16] According to OECD [7]
[17] Intraregional refers to changes within groups of all districts classified either as predominantly urban, intermediate, or predominantly urban.

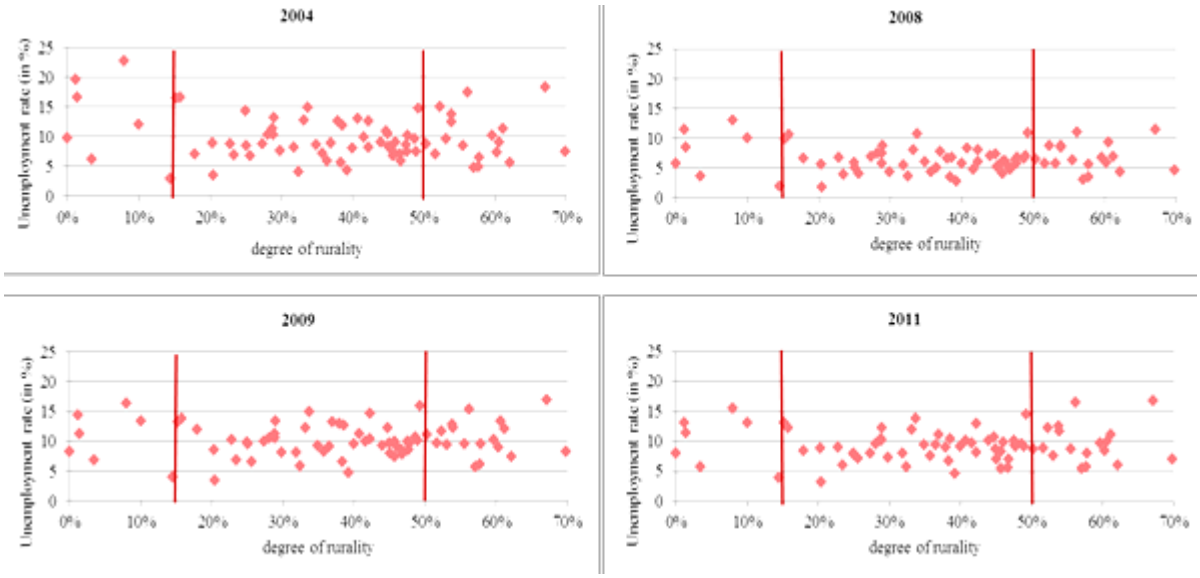

Figure 4: Unemployment rates in LAU 1 regions of different degree of rurality

The set of maps (Figures 5-8) displays the effect of the crisis on these groups that are considered to be mostly affected. These are the people with low education (Figure 5) that face the increasing demand from employers for appropriate qualifications and skills. On the other hand, this group is more often involved in seasonal work or not officially registered because they participate in black labour market that slightly constraint the interpretation of results. The next group of unemployed women (Figures 6) represents those labour market participants that face the greatest challenge when searching for the optimal work related to their household and family demands. The last two maps display different age categories of unemployed. The first one are young unemployed (Figure 7), mostly threatened because of their low skills, low experience and sometimes also inadequate job offers in the place where they live. The second group encompasses people close to their retirement (Figure 8) who are mostly negatively affected by the lower adaptability to new working conditions (new technologies, new processes, etc.).

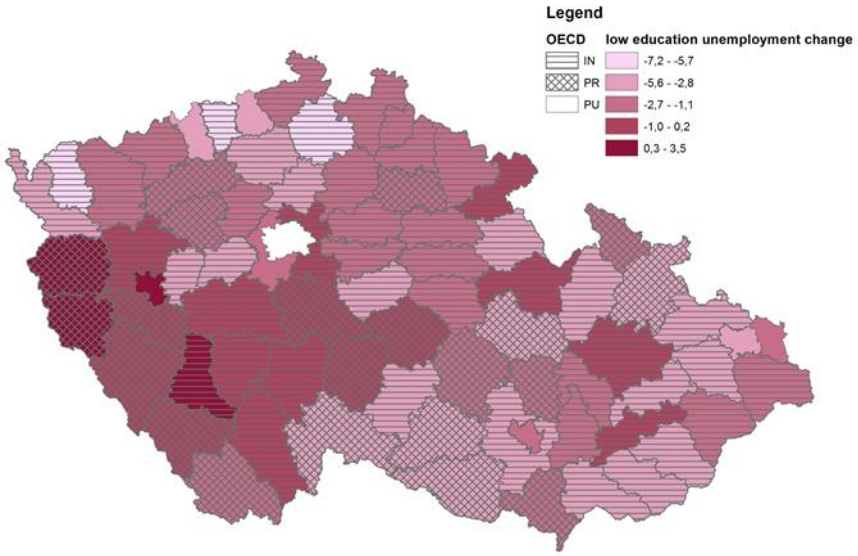

Figure 5: Percentual point change of low education unemployment between 2008 and 2011, by LAU 1 regions

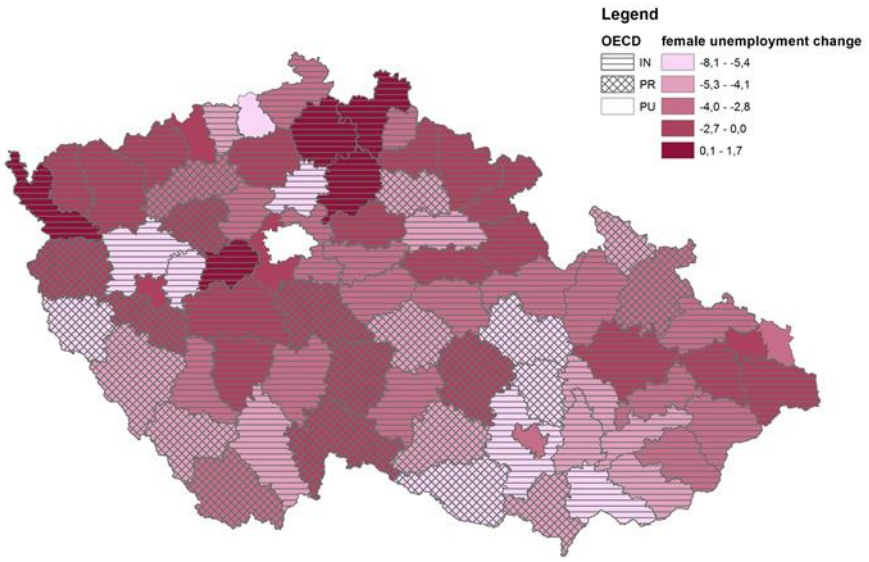

Figure 6: Percentual point change of female unemployment between 2008 and 2011, by LAU 1 regions

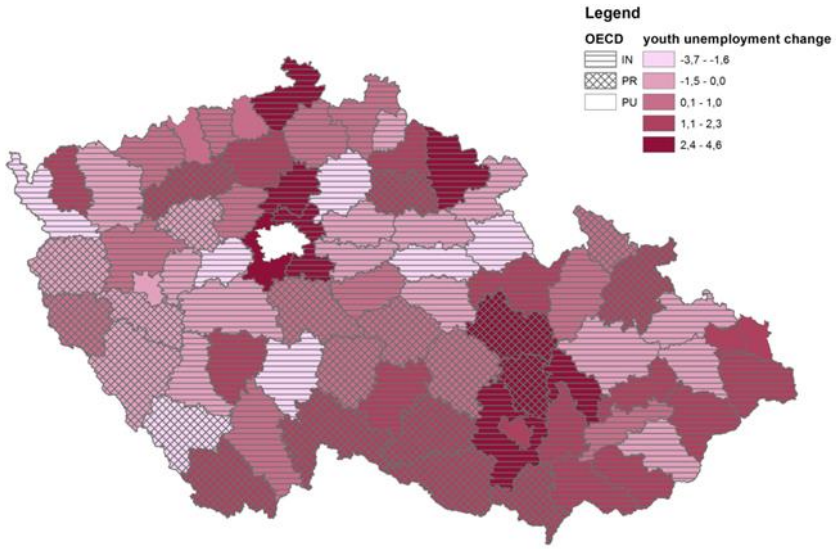

Figure 7: Percentual point change of youth unemployment between 2008 and 2011, by LAU 1 regions

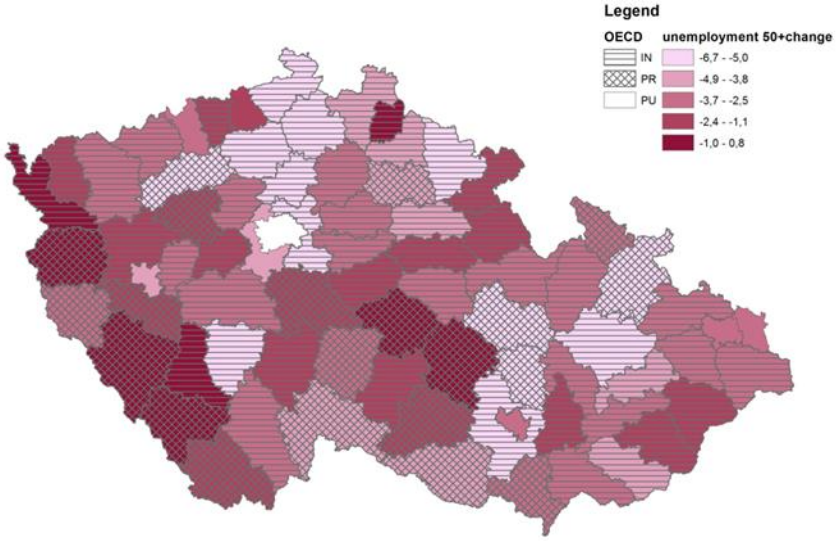

Figure 8: Percentual point age of 50+ unemployment between 2008 and 2011, by LAU 1 regions

The regional projection between years 2008 and 2011 shows very diversified patterns with regard to the effect of the crisis on selected labour market participants. The regional patterns are most compiled in the group of low-educated people where we may notice some clusters of a relatively high percentual point decline in East and South-East regions whereas the regions on the West and South-West are characterized by a lower decline and even the increase. The female unemployment is overall on decline, with an exception of a few regions in Northern part of the country. These regions were characterized by heavy industry in the past and so we may expect that the character of regional economy is not favourable to unemployed women and due to structural changes, not to unemployed at all. From another point of view, the decline of female unemployment may be interpreted as the result of conditions on labour markets, especially in those regions providing opportunities of part-time jobs and enhancing the adaptability of women to different job requirements (requalification courses, specialized computer courses, etc.). Youth unemployment change indicates how easily the young people are able to find a job and the availability of the work for young people in the region. We can see that the most difficult situation during the economic crisis is in the proximity of the main economic centres (Prague, Brno). On the other hand, the lowest values may be explained by the fact that the youth unemployment is keeping relatively stable records (either high or low) over years. The decline may also refer to the out-migration process when young people decide to permanently move out of the location with unsuitable labour market to their qualifications. The number of people aged 50+ in the group of unemployed decreased between 2008 and 2011 in almost all regions. The possible explanation may be that older people rather choose the option of early retirement than long-term search for a suitable work position.

Generally speaking, regional trends reflect the revitalisation from the crisis with only very few examples of regions where the unemployment of certain social groups is still increasing although the crisis reached its peak in 2009.

2.5 Cumulative negative trends and creation of most vulnerable spots – any regional evidence?

According to the maps displayed on the previous pages, we may identify the most vulnerable spots that are also most fragile to a changing economic environment, ongoing global changes on markets (mainly labour markets) and that are under the greatest threat of further decline of their development potential. The most negative scenario is present in ageing regions, combined by the negative population trends that impose a higher dependency burden on preserving an active-age population, and a slow regeneration from the economic crisis followed by the preserving vulnerability of some social groups on the labour market. With respect to this description, we may observe these spots located on national borders and especially in old industrial districts, and on the edge of the Czecho-Moravian Highlands.

2.6 Position and prospects of rural regions

Predominantly rural regions are under several threats. They gain the percentual point change between 2001 and 2011 that in most cases describe negative trends. The exception seems to be the dependency burden for which the value decreased in several predominantly rural regions. However, with a more detailed analysis it may be proved that this decline can be explained by very sharp percentual point decline in the young-age dependency followed by the increase of the old-age dependency.

This is a very important signal, especially in relation to the labour market, where it generates the threat of enhanced demographic pressure. The most affected are the predominantly rural regions located on the national borders and the Czecho-Moravian Highlands. On the other hand, some positive developments (either of positive or relative stable values) are observed in districts located close to the axis Plzeň-Praha-Mladá Boleslav that further enhances their development prospects.

2.7 What/Whom to blame for that?

It is hard to find any single denominator that would serve to explain trends in the chosen processes either of positive or negative nature. In fact, there exists a group of internally related factors that may be able to detect the ongoing changes. Among the most important ones are:

- Restructuring of the national economy, the changing economic power and importance of regions and industries within them (especially preserved negative developments in old industrial districts).
- Revitalization from external shocks either of political or economic nature that affect the development path for a longer or shorter period of time
- Geographical position within the regional, national and international networks (infrastructural, economic, trade, etc.).
- Local and regional endowments in the form of natural and human capital.

As we already know, and the graphical illustrations only support our understanding, the character of population density and so the rurality itself is not necessarily the most pronounced factor of decline. However, in the presence of other factors simultaneously the regions with an increased degree of rurality face the greater vulnerability.

3 CONCLUSION AND POLICY RECOMMENDATIONS

The development prospects of Czech regions are very uneven. This fact may be explained by the strong polarization of economic and geographical cores (Praha, Brno) leading also the positive prospects of adjacent areas. On the other hand, regions located either on regional or national borders are more threatened by ongoing changes as well as industrial districts that are most affected by structural changes. Therefore, the necessity of regional dynamics assessment is crucial. The same holds also for assessing development prospects of typological regions that cannot be directly linked to positive or negative prospects only with respect to the character and degree of their rurality.

By creating strategies for the mitigation of identified negative trends, it is important to consider the level up to which they can be modified. For example, ageing is very hard to be reversed (we may only improve the quality of life of the ageing population), for the rest (population change connected with population flows and change in dependency burden, labour market conditions) we may intend to develop strategies with regional sensitivity. The aim should be to overall increase the quality of life in these areas, by both boosting their social and economic development potential.

Another important aspect of a development strategy for rural areas is the creation of a rural-sound strategy of revitalization. This means that it should respect regional and even local conditions, and empower the strength and opportunities that are of the main source of either regional or local development potential.

Finally, we need to particularly focus on the most vulnerable social groups and especially on their employability that is directly linked to the quality of their lives. Therefore,

the important actions need to be taken with respect to creation of the employment (supporting creation of enterprises, new jobs), improving employability (requalification, training, competence development), and most importantly, find a medicine to cure the most pronounced negative development trends generated from the accumulation of problems, especially in relation to combined youth unemployment and out-migration.

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BREAD RATHER THAN CROISSANT! REPRESENTATIONS OF ROMA ETHNICITY IN THE PERCEPTIONS OF RURAL HUNGARIAN PROFESSIONAL MUNICIPAL CARE AND SUPPORT GIVERS ON NORMAL VERSUS DEVIANT PARENTING AND SEXUALITY

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ABSTRACT

This paper is to unravel in which way the perceptions of professional care-providers on proper parenthood and sexuality are inflated by representations of poverty and ethnicity and in which ways these influence judgments concerning the ability of families to provide care for their children. The paper is utilizing interviews with professional care and social support providers as well as information gathered through participant observations.

1 INTRODUCTION

Former state socialist countries indicate a higher frequency of taking children under institutionalized care compared to the EU average. There is a high degree of institutionalization of children in Hungary, where 44 children out of 10000 are institutionalized compared to 8 out of 10000 in Sweden, where the degree of institutionalization is among the lowest. Under state socialism the majority of institutionalized children were of Roma origin. With the intensification of social differentiation and impoverishment, which is disproportionately burdening Roma communities in the post-socialist period, the overrepresentation of children of Roma origin among those taken into institutional care continues. Recently efforts are made to counteract the placement of children into institutions. Instead, children are preferably placed into the care of foster parents. In 2005 there were 17456 children who had a state appointed legal guardian, the majority (65.9 %) of the children were of Roma origin, a proportion which is an overrepresentation compared to an estimated 7% of Roma ethnicity in the population [1]. This proportion is an overrepresentation even if current estimates indicating that the proportion of children of Roma origin constitute close to half of those children born in Hungary today.

Although the law does not permit the institutionalization of children only on social grounds, poverty and a family's inability to provide for children is identified as a common reason for intervention [2]. Increased social marginalization has been the side-effect of the structural transformation that followed the transition from state socialism to capitalism that led to the exclusion of large segments of society from the labor market. This exclusion has been severed by the devolution of universal social rights and through the establishment of a neo-

liberal welfare model, with increasing social conservatism during the current governmental period. In this transition, individual, rather than societal responsibility for poverty has become emphasized. Not the least, parental negligence and the misuse of state support for childcare have been profiled in the moralizing media discourse about poverty, where the Roma community is specifically targeted.

According to the administrative reform of the post-socialist period, the duty to provide social welfare is delegated to the municipalities, which are to administer social provision according to state regulated principles and through the requisition of such means according to the estimated need of the given citizenry in their jurisdiction. Thus, social provision is not provided as universal right, but is to be acquired as a result of means tested decisions. Welfare decisions concerning deservingness for eligibility are handled by municipal officials, just like decisions concerning deservingness as parents are handled by childcare authorities, where local welfare servants form a professional group with power to decide over the life of those in need. This interconnectedness of professional groups makes a joint analysis of decision making concerning social welfare and childcare issues of interest[18].

When critically analyzing the approaches of professional care takers administering the duties and resources of the state the scarcity of the resources and the structural limitations of municipalities for solving these issues is often put into the forefront. Without disclaiming the limitations placed by these structural conditions, this paper is nonetheless focusing on the acting space that state officials nonetheless possess when administering the resources and duties of the state. I am going to view the role of professional care providers as members of moral communities [4] with perceptions guided by normative values forming views on individual clients based on these perceptions, having means to enforce rules to promote conformity. Furthermore my interest is to explore how representations of ethnicity, gender and poverty play a role in forming judgments concerning proper parenting and sexuality and how these judgments serve as grounds for making decisions on taking children into institutional care or leaving them in the care of their families.

Since I have not access to individual case files motivating decisions I cannot analyze the praxis of professional care providers concerning the surveillance of problem families and their formal decisions about the placement of children under institutional care. My data allows me therefore only to scrutinize the moralizing discourses which the professional caretakers engaged in during my interviews and my participant observations.

2 POVERTY, GENDER, ETHNICTY AND CHILDCARE IN THE LOCAL WELFARE CONTEXT

"*Everybody knows that the majority of children is born in order to provide income*" argues a small community major writing an open letter to the Parliament urging new laws, which would abolish family subsidies for families of children under three, and would channel child support payments to institutions rather than families [5]. She claims that many use childcare subsidies "*to go straight to the local pub on pay day of subsidies only to behave aggressively with people after getting drunk*". This ethnified discourse is combined with a social conservative rhetoric arguing "*that many have a better living from living on subsidies than from real work*" and thus the current system of benefits is encouraging irresponsible family planning practices [6]. This argument echoes earlier parliamentary debate, in 1996, when the generous state socialist childcare subsidy policy was reformed abolishing the

[18] See on this point a similar argument concerning the interaction between different institutions made for the Swedish case of the police-register on Roma, see [3].

employment bound EPA, while maintaining the flat rate FRA. Maintaining the subsidy was a central pro-natalist measure, while arguments for it were either framed in a social need context, as by socialists or in a nationalistic context, referring to the dying out of the nation, by FIDESZ. However, the danger of being misused by "*certain groups in the population to make a living by having a string of children, with all the undesirable consequences that go with that*" [7] echoes similar concerns to that raised by the mayor above. Referring to concerns with certain groups, i.e. the poor allowed not having to identify Roma, yet, implicitly doing so.

During this summer 10 prematurely born children died within a week in the regional hospital of the town of Miskolc in North-East Hungary, out of which 9 children were indicated to be of Roma origin [8]. Accusations were formulated on the one hand against the hospital and in extension against the medical profession for discriminatory negligence. On the other hand, hospital gynecologists warned for the alarming consequences of poverty, from which the mothers of these children came, and the signs that they have not been attending prenatal maternal ward and observing dietary and health recommendations. Many of the mothers were also under adult age.

An ethnified moralising of standards of parenting and mothering has also real life consequences. Eastern Europe and Hungary specifically has comparatively high frequency of institutionalization of children from families identified as not having proper childrearing practices.

Ethnified discourses on gender roles have been identified even in the context of Swedish gender equality discourse, where equality between men and women is central in defining progressive Swedish values characterized by women's high labour force participation and the availability of an extended and comprehensive institutionalized childcare system [9]. Immigrant women of deviant cultures and lower educational and social background are seen to represent deviant attitudes to the role of women in society. These attitudes are seen as patriarchal compared to the gender equality ideal of Swedish society. One key argument in the ongoing debate between the current dominant system of institutionalized day care and the alternative system of paying families who take care of their children themselves a "vårdnadsbidrag" (childcare subsidy), that the latter had been feared to encourage mothers to stay at home. Immigrant low educated mothers staying home on paid childcare subsidy are feared to prevent their children from the opportunity to participate in daycare and childcare services. Daycare provision is seen as an integrative instrument. Deviance from the normative Swedish gender ideal is also central in the construction of certain immigrant groups' otherness in the so called honor violence debate [10].

Similar to the Swedish case, images concerning Roma women's reproductive practices emerge intertwined with majority society's institutional practices and dominant discourses and are formed as elements in creating the image of Roma as the symbolic "others". Meanwhile, Roma women's living conditions are formed in intersection of systems of dominance beyond those formed in relation to the dominant society. Lidia Balogh & Angela Kóczé [11] identified the following as key systems of dominance which inflict negatively upon Roma women's integration and life chances: Human rights abuse including domestic violence, arranged marriages, including forced marriages and child marriages, trafficking and enforced prostitution, threat by right wing extreme groups, multiple disadvantages in education, lack of access to employment, lack of access to social benefits, intersectional discrimination in reproductive health, lack of access to finances. These exclusionary practices emerge along multiple intersecting systems of differentiation, such as class, ethnicity and gender [12].

2.1 Different conceptions of the welfare state

In Hungary key welfare tasks are delegated to the municipal level. The possibilities of municipalities to provide social welfare are largely limited, since the economic preconditions and the system of entitlements are defined by national law. These entitlement based revenues might be complemented by project based revenues, which assume locality based initiatives [13]. These changes to neo-liberal governance implied the municipalisation of welfare, which was also identified to lead to a fundamental division in society, where the state resigned to conceive overbridging efforts for the integration of the marginalized [14], designating the responsibility over the wellbeing of these vulnerable groups to the abilities of poor municipalities and by this dividing the country into two societies [15]. This division is underlined by spatial segregation, since the most impoverished municipalities are also regionally segregated.

The Hungarian Government launched a new regional development policy in 1996, signifying a turn towards the EU trend. With Hungary's joining the EU, the power relations of local resource distribution were rearranged and became multi-participatory ([28], 174-177). Projects available through a quasi-market distribution became the primary means of accessing resources, leaving behind the former system of support that guaranteed revenues calculable on universal principles. The projectification of rural development can be considered as an accompanying symptom of the neo-liberal turn in welfare systems, which was signified by the retrenchment of the universalistic benefits of Soviet-type welfare regimes toward means tested systems [29]. Just like in the EU, the new style of governance is characterized by a plurality of interests, actors and networks, strengthening the role of local particularities in local welfare regimes: "*Poverty, as social problem becomes a small community issue … the conflict between poor and not poor appears as the malfunction of the local communities*" ([29], 39).

The moralizing work ethic of state socialist work societies made long-lasting impact on local societies. This work-centred ethic has been reassured by liberal and conservative turns first by the former socialist-liberal coalition in introducing limitations to social benefits in the frame of the "Back to work" program. The current national-conservative government further tightened the conditions of eligibility. According to the latter eligibility to social assistance was decreased to ca 80 euro a month and eligibility limited to those who have been engaged with legally approved labour (wage labour or voluntary work) for at least 1 month during the past year. Meanwhile, the so called START program provided additional boost to so called disadvantaged municipalities to arrange municipality communal work opportunities providing a wage from 160 euros up to 200 euros a month depending on the level of skills of the employed. Municipality communal work opportunities of this kind, nonetheless, do not cover the number of unemployed eligible for the support, opening up for local officials' judgment concerning the deservingness among those eligible. Among those benefits, which still belonged to universalistic, such as family subsidy (between ca 60 euros per child a month) and childcare subsidy payments (75 euros per child up to 150 euros), further restrictions were introduced in 2013, which limit the accessibility to the child's participation in school, withdrawing the payment in case of the child had missed more than 50 hours a year from school without medical certificate.

Lévai [17] argued about the changing role of welfare professionals. At the down of state socialism the profession was formed in order to critically assess the weaknesses of society and provide for the marginalized. In contrast, social workers became all the more the "servants" of the state, aligned with carrying through the surveillance functions of monitoring benefits, rather than genuinely engaged with taking part with those on the margins.

Lévai's critique of welfare professions corroborates with critical views on the welfare state internationally. Yvonne Hirdman [18], analyzing the development of the Swedish social state "folkhemmet", elucidated the state as a "well-intending" suppressor. The state promoted the integration of individuals into society according to its utopist visions. By social engineering, experts obtained a superior position to form citizen's lives with the means of social policy and praxis through regulating its citizen's lives, by this limiting individual freedom and autonomy. The life of families and children became politicized. Norms of raising children became expressions for social problems [19]. From this perspective social policy is seen as a means to exercise power [20], where Berge [21] differentiated three levels: Discursive, social organizational, and social work praxis. The constructivist approach is critical to the way how discourses are interwoven with power [22]. Norms and perceptions form praxis and through the frame of institutions they have disciplining power. Foucault [23] argued, that prisons and healthcare are representing broader social interests, and are not necessarily serving primarily care about the individual. The professions primary interest is to form a "*control system where the primary goal is to protect society from the 'sick and deviant' or to normalize and adjust the individual to society*" ([20], 19).

The decentralization of welfare to the community level in post-socialist Hungary gave power to local officials to negotiate entitlements to benefits. These negotiations lead to a differentiation among deserving and undeserving poor [24]. Theories on the role of ethnicity for entitlements emphasize the dynamics between majority and minority societies and the role of institutions: "*Existence and maintenance of poverty and exclusion (…) is not only rooted in commonly known structural factors, but also results from the working methods of educational and social security institution*" ([24], 101). Social welfare agent strategies were argued to play part in the reproduction of poverty. Conforming alternatively none-conforming to the norms of majority society was seen to result in differential access to welfare benefits. These divisions were cutting through ethnic divides, differentiating between "proper" (*rendes*) Romani and "real" (i.e. none-proper) Romani [25]. Through these constructions, as the case of the social land program exemplifies, even if the grounds of entitlements for the project were not sanctioned by ethnicity per se, they were made available primarily for those Romani who were ready to adapt to the majority society's values.

The welfare praxis of the neo-liberal welfare state is based on the means testing of the individuals' entitlements to rights and benefits, opening for moralizing praxis, where deservingness is introduced in enforcing rights. Clientisation is identified as the process through which welfare state agents compartmentalize those cases they handle. This involves an exercise of power; where welfare agents have an acting space to interpret the script of the law. Clientisation implies also the individualization of cases, where the spotlight is directed to the individuals' moral and social eligibility, rather than on the faults of the system, creating special forms of vulnerabilities.

3 RESEARCH PLAN AND METHODS

3.1 Methodological issues

The analysis presented here is based on field work material, which is composed of interviews and participatory observation. I have conducted a series of interviews in the municipality of Palotás, which is represented here by a pseudonym, in order to protect the integrity of those participating in the study. I have visited the community four times between the spring of 2012 and the summer of 2013. I have recorded an interview material of ca. 16 hours, where the concern of interviews ranged from social development projects, municipal welfare provision, school strategies to the issue of child-protection and reproductive health. I have also conducted a participatory observation during occasions when professional care providers interacted with their clients.

The underlying interest of the research was to study the life-conditions of marginalized, long-term unemployed members of the community, where ethnicity and the condition of the Roma community was also a key concern. In Palotás I have conducted interviews with the local mayor, the school principle, the local nurse (*védőnő*), the social worker responsible for child welfare as well as family welfare issues. I have also made shorter interviews with five Roma and Hungarian origin residents in the so called "colony" part of the settlement.

The analysis in this paper is focusing on the issue of professional care providers' perception of the situation of Roma minority in their community with special attention to the issue of reproductive health, sexuality and childcare. The material, upon which this analysis is based, contains limitations as to which kind of questions it allows to answer. I have not been able, to the date of this analysis, to conduct research concerning the cases of taking children to institutional custody. Thus, I cannot answer the question of whether these welfare agents have or not been engaged in discriminatory practices. Whether they were more likely or not to take reprehensive measures against Roma parents compared to none-Roma parents, or whether they have been engaged in taking Roma children under institutional care on unfounded and prejudicial grounds.

3.2 Professional care providers in the local community

The analysis below focuses on the understandings of three key agents of the local welfare state in Palotás, who have crucial importance for the wellbeing of families: Social care worker with responsibility for child welfare and family welfare, the local family nurse (*védőnő*) and the municipality mayor.

Palotás is a small municipality counting 1300 people, where the proportion of Roma minority is around 30%. There are 27 Roma families with children until 6 years of age belonging to the district of the local nurse "*védőnő*". These families live in two different neighborhoods: 20 families live in an integrated community in the main settlement, while 7 families in an enclave 3 km from the main settlement, in houses that had belonged to a closed down mine.

The tasks of the municipal nurse "*védőnő*" are to keep ongoing contact with families with children and to provide maternal care for pregnant women. She is also working in the local school as nurse. This means that she has contact with children until they reach grade 8, i.e. until they become ca. 16 years old. As nurse, she is also involved with the sexual education of children within the school curriculum. Her duty is also to keep close contact with the childcare authorities, which work for taking charge for issues concerning the safeguarding that families provide safe upbringing for children, according to human right provisions for the best of children. This work includes face to face contact with every family with children in their homes. Acting as authority includes the responsibility to provide health

care support and information to families on the one hand. However, on the other hand, due to the close contact of nurses with families, they act also as whistle blowers towards the authorities. Thus, in case of observed hazards for the well-being of the child, they can initiate that the authorities take the child and her/his family under supervision. The final stage of such supervision is, in case of none-compliance, to take the child under state custody. Thus, the nurses have an importance role in institutional surveillance.

Social workers of the *Childcare Authorities* are the ones who receive notifications on child abuse or child neglect from the community. These notifications often come from other professional groups (teacher, daycare pedagogue, nurse, and police). The officer is obliged to create a file for the child and initiate contact with the family. A typical case would be if the child has missed to attend school and has not provided a medical certificate. Uncertified absence for 50 hours a year can lead to cut of family allowance and the initiation of taking the child into custody. Small thefts or fighting in public is another reason for notifications. Bringing families under state supervision or implementing the apprehension of children has been formally ordered by the municipal attorney (*jegyző*) until 2013, when this function was moved to a regional level authority.

Dealing with families living under austerity due to long term unemployment, many of the issues that concern the satisfactory living conditions for the children are related to these families' ability to provide properly for the basic needs of children: Food, clothing, shelter, medicine and participation in school. Social workers responsible for *family welfare as well as social welfare* are those who channel the benefits to those who have entitlements, which entitlements need to be certified. They are also making decisions on extra, occasional support payments. These means are very limited due to the scarcity of municipal resources. Furthermore, they can be pro-active in attracting extra support from various charity organizations or can initiate various project applications to developmental foundations and grants. These latter tasks however vary largely according to personal engagement. The personal engagement of the local mayor, who is an elected representative of the inhabitants, has a central role in exercising pressure and forming opinion concerning social welfare issues.

Acting on behalf of state institutions state social workers and district nurses are active in making judgments on the division of social benefits according to entitlements. In their role they can be seen to exercise disciplining power over those citizens whose life is depending on their judgment. All the more is this case for families with children living in deep poverty. These families are in dependency both as citizens depending on public support for their survival and as parents aspiring to maintain custody over their children in a desperate situation.

4 RESULTS AND DISCUSSION

4.1 The symbolism of the "Gypsy" and having Roma origins in the understandings of professional care providers

The categorization of people into Roma alternatively "Gypsy" (*cigány*) and "Hungarian", alternatively peasant (*paraszt*) is both paramount in form of Roma self-identification and as labeling used by majority society. Nonetheless, when inquiring about the ethnic composition of the community, the mayor started with pinpointing the difficulty to provide such information. He/she highlighted that to categorize people or to gather information according to ethnic origin by public authorities is against the constitution. However, in diverse applications, municipalities are expected to provide information concerning the size and

social composition of the Roma community. Although Roma is a multifaceted group with both vertical and horizontal differentiation, Roma are overrepresented among marginalized communities. Thus application for projects for the improvement of conditions of Roma specifically assumes the identification of Roma as a specific group for governmental purposes. However, when the concerning application or provision of data is over, she is expected to destroy such files. Ethnic belonging and identity is also recognized as ground for specific civil rights. Such right includes in Hungary the formation of municipality based minority self-governments. The nomination to such authority assumes that citizens self-identify themselves as belonging to the minority. Civil society initiatives form also on base of self-identification as Roma, or through identifying Roma as a preferential target of civil society initiatives.

Professional care takers emphasized that they are realizing the social law and administer social benefits according to entitlements based on the law as well as interact with parents according to norms prescribed by the law, without differentiation according to ethnicity. Nonetheless, in discussing normative aspects of their work different client groups emerge associated with geographies and ethnic and gender specific features.

While professional care takers make me understand their awareness of secrecy surrounding the gathering and categorization of citizens according to ethnic origin, they are giving recognition to the presence of a Roma minority, both due to the existence of the local minority self-government, the self-identification of Roma members of the community and through the meanings that the members of majority society are attributing to "Romaness" today and historically. My concern was to bring to light what kind of meaning did they attach to the term and how these meanings obtained relevance for how they formed their perceptions about their clients.

Both the district nurse and the mayor differentiated between having Roma origins (*Roma származás*) and behaving as a "Gypsy" (*cigányos*). Being of Roma origin was referring to the degree to which one had or not Roma ancestors. There were many cross marriages, which made a differentiation along lines of origins complex. Whiteness is seen as a potential although not necessary indication of Hungarian origins, as is exemplified by discussing a custody case:

"*The girl was Hungarian, that is to say white, since the father was also white.*

She is also half Roma, since the mother of the child was also Roma.

I do not know. Was the mother of Roma origin?

She was the daughter of X … but she was taken into institutional care. But X is the mother. She is also Roma."

Nonetheless, if one had a known Roma origin ancestor, it meant having Roma origins, even if the person has not been brought up in a Roma family.

Meanwhile, Roma origins were not identified as a necessary prerequisite for being considered behaving in a "Gypsy" way (*cigányos*). Due to this distinction made by my informants I identify in this paper as symbolic "Gypsyness" (*cigányos*), which I see discursively created as the other compared to the normative Hungarian. Conforming to the norm, to expectations, i.e. behaving as a symbolic "Hungarian", was associated in the narratives with having a tidy garden and house, industrious, being responsible, planning with resources, self-supportive, not abusing the welfare system, being law-abiding, self-controlling. In contrast, those seen as symbolic "Gypsy" (*cigányos*) are perceived in opposite terms: Having untidy gardens and houses, being lazy, abusing the welfare system, not

shying away to break the law, temperamental, not having a plan for the future or economic consideration about subsistence, having an ad hoc attitude to life, spending money unplanned and in a way risking the subsistence of the family, finding loopholes for subsistence and being irresponsible concerning the future of their children.

While much of these apostrophes were named in association of those residents having Roma origins living in the colony, nonetheless when discussing individual people who are identified as of Roma origin, this terminology comes more often in the way in the descriptions, than being an applicable way of describing people. Individuals, let it be persons identified as Roma persons in the colony or outside of it, are associated with characteristics completely contradicting this very category. Several elderly Roma women, now grandmothers or grand-grandmothers, are depicted in very positive terms, also as contributing to the transfer orderly values:

> "*The grandmother had the good intention, since she has been brought up in that old world, when she had a workplace, and she pursued her children to work. Despite of this, the younger generation did not take her example. Perhaps with the exception of her grandchild, who she raised: 'You will get money my son only if you work. You must work. You have two children, you have to support them, your wife…' and he [the grandson] is going ahead in life.*"

Neither did being of Hungarian origin exclude, being classified as being socially "Gypsy" (*cigányos*). A man of Roma origin became well accepted in the community and considered as socially "Hungarian" (*elmagyarosodott*), while his Hungarian origin wife is seen as having become socially "Gypsy":

> "*I do not mean that he [the Roma origin husband] does not have the Gypsy temperament, but [this temperament] is manifesting mainly in this behavior of his wife… she has fully taken over the temperament…. When they are in company, she is always the one who is making trouble, even though she is of fully Hungarian origin.*"

Symbolic "Gypsyness" is both fixed, since it is formed in relation to the normative values of being "Hungarian" and with connotations to Roma origin, but is also unfixed, since it is not in a deterministic way related to Roma origins, it is challenged by experiences of inhabitants of Roma origin not fitting the label, as well as by historical images of alternative connotations attached to symbolic "Gypsyness".

One challenge to the category of symbolic "Gypsyness" is related to the geographies of Roma origin settlements. There are two major settlements inhabited by Roma origin families in the community. Historically Roma settlements lied in the outskirts of the villages. In Palotás the former Roma colony grew together with a former mine area. When these mines were closed in the late sixties, the families from the colony and the mine area were moved into the village and the families were offered so called "cs houses", which were half-comfort 30 m² houses located in one street. Although, the former mayor's project was received by bad feelings by the local Hungarian residents, with time this part of the village became an integral part of the village. The families had well-paying jobs in the neighboring mines and became accepted as proper: They became "Hungarianised" (*elmagyarosodtak*), i.e. conformed to the norm.

The professionals see the current conditions of the colony as a dismay of former glory; they also see the conditions of Roma inhabiting the colony as a dismay compared to a former glory. Thus, the historical condition of the Roma in the municipality is described in positive terms: They were employed, there was money in the families, they were making improvements in their standards of living and housing. This positive image is associated

specifically to some of the good old Roma women, portrayed like matriarchs. Today's Roma grandmothers were seen as hard wage workers and care-takers of their families:

> "*She has worked in the G mines, she has collapsed physically since then, but it is very strange for me to see her like this, since I remember her from before, she was really very pretty, in fine clothes and hard working. …. She is working very hard even today. She is …. collecting mushrooms, when the time comes, is all the time in the forest, picking what is possible to pick.*"

Thus, Roma livelihood is remembered as secure, and those in the generation that became adults during state socialism are seen as leading orderly lives, with values holding out today.

Meanwhile, the houses that belonged to the closed down mine have not been destroyed, and these houses turned to a large degree into social housing. When even the other mines and factories in the region that provided jobs for locals during the state socialist period all closed down in the broader vicinity unemployment became generalized. Those inhabiting the former mining colony housing area were hardest hit. During the past 20 years close to all of those inhabiting the area had been without formal employment, not counting the welfare related short term contract community service employments (*közmunka*). Meanwhile, the resource weak municipality had no resources for improving the standard of social housing there, leading to large scale deterioration of living conditions. The majority of those living in these municipal houses remained Roma. A process of social disintegration and impoverishment, which in its underlying forces was driven by social and economic dislocation of the population due to deindustrialisation, became labeled as ethnified and as a process of "Gypsyfication" (*elcigányosodás*). Thus, although local authorities are aware of the impact of economic crises, those unemployed became problematized and blamed for their marginalisation.

4.2 Parenting and moralizing about poverty

Being poor is not seen as purely an outcome of the acute lack of employment opportunities, but also as an outcome of undeserving attitudes. Judgment about the social and moral deservingness of parents is put at its edge in case of decisions about taking children into institutional care. However, social and moral deservingness as parent is also constantly evaluated in the process of deciding about social welfare revenues.

Welfare dependency was seen as a personal weakness even if the lack of jobs in the vicinity was known. Travel expenses seem to be a problematic issue in accessing potential jobs. When families well find themselves in welfare dependency they are expected not to live beyond their abilities.

> "*We have the municipal car available if some mother would not have the money to pay for the transport to health control. And then I. comes and would like to ask for aid to be able to take her child to the doctor: 'Yes but it is not only the transport' she argues 'Aunt K, it is not just the transport. I cannot buy the child a kifli (croissant).' I tell her: 'Why do not you put in a slice of bread at home, God Bless you?' They must go to the pastry shop, where it is the most expensive. – Yes, and they have to buy Fornetti (even more expensive specialty with filling). Buying the kifli (croissant) is not even enough.*"

Thus mothers coming applying for small sums of money are turned down with reference to moralizing principles about "luxury" and irresponsible consumption. Mothers on social benefits are expected to keep to the budgetary limits of their meager incomes. An expression of irresponsible life styles of those living in the colony was named as "Hawai-

lifestyle". As one of the officials argued, the families make a grate party for everyone when money comes to the house with alcohol and chips, items that are seen as luxury for families living on social benefits. The large part of the income is burned up in these parties, leaving the families without money for the rest of the month.

Many families are seen not paying attention to their environment, leaving garbage lying around. Some degree of gardening culture seem to be developing however, which the local mayor attributed to her influence on the community, since some of those living in the colony could participate in municipal work with ecological cultivation, where they learned the skills for gardening.

4.3 The child's best: Parenting and deservingness: institutional custody or family care

One of the cases was clearly associated with those symbolic features that belong to the symbolic "Gypsyness". In this family, the new-born child was not allowed to be taken home from the hospital to his/her biological family. In this case the father was only 15, and the mother 17. The father was still of obligatory school age. Neither had the juvenile father, the mother of the child or the fraternal grandmother, where they were residing, employment. Their only income was the grandmother's social benefit income (80 euros for a month), which was to provide for the grandmother, her living companion, her son and his family. The grandmother of the child lost her entitlement to family allowance, since her son quit his studies, feeling inappropriate to sit in a school bank with much younger children, and being a father at the same time. Would authorities have approved of the child being brought up in the family, the juvenile father's custodial representative (his mother) could have received the childcare benefit for the new-born (under 40 euros a month). Beyond the economic conditions judged as inappropriate to raise a child, the family had other unsettling issues. A new cohabiting partner of the fraternal grandmother, where they were living, moved in. They have decided to take back the cohabiting partner's child from institutional care. However, the 12 year old daughter has been given back to the public childcare institution ("was left at the door-step") by the fraternal grandmother, who, according to the account of the officials "got tired of her". There were reported incidents of battering the child. There was an also a reported incident of the child playing out sexually in the school, which was perceived as indication of a lack of intimacy in front of the child in the family. Even the fraternal grandmother was allegedly battered by her own son, the father of the child who was taken into custody by the authorities.

This case indicates a rather troublesome family background, where the Roma origin of the family, is perceived as an indicator of and support to the perception of the image of "Gypsyness" discussed earlier. According to the welfare agent, the son was encouraged to early sexual initiation by his mother, not thinking that the consequence of sexual activity could be the conception of a child. Furthermore, not reflecting on the responsibilities such an event would draw with it in terms of caring for a child. Despite of having taken the first child of this father into institutional custody, the son and his partner are expecting a child again.

Seen from the perspective of professional care providers, the ability to provide for your family and your child is seen as a key feature of adult masculinity. This norm is also seen as signifier of "Hungarianness". Thus, in the view of the professional care providers the young father became infantilized and demasculinised. Early parenting is seen as deviant from this norm of proper age for parenting. Looked at from the perspective of Roma families, the juvenile fathers are not expected to shoulder the burdens of providing for a child to the same

extent. The larger family, in this case the parental grandmother, was ready to shoulder this responsibility, had she been in that economic situation.

While the above case corroborates with the preconceived images of symbolic "Gypsyness", the welfare agents' familiarity with Roma families, where children are properly taken care of, despite of poverty, are not challenging this image.

The process is legitimated by reference to the child's best. However, local welfare discourses impact on the way how local professional care providers interpret the best of the child and which kind of practices evolve in relation to families with children. It is clear that among the discussed cases which professional care providers handled neither being of Roma origin, living in poverty or living the impoverished enclave had been used as single indicative of taking a child to custody. Nonetheless, there is indication decisions might have been casted in arbitrary fashion. Welfare agents accounted for a sudden increase of the number of children taken under institutional custody during the period of one year service of formal vice public attorney. Under her short period 10 children were taken from their families in two neighboring communities. Her praxis made such an impact, that, according to my respondents, parents were warning their children if they were misbehaving: "Behave orderly my son, otherwise the woman comes with the sack!" referring to the attorney. Although, the attorney replacing her was described as socially more sensible, and more restrictive in ordering custody, the taking of children into custody is continued to be applied by the authorities.

Recently, two sisters, 4 and 5 year old were taken into custody in a family with a Hungarian origin father and a Roma origin mother. They perceived that the children were not being taken care of. The mother seemed absent, while the father was an alcohol abuser: "*The father tried to raise the children, but instead the children were raising the father. The father was on the way home drunk trying to keep his bike straight. The older girl tried to take care of both the little sister and the father.*" They had no proper clothing and were malnourished. The professional care providers argued that the children came to proper foster parents, similarly to all the other children who were taken into custody. This is a practice that conforms to current laws facilitating the placement of children to foster parents rather than in institutions. In this case, even if the alcoholic father was of Hungarian origin, the case was associated with the symbolic "Gypsy", since the father was seen as having become "Gypsyfied". This case indicates that the term of being "Gypsy" is not necessarily attached to a person's Roma origins. It also indicates that marriage between Roma and Hungarian origin persons is perceived to contribute to shifting identities.

4.4 Sexuality as an arena for the construction of symbolic "Gypsyness"

One of the fields of direct contact between professional care providers and Roma families is through of sexual consultation. Here several interrelated issues are of importance: What is perceived as the "normal" start of sexually active life, reproductive planning, attitudes towards conceived pregnancies and birth-giving and the views on parenting at school age.

The professional care providers expressed ambivalent views. On the one hand they indicated that the time of sexual initiation has been pushed earlier among the youth in general. They view this development as having been influenced by media and internet. Rather than being critical to this trend, they see it as a shift in normality and respond to it by offering sexual education in the school.

> "*I cannot say much new to them otherwise. When I come in grade 7-8, they look at me and question, what can you tell us? Since they obviously know among each-other, and the school-age boys are with no shame watching sex magazines, and sex on the*

internet. This became very open. This is true not only in case of the Roma. Roma and Hungarians alike."

In this education they not only inform about the biological aspects of sexuality, but also about ways of contraception. As part of the information they also show different methods of contraception both for girls and for boys. They also hand out condoms. However, they note, that those methods of contraception that exist are not realistically available for those young people who live in poverty. Although they can hand out one condom, which they obtain as part of promotion package of the manufacturer or part of an educational material, they do not have means to provide such free to youth. Neither can the young people afford buying these. Since the majority of children from long-term unemployed families in deep poverty are of Roma origin, this applies also to them. Thus, while there is in general terms an open attitude towards early sexual initiation, the lack of reliable contraceptive aids raises the probability of early pregnancies. Early pregnancies create extra challenges for school-age youth where the two major options are to initiate abortion or as an alternative to give birth to the child. While engagement with early sexual initiation might happen without recognition, early pregnancies bring the event into the forefront of the community.

Professional care providers integrate images of cultural difference in their ways of problematizing the responses of Roma youth and their families to early pregnancies. The professional care takers perceived a greater sexual permissiveness as being a part of the symbolic gypsy culture. They exemplified this image with experiences that they found have corroborated this image. Referring to a case of the 15 year old father of Roma origin, they got to know that the mother has been active in initiating her son to sexuality:

"*I was discussing with Roma mothers, how could X allow her son to conceive a child at 15? And then one of the Roma mothers said: 'How come how? She was the one who showed her own son, how to open up a bra'. She took the son to the city to a shop with women's underwear and showed him which kind of panties women have, already when the son was 13-14. And, when he turned 15 she, gave him as a present a girl, who was 2 years older, to take his virginity.*"

Another image, that can be seen as having more positive connotations, associates lesser prudence attached to the reproductive function of the body in Roma culture. However, even if having a more open and incorporating perception of giving birth could be seen as liberating for women in this context it is narrated as being a feature of "otherness":

"*While working as day-care teacher she found two Roma girls playing with a doll. A doll was on the stomach of one of the girls. And I asked, 'What are you doing?` ´Aunty teacher I am going to give birth.' And they had everything staged in a way that a giving birth would look like.*"

The professional care providers articulated their point with reference to their feeling of responsibility and planning for the future. They argue that school-age sexuality without reproductive control is irresponsible, since the potential parents do not have means to provide for the child. In case of youth from families in deep poverty, not even their parents have the means. Furthermore, giving birth to a child inhibits the possibilities of the parents to complete education. They see abortion as the choice of the individual, and find it an acceptable alternative for the pregnant youth. Nonetheless, they respect the choice of keeping the child. Where they attach moral values to the issue of early pregnancies is the ability of these young parents to take care of the child, and provide a safe future.

In this context, the above mentioned young boys' becoming a father is viewed as an act of irresponsibility. Becoming a father is seen as a social responsibility that involves

providing for the child and family, a responsibility that the young man is obviously not capable of living up to. Thus, his sexuality is made irresponsible, when not taking into consideration the responsibilities a consequent fatherhood would bring with it:

> "*When I asked M: 'How are you going to provide your child when you become a father at the age of 15?' Since at that time he was still going in grade 5 or 6. 'Why, what is needed for a child? Some medicine and nappies?'. 'Yes, of course' I said: 'And then father state is going to take care of the child instead of you?'*"

While, obviously referring to concrete cases involving Roma youth, these cases were discussed in reference to images of symbolic "Gypsy" culture. The aversion to abort is discussed as a deeply rooted value within "Gypsy" culture: "The life of the conceived child is Holy". Roma people are seen to have a great affection to children, a quality that is seen as positive. This quality seems to be invoking respect and acceptance, while at the very same time is also seen as an immature compassion. For the professionals giving birth to a child is inseparable from the ability of the prospective parent to perform according to the expected norms of parenthood. Thus, the compassion to give birth as part of symbolic "Gypsyness" is constructed at the same time as a positive quality and the sign of immaturity and argument for the infantalisation of the group.

Meanwhile, professional care providers are also referring to Roma clients whose cases do not corroborate with the image of symbolic "Gypsyness". The professional care takers are positively reinforcing a young woman of Roma origin, who gave birth at 18 first, having her second baby. She is described as one "going forward", tidy and conscientious. These examples are named, however, without challenging the overriding image of "Gypsy" ways, and ascertaining the values attached to the normative "Hungarianness".

4.5 Birth-control versus irresponsibly many children per family

As mentioned earlier, the aversion of abort has been identified as a positive characteristic of symbolic "Gypsyness". Meanwhile, having many children, whom the family cannot provide for properly, is seen as negative. In this concern, having many children, whom one cannot provide for and for the raising of whom the families depend on social benefits, is an image corroborating with media images of "Gypsyness" mentioned earlier. However, the practices of Roma families in the municipality do not conform to this image. The professional care providers consider that Roma and none-Roma women's reproductive behavior does not differ to large degree, both groups having on average 2 or 3 children, which they consider as being on a desirable level. However, they contemplate the time of first births as being of different type. They perceive Roma mothers to give birth at an early age, during their school years. They interpret this both as irresponsible on the part of the parents both in terms of the young parents not being capable of living up to the requirements of raising children and because this act contributes to the young parents breaking their education. They see this praxis to be also related to poverty, and the lack of economic means among the youth to purchase reproductive planning instruments [26].

According to the perception of the district nurse, love and care are seen as paramount for securing the well-being of a child. Nonetheless, when the social conditions of the families do not warrant the economic safety seen as necessary for securing proper upbringing of children, the enlargement of the family is perceived as undesirable and the application of birth control becomes indicative: "*The problem is not the lack of love [by the parents]. We pay the social assistance, but we see that we help without a meaning, since the problem is not solved, it is just a momentary treatment of a problem, and we see that the child is not among appropriate conditions.*"

Seeing the economic hinders in practicing reproductive control the municipality decided to provide financial coverage of spirals placed into the uterus of mothers. Such instrument can only be placed into the uterus of women who have already given a life birth previously. They perceive this as an opportunity offered to women in economically week positions, thus even Hungarian mothers could obtain. However, it is clear that the opportunity is made use of first of all by Roma mothers.

Roma men desiring (many) children and giving birth to a child in a relation is understood by welfare professionals to be considered by Roma women as a way to keep the husband or partner, without which the bond between a man and woman would be incomplete and unreliable. This is exemplified by a Roma woman, who decided to take down the spiral, even though she has already given birth to 4 children, when she moved together with a new partner: "*She wanted to catch and keep him by giving birth to a common child.*"

Youth without the economic background are not seen as mature to give birth to children. But if they happen to be pregnant, they insist on giving birth to the baby, from the very first moment. From that moment, not only the families are in hardship, but even the nurse and the municipality, whether they should let the child go home or not.

> "*Are the conditions satisfactory? If the conditions are not satisfactory, the child might have to be taken under state custody at once. And that strikes immediately animosity. The parent, the mother is angry at the nurse, at the attorney and the municipality, that we have taken their child. But according to our judgment, the child is at better place at the custodial family. …*"

However, taking a child into custody is causing conflict with the families:

> "*In order to avoid such confrontation we offer [spirals] in form of occasional social assistance. Not as they should do so. Rather, we explain that if they would like to avoid having a child in the near future, or if they feel they have enough children for the time being, then, if they ask the nurse, then we give this support. …*"

This is offered even to socially disadvantaged Hungarians. … There is no pressurizing, we just give the opportunity.

> "*The child is sacred. They obviously love the child. … And if the child is in the stomach, then they are attached to it, insist on it". "It calls upon way larger protest if we take away the child from the family, than to prevent.*"

Images alike the above corroborate the perception of desiring many children as well as desiring and giving birth to children without considering for the ability of the family to provide for the child as inherent feature of "Gypsyness" even if the benefits are made available to those in economic need irrespective of ethnicity.

4.6 Cognitive dissonance between life stories of Roma and the symbolic image of the Gypsy

When referring to "Gypsy" ways of living (symbolic "Gypsyness") within the local community professional care providers refer to the conditions of those families living in the colony. Nonetheless, they are at the same time making exceptions by individualizing those Roma origin members of the area who are not conforming to the label of symbolic "Gypsyness".

The image of symbolic "Gypsyness" is in ongoing challenge facing individual life courses deviating from the meanings attached to the term causing cognitive dissonance. Referring to the course of professional conduct, professional care providers emphasize that their judgment is made in reference to individual merits:

"*G [one of the clients of Roma origin] is fully acceptable, fully fine. She after all lives separate with her 3 person family in this little housing, with three rooms, which is fully suitable for them.*"

"*I used to visit the old lady, 80 years old. She had been living tidy, compared to her age. She lived her life there and did not become Gypsyfied (nem cigányosodott el). All an all the wall is clean, it is equipped, they have everything to their little life. They have a cooking stove, oven, even a crane, although I do not know if they have water in it or not?*"

"*This young couple … I believe that they can create a proper environment around them. …. So they can move forward.*"

Professional care providers refer to several dissonant examples: An elderly Roma woman having only one child, as is the case of the grand-grandmother of the above mentioned young father, or families raising their children responsibly. Even Roma families are found who discourage their children to give birth at an early age:

"*If they want to think further, if they want to plan their life in another way. But it happens even with Roma families that a parent did not let her child give birth to the baby, since they felt that their daughter was too young. But after a year she was pregnant again.*"

I could find two indications to the matter of how these dissonances are resolved. One indication was named earlier. Those families, who moved into the center of the village during the seventies, were considered integrated. They were seen as having been "Hungarianised" (*elmagyarosodtak*). Thus, rather than considering them as representatives of the Roma community challenging the negative images of "Gypsyness", they were lifted out of that imaginary.

Another pattern for resolving this dissonance could be seen in the ways how professional care providers reflect on their own practices. Those interviewed by me share a kind of welfare optimism that was earlier referred to characterizing one brand of describing the evolution of welfare services. Welfare service workers share a professional pathos for reforming society. They perceive a family model with 2-3 children as the desirable size of family. They do believe that completing school is necessary for the youth in order to prepare them for working life. They do believe in the importance of having families where fathers can provide for their families and mothers are good care takers and favorably even they have employment. Thus, when they are confronted with Roma families or individuals conforming to this image, they do identify this as their own civilisatory achievement:

"*We approach the families with the aim of helping. And even they realize how severe their poverty is, that they are starving, and that it is not sure, that they have the circumstances and preconditions to fit in a second or third child. And if they later consider that the circumstances allow it, they can always take it [the spiral] down.*"

Thus, they refer with pride to their ability to reach out with this message, which one nurse attributes to the fact that she is well accepted in the Roma community:

"*I start the contact when women become pregnant, when they report to us. And then I follow the child until it reaches 6 years in the family. After that I have contact with them throughout their school period. Since many of them start to plan family life, and having children earlier, the circle becomes completed often already during the school years.*"

Thus, keeping the image of "Gypsy" cultural difference is also indicative of their achievements and contributes to feeling as making a difference in "civilisatory" terms.

Despite of positive and civilizing self-images of professional care providers, it is difficult not to pass a critical guise on their roles as supervising, disciplining authority, which, with ongoing attention and concurrent suspicion is scrutinizing the private lives of families. In this critical guise over the family, the best of interests of the child might one-sidedly focus on economic preconditions of parenting, where individual misbehavior is put into the focus of critical attention, rather than the inadequacy of social and economic conditions, the failure of an entire epoch following the dismantling of state socialism to provide means for living a respectable livelihood to large sections of society, out of which the overriding majority are of Roma origin.

Access to social and civil rights is mediated through moralizing discourses of deservingness where the right to define what is normative and morally desirable is in the hand of the authorities. Although, the mayor has been sensitive to the social problems of the unemployed and was active in mobilizing local and external resources for the improvement of the conditions of the locals, these efforts alone could not counteract the severity of limitations caused by the economic recession. Despite of awareness of these limitations, a moralizing and paternalistic attitude prevailed among the professional care providers of the municipality, where assimilation to “Hungarian” norms with a parallel denial of their association with “Gypsyness” were seen as mutual prerequisites of acceptance of the Roma members of the community by the majority.

5 SUMMARY

Decisions concerning taking children from their families are to be taken with the child’s best in mind. Judgments should be taken without difference made according to the ethnicity or the social standing of the parent. Poverty and social position of the family should not legitimate the act. Nonetheless, the basic needs of the child are to be supplied for. If families do not meet these needs due to neglect of the child or the child can be feared to suffer malnutrition or failing to attend school, lack basic clothing, the issues of satisfaction of basic needs might become of importance in decisions made about the child’s future. However, there is obviously a great deal of discretion left to the local authorities in their agency. Moving the child out of the family means also moving the child away from her/his relatives and the surrounding community. Thus strategies dealing with troublesome issues could also be formed with focus on assisting the families to improve their conditions or with focus on trying to allocate the child among close-by relatives within the same community, by this making contact-keeping with the biological family easier.

It seems that in the cases discussed above poverty alone was not used to legitimate taking the children from the families. Nonetheless, poverty, and the disability of parents and or grandparents, to provide for a child figured as an important argument for the decision. The conception of children without being able to provide for the child was seen as irresponsible behavior by itself, where the poor assume that the state would take care of them and their children. When poverty is an underlying motive legitimating the decision taking a child into state custody, the disadvantaged family’s trust in institutions is challenged. Rather, it strengthens the individual’s feeling of defenselessness to the state. From another perspective it also contributes to the creation and reproduction of family patterns, where being taken into institutions and moving in and out of them becomes normalized. While the family is seen as the normative institution of childrearing, the children of families, who are judged as non-conforming, are placed on deviant paths of upbringing, often moving between institutions, foster families and biological families.

Although there are children of different ethnic origins among those taken into custody, the proportion of Roma children among those taken under state custody is unrepresentatively high both in the national statistics and in case of the chosen community. The local care professionals utilized a complex set of images reflecting on the Roma minority at large and Roma families among their cases. We can differentiate on the one hand primordial images of ethnicity, which bind cultural features to a certain community formed through decent. This reminds to the ways how gender conceptions based on difference bind gender to biological difference between men and women. On the other hand there are instrumental or relativistic images of ethnicity, where ethnic features are not fixed to a group for all times. Similarly, likeness based images of gender are not assuming a fixed connection between biological ground and behavior. Official care providers in the study utilized essentialist gender expectations, where proper maternal and paternal roles, proper sexual behavior was at the same time conceptualized as associate with “Hungarianness” and with mores of the Hungarian majority. The proper “Hungarianness” was also associated with the morality of state socialist working societies, where the role of the father is to be the main breadwinner and the role of the mother is to both care for the child and household and engage in paid work. Deviation from this norm is sanctioned. As the analyzed interviews indicate deviation has also obtained ethnified labels.

Although being Roma was also coded by physiological features of being black in contrast to Hungarians being white, the physiological characteristics were not conceived as primordially attached to what they refer to as social features of “Gypsyness” (*cigányos*). The term “Gypsyness” is clearly identified as “otherness” in contrast to the normative “Hungarianness”. While “Hungarianness" is seen positively as being “orderly” (*rendes*) “Gypsyness” is seen as temperamentally and morally deviant from this norm. Among the dimensions of this otherness the paper has explored the meaning attributed to deviant sexuality and parenting. Sexual ethnic difference was elaborated as early engagement with sexual activities without thinking about the consequences and preconditions for shouldering a parental role in case of conception. The perceptions echoed also public discourses accusing Roma families and women making use of state subsidies for child rearing without taking own responsibility for a provider role. Although Roma origins are observed as significant and as potentially signified by “Gypsyness” cases with lacking correspondence were noted in abundance. Different patterns prevailed to dissolve these dissonances. They were viewing their role as welfare state agents representing a kind of civilisatory mission where “Gypsyness” was seen as culturally backward, associated with moral immaturity. Thus, those Roma in the community who were not conforming to the deviant image of “Gypsyness” have been understood as “Hungarianised” either as a result of the civilisatory efforts of state socialism or by recent policies. Another connected strategy is the differential use of the term Roma and “Gypsyness”, with which they open up for unfixing the negative connotations of “Gypsyness” from the more politically correct term of being Roma and Roma origins. The parallel normative use of “Hungarianness” implies that difference is not located to origins in a fixed way. Cultural assimilation and acceptance to majority society is possible. Meanwhile, a positive association with symbolic “Gypsyness”, let it be by members of the community of Roma origin or by those of Hungarian origins, is excluding acceptance. Thus, multiculturalism [27], the mutual acceptance of “Gypsy” and “Hungarian” cultures as equivalent, is hindered.

Despite of the fact that local municipalities are not capable in counterbalancing the endemic absence of work opportunities that followed deindustrialization, impoverished families are blamed with deservingness and wastefully lifestyles contributing to their position. “Gypsyness” becomes a signifier of underserving poverty. Even if “Gypsyness” does not by

necessity correspond to being of Roma origin, the ongoing ethnification of the normative discourse, which associates the norm-given with Hungarian and the deviant with "Gypsyness" creates a climate of surveillance and ongoing monitoring especially focused on the geographically distinct inhabitants of the colony. Meanwhile, this surveillance is also combined with well-willing paternalism, utilizing the limited resources of the municipalities to improve living conditions for those living in the colony. This paternalism is at the same time burdened with infantalising rather than empowering those it aims to help.

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HEALTH CARE AND COMMUNITY AS COLLATERALS IN RURAL ROMANIA AT THE TURN OF THE MILLENIUMS

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ABSTRACT

The following paper describes the effects of the post-socialist and post-transitional periods on the rural society in Romania with an emphasis on the demographic changes that have led to a continuous ageing of the population and a decrease of the economic situation of rural settlements. Out-migration of young (and active) people caused by a lack of employment opportunities as well as the bad housing and educational conditions and the immigration of retirees have contributed to the ageing of the population and the diminishment of the labour force supply. This process has contributed to the appearance of new social problems also connected to the ageing of the population, such as health care problems, more present in the case of the elderly.

After 1989, the state could not manage to re-build a welfare and also health-care system that might handle these recurrent problems, so the civil society and community involvement try to replace (of course only where it is possible) the role which the officials should have in solving health care problems. At mid-level administrative units (county councils) of course we cannot state that it has been a success-story overall Romania. In the paper I would like to present a case-study from North-Western Romania where bonding and bridging such a network of social capital could be of great help as a partial substitute in the formal health-care system.

1 INTRODUCTION

1.1 Social and economic background

Even if there is no international standard for defining rural areas, the most commonly used methodologies fall into two main camps: Population-based factors and geography-based factors. The methodologies used for identifying rural areas include population size, population density, distance from an urban centre, settlement patterns, labour market influences and economic structures. Among the EU members Romania belongs to a group of countries (together with Bulgaria, Latvia, Lithuania and Poland) with a proportionately large rural population. Actually Romania has been the only country where the percentage of rural population has increased after 1989. Partly this was due to the land-redistribution, in 1991 the first post-socialist government has tried to restore partially the land property system that existed previously to the communist regime. But this was only a partial restoration, Law 18/1991 has stated the upper limit to which land could be given back (no more than 10 hectares of arable land and 1 hectare of forest). Analysis have been made on the negative effects on the post-socialist agriculture and rural development, as this tended to lead to a re-peasantisation in the sense of returning to low-efficient traditional agriculture [1].

Another cause of the increase of rural population was the restructuring of post socialist economy, where many industrial plants were closed and in the transitional period for those who owned some land, going back to the roots seemed a good life-strategy. After the first law of land redistribution there have been several land-redistribution reforms but seemingly they have failed in the revigoration of new agricultural structures, this leading to a serious decline in the profitability of agriculture, the abolition of collective farms and their substitution with belt-type small-scale private farms. This has produced a serious agricultural crisis and led to a worsening of the socio-economic indicators characterising the quality of life and well-being of the rural population, indicators that at the beginning of the 21st century have been worse than in the eighties.

The phenomenon of demographic ageing has both affected the rural and urban society, but the urban economy has recovered experiencing a more significant growth during the late nineties and attracting younger active population while the rural settlements were continuously affected by the non-existence of an overall strategy for rural areas, and only a small percentage could register a socio-economic progress. The great majority of the peripheral rural settlements were marginalised and social exclusion and rural poverty affected them. Ageing was one cause-effect phenomenon in this process, elderly people account for an increasing share of the population, this is due to sustained reductions in mortality in past and future decades. The ageing process can be characterised as ageing from the top, as it largely results from projected increases in longevity, moderated by the impact of positive net migration flows and some recovery in fertility.

At the beginning of 1990 in the Romanian rural areas the percentage of the rural population over 65 years was of 13,5% of the total population and has grown to 18,3% in 2012. Another important manifestation of the ageing in rural areas is the growth of women in the elderly age-category, a process of ”feminisation of the ageing”. The structure of the ageing population proves this disproportion: At 1000 women over 65 years there are 674 men (in 2012, confer data of the Romanian Statistical Institute) [2]. And further while the report of masculinity in the age-group between 65-74 years was of 737 men for 1000 women, in the age-group of over 85 years, the women's share in the population was much higher, almost two times exceeding that of men (522 men at 1000 women).

The ageing of the population has influenced also the structure of the rural households, out of the households of retired people from the age-group of over 65 years, approximately 38% of the households are run by a single person of over 65 years. So we can affirm that in the rural areas the number of the social risk groups has largely increased during the last 25 years[19].

2 HEALTH CARE IN RURAL ROMANIA

People in rural areas generally have less access to healthcare than their urban counterparts. Focusing on industrial, meaning by this mostly urban development has led to a lagging behind of the infrastructure (both physical and human) in the welfare services, process that has started even from the sixties. Still until 1989 every commune had a medical doctor and nurse who could take care of the less weighty health problems, more serious health problems were dealt with in the urban-placed hospitals and nurseries. Of course all of these services were free of charge (officially), sluh-funds were in use and have remained ever since as set figure in the medical services.

[19] Social risk groups are those persons who can be in a common difficult situation, which produce social marginalization or social exclusion for a shorter or longer period of time. Such groups can be children, ethnic minorities, migrants, youth, aged people, persons with disabilities, women.

After 1989 the situation has worsened drastically. Funds for social and healthcare decreased both in urban and rural, but in the urban due to the slow but steady economic development things got better. But in rural areas the situation has worsened: Fewer medical practitioners, mental health programs and healthcare facilities and the governments of the last 25 years did not make up a strategy in welfare services. Rural areas but also urban ones have greater difficulties in recruiting and retaining qualified and skilled professionals in the healthcare field, the out-migration of well-trained professionals is a well-known fact for all, but so far the officials did not make-up a coherent strategy for retaining these people in the country and even more in the rural area. Even if the Romanian constitution stated that every citizen has the right to basic free health care, in reality things look much differently. The involution of the socialist medical system meant that many rural settlements, mostly the peripheral ones were left without any medical infrastructure, doctor's offices were few, in many cases the doctors were commuting to villages from the city, so in the late afternoon there was no one who could take over the urgent cases. The lack of healthcare workers has resulted in unconventional ways of delivering healthcare to rural dwellers, such as implementing a "social mediator", in almost all cases a woman who could provide basic medical services, but for special medical examinations rural people had to go to the nearby city where such a service was available. Privatisation in medical services, e.g. the appearance of private hospitals had also led to a polarisation in the supply of these services, rural dwellers who are mostly pensioners (the average agricultural pension is of 340 RON (around 75 Euros/month) cannot afford to pay for highly-specialised and not free of charge services. We must say that the gap between the urban and rural welfare has increased constantly after 1989 and this has led to the widening of the new category of the underclass.

Public spending on health care has been one of the sore spots in the last 25 years, Romania being one of the countries of the EU with the lowest share of the GDP for health care (varying in cases from 1-2% from the GDP).

3 COMMUNITY AND HEALTH CARE IN THE RURAL: A NEW WAY OF HANDLING LOCAL PROBLEMS?

As I have stated before, a "fireman" solution to the inexistence of local skilled health-care was in the late nineties in certain rural communes the implementation of a so-called "social-mediator" who got a short training of six months by professionals in health care in order to be able to perform basic health care services: Giving an injection, taking blood pressure and making sure that the ill people take their medication as it was prescribed. We might say that this social mediator had to be a kind of Superman (or Superwoman) who in many cases took over many of tasks of a social worker and a rural animator.

3.1 ACCEPTIONS OF THE COMMUNITY

During the last two hundred years, social sciences have been using the concept of community mostly when referring to positive things. Even if some scholars consider it as an anachronistic concept with the help of which we cannot define the processes undergoing in our postmodern world, in the last few decades there is much more to be said about community. After Tönnies who has in 1887 invented the concept of Gemeinschaft as a communal society where personal relationships are defined and regulated on the basis of traditional social rules. People have simple and direct face-to-face relations with each other that are determined by Wesenwille (natural will) - i.e., natural and spontaneously arising emotions and expressions of sentiment. Most often the concept was used to describe the

traditional peasant society. During the sixties and seventies literature has used it very rarely to describe the actual social and economic processes but things have changed in the late eighties and postmodern literature „re-invented“the concept of community in a way and in many cases has tried to purify it from the Romantic acception that has been attributed to it after the 1st WW. Without intending to go through all the definitions of scholars of the past few decades on community I would like to present just two acceptions I consider as being important in using the concept of community and that define well the concept. So nowadays community is associated with social inclusion, friendship, warmness. There is a principle of community unity of solidarity and respect which as principle has importance in the everyday life [3].

In the book of Baron et al. A.Cohen attributed to be the author of the definition of two fundamental elements of a community: All the members have common features, on the other hand they distinguish themselves from the members of other groups. So it is an implication of similarities and differences in the same time. So due to Cohen people are constructing in a symbolic manner community, making a source of significance, a referent of identity [4].

The elements of community are crucial values for construction and maintenance of community. Selznick (1992) proposes a complex of variables in the production and maintenance of community: historicity, identity, reciprocity, plurality, autonomy, participation, integration. There is a continual equilibrium between these components. The aspects linked by the past permit the appearance of new, and mutuality and participation are equilibrated by plurality and autonomy. The moral quality of a community is expressed in ability to protect all the important values. The personal deep implication is condition of appearance of the community spirit. The community spirit is important, is linked by wellbeing of others, so there is need of moral imperatives. There is need of an efficient social control, but not of law nature, and the community is expressing social control on own members which is important in ordering social life [4].

In a historic perspective communities can be developed in the sense of integration, but in the same time there is a process of fission and rebuilding of communities. Some communities are losing features; the communities of present time are different, compared with those existing in the past. The communities of our times could be adapted for new challenges; this is an expression of capacity to cooperate between people.

One concept that has been connected lately as a basic element for the sustainability of the community is that of the social capital. Social capital is used in correlation with community development. The existence of stock of social capital at community level is a condition of social development. General features of social capital are: Intensity and quality of social relations, the levels and types of trust, norms and tolerance in doing with success collective actions.

Social capital is a source for the individual or a social group in some actions. There are some difficulties in use, maintenance or transformation of social relations. Putnam is characterizing social capital as characteristics of social organization such as trust, norms and relations which can develop social efficiency through facility of coordinated actions.

Dimensions of social capital are: Networks, relations and forms of organization. There is an individual and collective level of social capital.

Trust is an important component of social capital. J. Coleman [5] made a good description of how trust is working on the individual level. Investment in trust has result resources for the person who is making investment, facilitating action.

Norms of reciprocity are another dimension of social capital if it is facilitating the access of individuals to resources. Respect of norms of reciprocity is diminishing the transactional costs [5].

3.2 Social capital at community level

In those communities which has an important stock of social capital the cooperation and efficiency is higher and in this way the capacity to solute the problems of the community is growing.

The principal dimensions of social capital are norms of generalized reciprocity and networks of civic commitment [6].

Generalized reciprocity supposes "*a permanent relation of change which remained in equilibrium for moment, but which supposes from both parts to return later offered favour*." [6]. Fukuyama (2000, 3) is making an extension of this normative dimension of social capital to informal norms which generate cooperation between two or more persons. Trust, networks or forms of association are only epiphenomena of social capital, to not mix up.

The second dimension of social capital is networks of civic commitments. This is referring to cooperation forms on horizontal level (neighbourhood, associations, clubs etc.). The higher the density of such networks in a community, the better the level of cooperation between them, for common interest with important advantages for them: Higher potential cost for those who are not fair; maintenance of norms of reciprocity; facilitating communication; better informational flow linked by credibility of individuals; conservation of earlier successes in cooperation, as a model for a future collaboration.

The networks of civic commitment and the norms of reciprocity are linked by a third dimension of social capital, trust. When there are monitoring contracts, and interactions are too expensive, or impossible, trust is a fundamental element in coordination of collective actions. The level of trust is determining the probability of cooperation. The forms of trust are: The general form and the moral form. The generalized form of trust, in opposition to the particular form (trust in individuals with similar characteristics) supposes trust in people whom we don't know. Sources of this type of trust [6] are represented by the other complementary dimensions of social capital: Norms of generalized reciprocity and networks of civic commitments. By exercise of interactions in more and more extended networks practice of changes based on norms of generalized reciprocity, trust in others has a larger and larger extension.

Moral trust, as second form of trust is the opposite of strategic trust. If strategic trust is supposing to know the situation of an individual in whom investment is made, and based on a rational counting, the moral trust is not dependent from the social context and is based on an optimistic view.

Putnam [6] identifies two distinctive features of social capital: The aspect of good public and auto-generative capacity. Social capital is not the private property of somebody; it is belonging to the community as a whole. Putnam is speaking about auto-generative capacity of social capital stocks. The stocks of social capital, trust, norms and networks can be auto-generative and cumulative. When the auto-generative mechanism is working in a positive sense social equilibrium can be realized with a high level of cooperation, trust, reciprocity, civic commitment and economic wellbeing. The absence of such characteristics in non-civic communities produces also auto-generated: Isolation, disorganization, fraud, trustiness, shirks are intensifying.

Closeness of social networks is influencing production or destruction of social capital. Closing some networks is important when we are speaking about trust, a high degree of closeness of networks is important for individuals who are deciding to have or not to have trust. The stability of social structures is another factor which is influencing construction or destruction of social capital. Ideology is a third factor which is influencing social capital. An ideology can create social capital by calling individuals to act in direction of other interests [7].

There are other features which influence social capital; the governmental support for individuals makes them much less dependent from other people. The quantity of social capital is more important the more help is needed from one person to another.

4 „BACK WHERE WE BELONG“: A CASE-STUDY OF COMMUNITY-BASED HEALTH CARE IN INLACENI/ÉNLAKA, COUNTY OF HARGHITA, ROMANIA

As I have mentioned previously, through a case-study I will show the way of an alternative health-care in a peripheral rural settlement from North-Western Romania, the region of Transylvania. Inlaceni/ (in Hungarian Énlaka) is a rural settlement with an important share of the elderly people. I will make a short presentation of the settlement including elements of local history that where very important in the building and maintaining of the local identity, and can be considered as being starting-points for the development of the village.

Figure 1: Romania by counties, the county of Hargita is marked with yellow

Figure 2: The map of the Hargita county, the commune of Atid/Etéd marked with red

Situated at the Western border of Hargita county, in a hilly environment, at 449 ms altitude Inlaceni can be considered as being a perfect example of how the socialist industrialisation and urbanisation has destroyed the rural remote areas which could not get over this situation after the postsocialist transformation. Administratively Inlaceni belongs to the commune of Atid, situated at 5 kms of the centre of the commune. The closest bigger urban settlement is Odorheiu Secuiesc, situated at 24 kms from Inlaceni.

Figure 3: Panoramic view of the village of Inlaceni/Enlaka

Table 1: The evolution of the population of Inlaceni between 1850-2012
(Source: Varga A.: Erdély etnikai és felekezeti statistikája, [8])

	1850	1880	1890	1900	1910	1920	1930	1941	1956	1966	1977	1992	2002	2011
Inlaceni	585	608	635	695	643	659	590	588	597	450	375	228	187	157

You can see that overall the last century from 1956 onwards the population has decreased with 73%, and the latest census from 2011 has revealed that in the age-structure of the commune of Atid the age-group of people of 65 years and over have a percentage of 6,2%, but in the case of Inlaceni this percentage is much higher: it is of 70, 06% (100 out of 157 persons).

The village has an impressive cultural and natural capital. The village has appeared in the documents as an autonomous settlement in 1332. Archeologists working in the near surroundings during the seventies have found vestiges of the ancient Roman castle Praetoria Augusta, situated at the Transylvanian limes of the former Roman Empire. It is said that during the Roman Empire a stone-road connected Praetoria Augusta to Rome. Local people joking often and say that from those times there has never really been an important rehabilitation of the physical infrastructure, roads being in a very bad condition, so one of the reasons why health care is so problematic is the problems in accessing the nearby medical units.

Another important cultural asset is the Unitarian Church built in a late Gothic style, dating from the late 15th century, with a specific construction for Transylvania.

Figure 4: The architectural monument Unitarian Church situated in the centre of the village

The village was and is inhabited exclusively by Hungarian-speaking Szeklers. Historians consider that Hungarians and Szeklers where two separate populations which

came together to Transylvania and even if they both speak Hungarian, the Szeklers who had the function of guarding for the Eastern border of Transylvania and Hungary by that time, consider themselves as free people who were never enslaved and have a very strong Szekler identity. But when it came to the ethnical identification at the censuses they declared themselves as being Hungarians. Due to its position the main economic activities were during the times connected to agriculture (mostly horticulture) and animal-breeding, the village has some apple and pear speciality that can be found only in that region, the locals consider it that it grows only in that village. Another capital is the mainly unaltered natural environment and the rich heritage of local and regional legends and stories. I have tried to outline some of the strengths of the village, but because we are speaking of a problematic issue it is time that I make a more detailed description of the weaknesses.

5 COMMUNITY AS A SOLUTION TO LOCAL PROBLEMS

Industrialisation and intensive urbanisation started from the late fifties even in the more remote areas, leading to a significant out-migration of the younger fertile population, the consequences of this processes being seen after the nineties. Many people young at that time came home as young retired or unemployed due to the restructuration from the post-socialist economy, leading mostly to the closing up an the industrial plants. Many of these people returned to Inlaceni because the Law of land redistribution (1991) has given to many of them a hope in getting back to their roots and working their lands in agriculture seemed to be a solution to their problems caused by the socio-economic restructuring. But the inexistence of a real strategy of the governments of the late 25 years for the rural area has led to the increase of the social risk categories like aged people, unemployed or without occupation and low-educated young people because the local school slowly closed down because of the lack of children.

The late eighties seemed to make a difference in the life of the remote village. As an inchoation of the Western countries directed against the destruction of the Romanian villages, the Operation Villages Roumains, started in Bruxelles in 1988 as an indignation of the Ceausescu's regime of systematisation, meaning the destruction of the Roumanian villages, the significant cultural heritage. Through this the countries that took part in the operation “adopted” a village and got in touch with it, in the case of Inlaceni the adopter has been Bodenheim from England[20], but also after 1989 made excursions and until 2005 helped in many ways, not only with material help but also with advices and the transfer of experiences and networking. In the beginning of the nineties the local civil society has been developing, mainly through an NGO that took responsibility in development of the community and local development projects, this was the Foundation Pro Enlaka. Because of their Hungarian-Szekler identity many people were attracted by the cultural heritage and people from Hungary have bought up houses, but unfortunately this did neither change the age structure nor the quality of the welfare services. But why was this revitalisation an important factor? Community life and bonds were slackened through the communist era, as the locals tell distrust has taken the place of the trust and community-based social capital. My interviews with local people showed that they did not trust any more in people who were their acquaintances and sometimes even relatives and friends as the former regime of the Secret Services (the Securitate) has implemented a culture of fear and distrust, unfortunately this has led to serious problems after 1989 in building and bonding social capital in the village.

[20] The village helped through local developmental project in the extension of a gene-bank for horticulture and investments in the rural tourism, also through stages of visits for the local people from Inlaceni.

Health care has been a problem for the local people from Enlaka as they had to travel to the centre of the commune, Atid/Etéd and after 1989 local transportation means where minimal, the bus to Atid went out to Inaceni only three times a week and through the nineties there were no skilled professionals in health services.

6 HOW CAN COMMUNITY DEVELOPMENT HELP IN HEALTH CARE?

In our case-study we can say that the “top-bottom” model of solution came from the Hargita county-council's president, Kolumbán Gábor, who has been very helpful in hiring a local lady who has become unemployed and moved out to the village where she was born. At this time she was 43 years-old, but already with no real chances in finding a good job in the city of Odorheiu Secuiesc where she lived before with her family. Kocs Veronka took over the job of “social mediator” (now we would say a “rural animator”).

Figure 5: The “social mediator” ready to go

Among her tasks the basic health care service was included, so for ambulatory patients this was a relief. In certain cases for elderly people, mostly women who lived alone in their households, she accompanied them to the nearby hospitals.

Through this a small part of the problem has been solved, but even so the professionalisation of the health care was not managed and will probably be not managed as it is the case in the great majority of rural settlements from Romania (and not just here!). Solving them can go up in becoming central in the life of a community or going down being considered as a secondary need having no priority in the local, regional and national strategies in further rural policies.

7 CONCLUSIONS

On the long-run altogether, with the further ageing and pauperisation of some of the categories of the village, social marginalisation will increase. Family ties for some of them can be a temporary solution, but the real one could be the increase of the local networks. The intensification of social participation of individuals, of the informal networks but also economic development in encouraging rural tourism (with accents in the cultural and natural tourism) can be sustainable solutions for building social capital and economic development. Material resources of members of a community are in positive correlation with the capacity to take part in collective actions. Poverty produces social disorganization, a degradation of social capital, and the diminution of social participation. In the situation of a community in deep deprivation diminishing is the own-organization of the community.

Activism is giving know-how of participation. The sources of participation are strongly associated with socio-economic status, so the disposition of participation is transmitted to the next generation. The stage of the cycle of life is also influencing participation, young or old, unmarried or married, man or women. This might lead to the appearance of a new category of skilled people who is called by Kovách Imre in his latest book the „project class“ with a more serious know-how in applying for local and regional development projects [9]. But this also will not be a solution for the problems unless the number of young retired and younger people will increase.

If not, the solution will remain to build and bond social capital from “top-bottom”, with sustainable help from the city council of Hargita and the Agency of Regional Development for the Central Region. It is important to see what government agencies and other formal organizations can do to encourage the formation and strengthening of social capital and its application to rural development. Through this they might increase also improvements in physical and health infrastructure, but this means at this moment and probably on long-run also the need for “fresh” human capital, younger people. This is always the great question mark for tomorrow. How will things develop? Will the problem of health care and welfare services for Inlaceni will be the infusion of human and social capital or the “solution” will be in the slow de-population of the village that will become a place for relaxation for people who will just spend their holidays in a “green and pleasant countryside” [10]?

This is a question that no person can anticipate. We can only hope that on a long-term demographic aspects, as low fertility, out-migration of the active people will stop and maybe the solution might come even with the in-migration from other countries, solution for which at this moment local people are very much against.

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