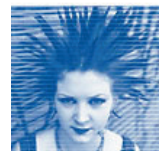




Hungary 2005

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**Basic social services  
in rural settlements –  
Village and remote  
homestead community  
care-giving**



on behalf of



**European Commission**  
**DG Employment, Social Affairs**  
**and Equal Opportunities**





### Some preliminary remarks

A few initial remarks about the authorship and composition and terms used in this report.

For Parts A and to some extent in Part B we have largely reproduced the original country expert report by Tamas Gyuris from the Hungarian National Institute for Social and Family Policy. Part B is long on general observations but short on quantitative results because, with the exception of the annual social statistics (Social Services Yearbook 2004), no quantitative data has been collected on the caretaking service making evaluation difficult.

Part C is, in part, based on a short piece of research carried out amongst our ESN members and other contacts in a number of rural areas in 8 countries and was also informed by a visit to the Hungarian village of Bokor and a number of discussions with Mr. Gyuris and Ms Vajda from the Hungarian Ministry of Youth, Family, Social Affairs and Equal Opportunities.

As regards some key terms, a 'village' refers to a location with a population up to 500 or 600 persons; homesteads and dens (groups of dwellings/farms etc) and satellite areas which are related to larger urban conurbations.

The word 'caretaker' and also sometimes the word 'caregiver' are translations of the Hungarian '*Gondnok*'. Neither term is normally used in English to describe tasks in the personal social services but the sense can nevertheless be conveyed. The nearest job title in use elsewhere might be 'community worker'.

At the time of writing the first national survey of caretaking was being carried out by Tamas Gyuria and the results will be available at the Peer Review Meeting.



## Part A Description of the main elements and results of the policy

### *A.1 Background*

Hungary has for many years experienced a declining remote rural population with consequent challenges to deliver social services for a socially and economically excluded and increasingly aging population. With 32% of all communities (total 1020) having less than 500 inhabitants (up from 601 in 1960), such small rural settlements frequently have no schools, health centres, social care facilities, post office etc. and access to such services elsewhere is restricted by a fragile public transport system.

This problem was accentuated by the Countrywide Settlement Network Development (1971) which restricted housing and social infrastructure development in small communities considered unviable. The consequence has been accelerated economic and social impoverishment with many younger people leaving the countryside but at the same time, poor jobless people moving from the cities to the emptying villages in search for cheaper housing. This appears to be the case, particularly, in areas where Roma are more strongly represented.

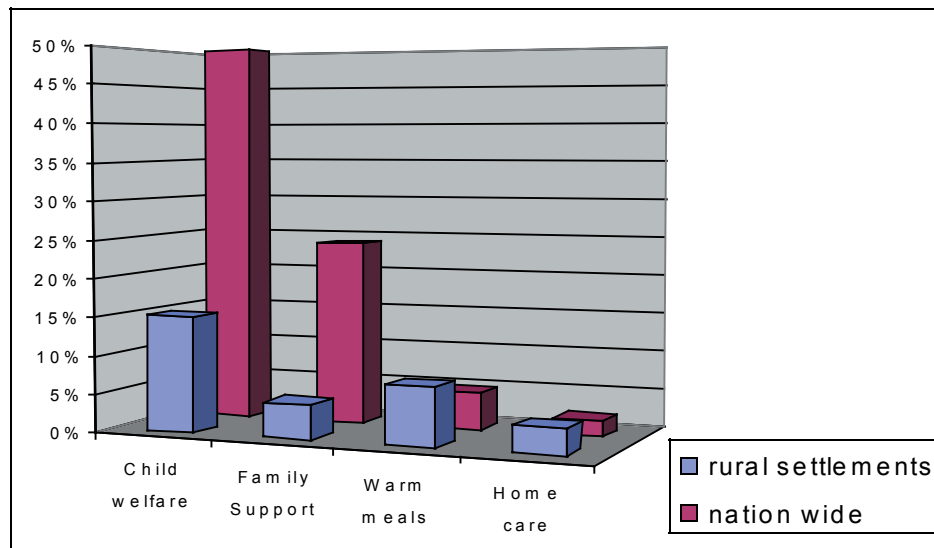
As regards social services, the *Social Act* lays down certain nationwide requirements upon local authorities to provide basic services and also optionally to provide day care social services in all communities, small as well as large. These are:

- **Child welfare.** The Child Protection Act directs child welfare services to promote children's physical and psychological wellbeing, to support in their families and to monitor risks etc.;
- **Family support.** This addresses a range of services and includes welfare rights, debt management, conflict resolution, working with substance abusers, mental health, disability, homelessness, long term unemployment, etc.(recent modification of the Act only now requires the provision of services in communities with over 2000 inhabitants);
- **Provision of warm meals** to those in need, and their dependants, including those with disabilities, older people, alcohol and substance abusers etc. In practice, in village communities, this service is uniquely provided to older people
- **Home care.** This comprises both cleaning and general support as well as nursing.



According to the 2003 Social Statistics Yearbook, the availability of the required basic services in communities of less than 500 inhabitants is as follows:

**Required services to all communities and actual provision to % of population**



With the exception of some day care and meals for older people which is at least offered in some areas, services for families and children, people with disabilities, the homeless and substance abusers, etc., are generally not available in rural communities.

In response to this service gap, more than ten years ago Hungary started developing a local service model centred around the employment of a village-based 'Gondnok' or 'caretaker' in 828 villages and settlements. The general purpose of this model, according to the Social Act of 1993 was *"...to reduce the disadvantage of small or remote settlements that lack local services in order to ensure access to basic public services to meet individual and community need"*.

The idea was first devised by Bertalan Kemény, Chair of the Hungarian Federation of Village and Homestead Community Caretakers in the 1980s and the Village Development Society was established in 1989. A few weeks after the 'regime-change' elections in 1990, the first caretaker services were estab-



lished in Cserehát, one of the most disadvantaged regions of the country on the Northern border with Slovakia.

This approach brought together the needs and priorities of the village communities and the interest of central and local government to find an effective, low cost way of providing basic services to village communities. In 1991 the Social Affairs Ministry began inviting applications and gradually included new counties so that now all qualifying village communities can recruit caretakers. The Village Caretaker Associations and the Village Development Society later funded the Hungarian Federation of Village and Homestead Community Caretakers in 2000.

According to the Federation, there is capacity for up to 2291 village caretaker services for a range of small communities and satellite areas. On this basis, the current 828 posts in operation reflect about a third of possible take up. The national expert expressed concern at the very uneven national distribution with some counties employing caretaker in only 2% of villages and others up to 74% having caretakers. The most underprovided region is North Hungary.

#### *A.2. Goals and target groups of the service policy*

The Social Act states that *"The village and homestead community caretaker service has the task of reducing the service-deficit related to disadvantaged small villages or satellite areas or remote areas and settlements by securing access to basic care, public services and to meet basic community and individual needs."*

The Social and Family Ministerial Regulation on the Operational Conditions and Professional Tasks of Social Institutions Providing Personal Care, adds; *"The Professional Programme of the Village and homestead community caretaker services must include the aims and objective of the service and the target population"*.

This would seem to suggest that overall objectives and targeting should be determined locally. Other regulations, however, emphasise specific service goals and targets (in brackets) for all, namely:

- providing social basic provisions (local authority to decide which);
- access to health care (for sick and needy);



- transport of children of kindergarten-and school age (aged 3 – 18yrs);
- purchasing goods (institutions of the local authorities); and
- managing public utility workers; (long-term unemployed, receiving social assistance who undertake paid work typically in public areas (e.g. parks) of a community).

There is some ambiguity as to which 'basic' service aims we might address. Whilst local authorities are legally charged with providing a range of identifiable basic services to all citizens (i.e. child welfare, family support, provision of warm meals, home care, and day care, etc) and caretakers are practically the only local authority 'representatives' in many villages and might potentially take on a wide range of tasks in response to local need, their service responsibilities are essentially restricted to school transport and support for elderly people.

It would therefore be unreasonable to evaluate the caretaker's performance against these 'basic' service aims.

The village caretaker service could generally be regarded as making an important contribution to combating social exclusion within the framework the Hungarian NAP as it provides a contribution to inclusion of deprived, poor and often neglected communities divorced from mainstream society and its infrastructure and services.

### *A.3. The legal, financial and human resources provisions to implement the policy at every stage of the policy cycle*

#### **The legal situation**

The village caretaker service is regulated by the Social Act III of 1993 and the 1/2000 (I. 7) Social Family Ministerial Regulation on Operational Conditions and Professional Tasks of Social Institutions Providing Personal Care:

*"Basic provisions can be provided within the frame of village caretaker service at communities having less than 600 inhabitants. If as a consequence of the village caretaking service the community's population grows by not more than 10% above the six hundred inhabitants, the caretaking service can still be operated." (Chapter 4)*



The tasks of a village caretaker are multi-faceted, from basic tasks requiring professional training through the various transport duties to a cultural role; almost everything can belong to it that raises the quality of life of the community. According to the Social and Family Ministry Regulations the village caretaker service should fulfil individual and community needs, in addition to those basic required services mentioned earlier. Other stipulations include the following:

- organising and supporting cultural, sport and leisure tasks, including those relating to theatres, excursions, local festivals, borrowing books, etc.;
- organising services for the residents, including shopping trips, repair of home appliances, procuring animal food or crop, managing administrative issues;
- buying goods for local authority institutions, managing public workers, providing information and assisting people and the local authority in handling official issues.

The regulations stipulate that the measurement and range of tasks be regulated by the local authority though no local authority monitoring has taken place, so we have no accurate information on the actual content and pattern of caretaker activities. More information on this will be provided once the survey of the village care taker's activities is completed.

The professional programme of the village caretaking service (par. 5) must include:

- Service aims and objectives;
- Target population;
- Content, methodology, structure, frequency and extent of planned services;
- Service access
- Rights and relationships between the service provider and the service users;
- Making information available locally;
- The annual budget (revenue and costs) of the caretaker service.

An important regulatory element is the 'operational permit' which is needed so that the service can receive government funding. This is issued by the clerk of the city where the relevant local authority is based. It requires local author-



ity approval that the village caretaking service is properly established with a trained caretaker, appropriate action programme, insured vehicle etc. Should the service be judged unsatisfactory, the operational permit can be withdrawn and with it, government funding. However, it seems that there is no monitoring by the operational permit authority, so we are not aware as to whether any permits have been withdrawn.

### **Financing of the village and homestead service**

Establishing a caretaker service usually involves an initial investment of an eight seat minibus. This usually exceeds the financial means of small communities. Since 1992 the Social Affairs Ministry has required a 20% contribution from local government.

Replacing overused buses began in 1996 and has used up much of the development budget which may, in part, explain the county-wide variation in caretaker provision. Since 2004 resources have become even more constrained. Between 1991 and 2004 the Social Affairs Ministry provided approx. 2.6 billion HUF (approx. € 105m). Village communities annually receive 70% of their operational expenses from the government on condition that they have a valid operational permit. In 2005, each village will receive 2.2120,000 HUF (€ 8.600).

Since the introduction of government funding, some settlements have resourced vehicles themselves leaving the service to be funded by government. The service can also generate its own revenue, as local regulations permit some charging for services.

### **The situation of the human resources of the village and homestead caretaker services**

A village caretaker area is provided for by one person, but several settlements may belong to one area. In 2003 there were 707 village caretakers, and according to the Hungarian Village and Homestead Caretaker Federation there are services in 828 settlements but it is unclear how many are providing for several settlements.

The legal requirements for employing the caretaker are that they should have a valid driving licence (with the precondition of having an elementary school qualification) and completed the necessary caretaker training. However, there is also some 'guidance', which will also become legal requirements;



- The caretaker should live in the village or homestead in which he will work.
- The authorities must make applications for the post public.
- The caretaker should be elected by the village assembly.

Caretakers should also have good communication and cooperation skills, be trusted by the people and must be multi-skilled. Their training takes 260 hours and comprises 60% theory and 40% practice.

#### *A.4 Institutional arrangements and procedures of implementation*

The key institutional arrangement for the caretaker service are the Ministry of Social Affairs who are responsible for funding the service, the local authority as employer and the caretaker associations which are established on a county basis. Unfortunately, there is no information as to their role of professional support or service development.

Although the caretaker service could legally be provided by civil society or entrepreneurs, it is believed that it is almost exclusively provided by local authorities. There, however, are no known supervisory or management arrangements by the local authority.

### **Part B The results so far**

#### *B.1. The quantitative results of the policy so far, in relation to the baseline situation and to the goals and targets*

Village caretaker service indicators have not yet been developed. The annual social statistics seem to suggest that all basic personal social services except meals and home care are underprovided in small settlements. These two services (meals and home care) may be better provided here than the national average because these services are undertaken by the village caretakers in small communities and older people form a substantial group within the rural population.



The evidence from other countries with remote communities e.g., Western Isles of Scotland and Finland highlights the opportunity for such 'non professional' low cost-low tech. services to be locally provided (see below). This can very much be the strength of small organised communities bring together local needs with available local supply.

The less impressive statistics on children and family welfare services must, however, be worrying as long distant outreach specialist services are unlikely to be improved in the near future and local alternatives will require a greater resource investment.

### *B.2. Other results and achievements of the policy so far*

The caretaker service whilst not yet objectively evaluated, might be assumed to have made a useful contribution to rural communities. It is no mean achievement by the Hungarian government and the caretaker associations to have trained and funded over 800 village caretakers over the past 10 years.

Many thousands of children benefit from a familiar face to take them to kindergarten and school every day and isolated elderly people can rely on a trusted fellow villager to collect their prescription and bring them a hot meal and ensure they are supported so long as they remain at home.

Caretakers themselves must be congratulated for providing services, largely on their own and making such a unique contribution to marginalised communities. The interest by counties in growing this service itself must be a testament to the values ascribed to this initiative and its potential to meet local need.

Cooperation between different professions, services and sectors in Hungary, however, is not widespread according to the national expert, Tamás Gyuris and this must inhibit development in areas requiring a collaborative approach, e.g. involving caretakers and centrally-based specialists.

The forthcoming survey should, however, better inform government and the associations about both strengths and weaknesses. Of current practice and thereby provide a useful tool to take the service forward.



### *B.3. An assessment of the obstacles and constraints encountered*

From reviewing the structure and dynamic of the caretaker model, there would appear to be a number of potential obstacles and constraints to the successful operation of a 'one person' service which are familiar to government and the caretaker associations themselves.

- The absence of reliable data on staff profiles, service activity, community relationships, service outcomes and cost/benefit seriously hamper any planning or management of the service
- An isolated job can present dangers of political or personal interference by the local mayor or other key figures in authority. The lack of any monitoring and supervision by the local authority, could leave an individual unsupported, overworked and the community with a poor service without redress.
- The lack of a framework for ongoing learning and development which can involve caretakers in sharing good practice and adding to their basic initial training would seem to be an obstacle to service development.
- According to the national expert there is very little to no knowledge of the caretaker service amongst the general public and service users, particularly those less empowered as the Roma or indeed those in extreme poverty. This could contribute to their exclusion from influencing practice and having their views heard.
- The apparent lack of a working partnership between the local authorities and the caretaker service must be dysfunctional to the 'mission' of public service, the most efficient use of its existing resources and the opportunity for service growth and increased quality.

## **C: The Policy Debate**

### **Definitions**

For the purpose of this paper, the term social services has to be considered in its widest possible sense to accommodate the range of caretaker activities. Both the village and den caretaker's job description and examples from other European countries include practices and services that a narrow definition of the term cannot cover. The most comprehensive and widely used definition



in EU policy and Member States comes from the European Foundation for the Improvement of Living and Working Conditions and serves our purposes here well:

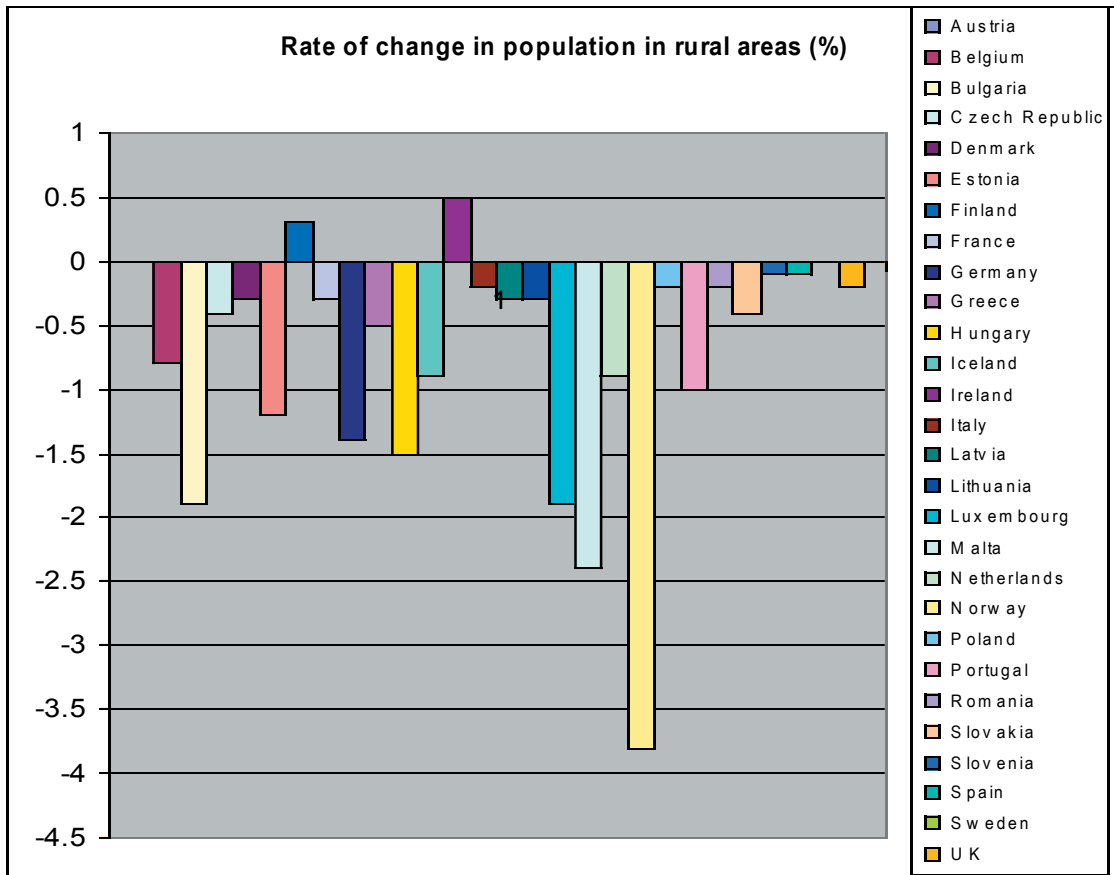
*“Social public services are services directly provided to citizens to meet their needs in relation to employment, health, housing, education, social security and care. The services are generally regulated and funded by public authorities at national, regional or local levels, but they may be provided by the public or private sector, voluntary or other third sector organisations.” (p. 3, 2001)*

Hungary’s choice of good practice - the provision of basic social services in remote rural areas – makes it also necessary to have a closer look at what is termed rural areas. Many EU Member States and candidate countries have large rural areas, most notably the ten new MS and the Nordic countries. There is no common definition but in the EU, the OECD and EUROSTAT classifications are widely used. The former uses population density as a basis for comparison and the latter also includes a reference to the number of inhabitants. The classifications however are not applied consistently. Lithuania and Slovenia, for example, respectively use the OECD and EUROSTAT definitions. Estonia has neither a national definition, nor does it use one of the above and Hungary only makes selective use of the OECD definition.

Consistent definitions, however, are necessary in order to develop much-needed indicators and also to formulate social policies that can deliver and adapt service provision to the needs of the population. National indicators which measure the wellbeing of the total population are of little use if they do not take into account the characteristics of rural areas. Regional and local variations, which can be significant, may as a consequence be obscured. This is also the view of the Joint Report on Social on Social Inclusion 2005.

### **Summary of issues affecting social service provision in rural areas**

Social services and infrastructure play a crucial role in combating social exclusion in rural areas and can be the decisive element in limiting out migration which is, together with changes in demography, one of the most pressing issues for rural social policy. UNDP statistics (2005) of the average annual rate of change in population in urban and rural areas from 2000 to 2005, demonstrate that rural Europe is undergoing drastic changes:



With the exception of Finland and Ireland, where the rural population is growing slightly, European countries are experiencing a fall in their rural population or growth is stagnating (or stable). According to a EUROSTAT news release (2005), the overall projected population decline until 2050, especially in the NMS, is significant. The largest declines will be in Latvia (-19.2%), Estonia (-16.6%), Lithuania (-16.4%), the Czech Republic (-12.9%), Hungary and Slovakia (both -11.9%), and Poland (-11.8%). In many countries, including Hungary, this is accompanied by a decline in social services and infrastructure which adversely affects the most vulnerable and can set in motion a downward spiral. The lack of vital social infrastructure, such as education also has grave consequences for the local economy since job opportunities and incomes depend on it. In Finland the last fourteen years have witnessed the closure of over a thousand schools in rural areas.

A longer life expectancy, coupled with the growing trend to have fewer children is putting strains on the provision of social services in Europe, particularly



in rural areas. Public outreach services are especially affected long distances as have to be covered by care personnel. In Iceland driving 200 km to reach users is not unusual. Social services in Western Ireland and the Western Isles in Scotland routinely use planes and ferries.

### *C.1 EU policy overview*

With its emphasis on rural areas, this peer review topic touches several policy areas, including agricultural and rural development policy, territorial and social cohesion policy and of course, the EU Social Inclusion Policy. References to the former areas of action will necessarily be kept brief, with the main focus on the Social Inclusion Policy since the peer review programme forms part of it.

#### **Rural and Regional Policy**

The EU Rural Development Policy has undergone significant changes since the accession of Southern European countries in the 1980s. Territorial and social cohesion, as opposed to purely sectoral policies, such as agriculture and forestry, are now a significant part of rural development. Both the **Cork Declaration** in 1996 and **Agenda 2000** promoted integrated rural development, the decentralisation of policy administration and territorial cohesion. The main policy instruments to achieve this are the **Regional Development Programmes** under the EU Structural and Cohesion Policy and the **LEADER+** community initiative, a bottom-up approach to rural development. LEADER+ also focuses on the development of service infrastructure. The European Regional Development Fund (ERDF) for example is funding the DESERVE Project as part of the INTERREG Northern Periphery Programme, a transnational exchange of ideas and practices which focuses on service delivery in remote and rural areas with partners from Scotland, Sweden, Iceland and Finland. Its main objectives, as can be found on the project website referred to in the bibliography, are the following:

- To improve the viability of service provision;
- To test the transferability of models of rural service delivery among the partners by implementing models employed in other partner regions: transferring and testing ideas and practices;
- To establish the extent to which these models must be adapted to suit regional contexts: how flexible are they and what barriers to success are there;



- To improve the delivery of services to remote and rural areas within the Northern Periphery region;
- To improve accessibility of services within the NPP region by mainstreaming the new approaches across the transnational partnership area.

The project has only recently started its main phase and will run until July 2007. The website nevertheless list several expected outcomes, including:

- Improving the level and quality of rural service delivery and implementing innovative approaches to common problems;
- Establishing more integrated ways of working – as opposed to the present sectoral approaches;
- Establishing a long lasting transnational co-operation.

### **Social (Inclusion) Policy**

The EU Social Inclusion Strategy is built on articles 136 and 137 of the **Amsterdam Treaty**, which came into force in 1999 and stated that the fight against social inclusion should be one of the EU's social policy goals. The **Lisbon Council** in 2000 took on the goal to eradicate poverty in the European Union until the year 2010 using the Open Method of Coordination which consists of the common objectives formulated at the Council, National Action Plans to tackle social exclusion, the Community Action Programme and the common indicators.

Importantly, the Treaty of Amsterdam (Article 138) also maintains that to achieve economic and social cohesion, the European Community must aim to reduce disparities between the levels of development of the different regions and the backwardness of the most vulnerable regions, islands, including rural areas. Implicit in this statement is that people should not be disadvantaged, wherever they happen to live or work in the Union. The **ESF Structural Funds**, (Article 139), are also an important instrument to further social inclusion, although not explicitly directed towards rural areas.

The most relevant parts of the social inclusion policy here are the Community Action Programme, which is currently funding a study to develop regional on access to public social services, and the National Action Plans for social inclusion. Access to services for all is part of one of the common objectives.



The Joint Report on Social Inclusion (2005), has identified several core challenges, among them *Guaranteeing equal access to quality services (health, transport, social, care, cultural, recreational and legal) and the Regeneration of areas of multiple deprivation*. The former refers especially to challenge of increasing access to health and care services for the elderly and the mentally ill. The latter points out that few Member States have addressed the issue of poverty and social exclusion in rural areas. Those that do, e.g. Ireland, Portugal, the UK and Greece, underline the issue of marginal rural areas with declining populations and poor services delivery.

In the NMS, the Report identified a serious deficit in terms of key social services at a community level, linking this to a low expenditure on social protection. The urban-rural divide in the geographical distribution of poverty is considered particularly worrying. Significantly however, the range of social services has broadened and care outside residential settings is starting to take roots in the EU10. In the National Action Plans, particular emphasis is given to improving the availability and quality of services, promoting individual approaches and community care, and training for professionals working in social services. Hungary has also emphasized these issues.

In this context it is also appropriate to touch on some aspects of social care policy in the European Union, especially with regard to care for the elderly, one of the most vulnerable population group in both urban and rural settings towards whom a significant and growing proportion of services is directed. The most important initiatives are the *'Green Paper on European Social Policy'* (1993) and the EU Communication on *"The future of health care and care for the elderly; guaranteeing accessibility, quality and financial viability"* (2001) and the 2004 Communication on *"Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies"*.

The 2001 Communication points out that demand for services is set to increase with higher life expectancy, identifying three long-term objectives, namely accessibility, quality and financial viability. The 2004 Communication recognises inequalities in the distribution of services and insists that access is ensured for disadvantaged groups.



### **Main questions and areas of debate on the policy in Hungary**

The main period of expansion for the caretaker service took place within a 'soft regulatory framework', creating very different practices during 1993, the year of enactment and 2000, when the Social Ministry specified the necessary services. According to the country expert, the precise reasons for the development of differing practices are the following:

- No professional control at the local level;
- The services are frequently offered as the result of a personal decision;
- A possibility that the local decision makers influence the services according to their needs and ambitions;
- No instrument to measure the caretaker service objectively.

At the same time it became clear that the needs of the population vary significantly between the different settlements because social exclusion has many aspects and sources and differing settlement sizes also require variations in services. In spite of this, the regulatory framework of the service takes a universalist approach.

Because of these issues, the National Methodology Department of the Village Caretaker Service Network started directing the expert coordination work which now has reached a consensus on areas of reform:

- **Prioritising of services listed in the Act.** Services will now be distinguished according to direct personal provisions and indirect services to the local distinction.
- **Documentation and itemising of the different service provisions.** Services will also be categorised in content and daily, weekly and monthly systems.
- **Quantifying the actual productivity of the village caretakers.**
- **Finance reform of the service.** The funding of the services will now be based on *output*, rather than on *input*, as is the case until now.

The above changes will substantially reform the village caretaker service. When the regulation is enforced, services will be better structured, more objectively



measured and evaluation of the caretaker services will be possible and more importantly, the provider and local authorities might show more interest because of the changed finance regulations which ensure that the settlement population will receive the services they need. Furthermore, the evaluation, documentation and measurement of the services provided will serve as the basis for new developments. In short, the new regulations will introduce quality measurement and a better integration of the caretaker services into the general social service system.

### *C.2 Description of Practices and Experiences in other European Countries*

For the description of practices and experiences in basic social service provision, eight countries were selected, all of which have large rural and/or remote and isolated areas in which a significant proportion of their citizens live. The countries below have a mix of ways in which services are provided, ranging from community initiatives to voluntary sector involvement and public outreach services.

#### **Care services for older and disabled people**

One of the most important issue for service provision in remote rural areas is the care of older people. On average, older people (65+), especially women, make up 20% of the population in these areas and their numbers are growing across Europe due to increased life expectancies, smaller families and out migration. In the EU15, 32% of people over the age of 65 and 45 of people over 80 live at home alone (Pillinger, 2001)

In all the areas examined, home care provisions for older and disabled people exist, although to varying degrees. The least developed can probably be found in Romania where social services in remote areas are almost non-existent. Where it is available, the initiative stems from the mayor who organises for example hot meals and basic care. Other services do not exist and similar to many other Eastern European countries, institutional care for older and disabled people is still very common. Across the EU15 and Iceland and Norway, by contrast, the aim is to keep older people in their own homes for as long as possible and promote their autonomy and independence. This is also the aim of Eastern European countries and advances have been made but until now, residential care prevails.



In the Outer Scottish Western Isles the number of inhabitants per settlement varies between 60 and 500. There are a total of 2695 inhabitants of whom 67 require home help which is mainly provided by public outreach services. In the Irish Western Isles, the situation is similar although community and voluntary organisations are more strongly represented and older people tend to live with their families. Local authorities are the main providers of home care in Iceland, Finland, Norway and Portugal although the situation is changing in those countries.

### **Example**

#### **Services for older and disabled people in the Scottish Western Isles**

Available services on the islands:

<b>Voluntary Services</b>	<b>Health Service</b>	<b>Social Services</b>
Dial-a-bus	Community Nursing	Home Care
Mobile shop	Continence Service	Day Care
Talking newspaper	Occupational Therapy	Respite Care
Red Cross Loans	Physiotherapy	Home Adaptations
Disabled swimming	Wheelchair Service	Aids and Equipment
		Community Care Alarms

Some of the services are only available on 2-4 islands, such as day care. Where it is not offered, day clubs are organised once a week. Older people's services receive approximately 46% of the total funding every year. The funding comes mainly from three sources: Orkney Islands council, National Health Service Orkney and the voluntary sector. The total resources spent on these services in 2001/02 equal approximately 12.332.133 Euros (6.528.776 Euros Social Services, 4.352.517 Euros health services and 725.420 Euros voluntary sector.) Social and health services have contract agreements with the voluntary sector and purchase many services from those. Government funding has considerably increased in the last four years and it is increasingly being linked to service outcomes.

*Excerpt Orkney Community Care Plan 2003-2006*



In Finland, people in remote areas have started to lobby for and also provide services for people in need. One way in which this is happening is the organisation of village associations. Village associations are not new but their more and more active involvement in service provision is a novel phenomenon. There are 3.900 voluntary organisations, including village associations, in Finland NGOs and private companies, often just consisting of one or two people who provide care services. These are mainly based and initiated at the local level and for a small fee they provide services such as meals on wheels, gardening, cleaning, hygiene, cleaning and escort services. Hungary's system of providing care for older people also seems to be a government provided service; with few non-governmental providers or private companies for people to choose with the service provider – the caretaker is locally based and therefore likely to respond to the needs of the individual.

In Portugal, services for older people are almost non-existent. For this population group, services (hot meals, hygiene and cleaning) are mainly organised by charities for which a small contribution needs to be paid.

### **Training of care staff**

- In Finland, home care provider training of is recommended, but not compulsory. A new three-year study programme is titled 'Household Services Entrepreneur'.
- In Iceland, mayors of small and very remote settlements hire local people to help out with meal provision, hygiene and cleaning. Basic training for several weeks is provided by the social services department.
- In Portugal, home care services are quite rare but in the area examined, Pampilhosa da Serra, there is a project organised by a charity which aims to train volunteers for this purpose.
- On the Western Isles in Scotland, health and social services are developing integrated training on health and safety, first aid, food hygiene, risk assessment and basic care and information technology.. For specialists, professional (counseling, substance abuse) training is required. The voluntary sector also provides training.

### **Other services**

Most countries concentrate on basic service provision in remote areas and specialist services are often not available locally. For children's welfare, Por-



tugal is the exception with one of the most developed services for children in a remote area examined. Services in Pampilhosa, including those for older people and others, are offered by five organisations; the local council, the local social security service (SLSS) and three charities, working in coordination with education and health services provided by local government. With regard to children, there is a home for those who cannot remain with their family (death of parent, violence, etc), there are two nurseries and three kindergartens, a children-at-risk service and out-of-hours activities, such as lunch for which parents pay according to their income and social care services located in schools. NGOs also organize activities during school holidays. For a comparison with Hungary, a map of Pamphilhosa da Serra can be found in the annex.

In the Irish Western Isles, in contrast, services for children are rare and located on the mainland. Similar to the Scottish Islands and Iceland, basic health care centres exist but visits from the doctor are only weekly. In Portugal, six out of the then municipalities are only able to make appointments with the doctor on a fortnightly basis. With regard to counseling and advice in cases of substance abuse, the Icelandic local authority Húsavík has invested in communication technology which makes it possible to conduct telephone interviews and some casework via the telephone and email. In the case of Norway and Scotland, child welfare/protection services and family support is only available at the municipal level but referrals can be made by visiting social workers.

## **Education**

Smaller families and particularly out migration are clearly affecting the availability of educational services in remote and isolated areas.

In Finland according to STAKES, approximately 1000 small village schools were closed during the last fourteen years. In the Scottish and Irish Western Isles, primary schools are usually available in all small communities although it is often difficult to maintain them when there are only 10-20 pupils in total. Children who are eleven years and older have to use school hostels on the mainland. Access to education is less of a problem for Iceland because most villages have their own school for children up to 16 years of age (as in Finland, education is not separated into primary and secondary schooling but is organised into a ten-year block for all). For those children living on isolated settlements or farms, there is a school bus. After that, education can continue at a municipal level with school hostels. In Hungarian settlements where the caretaker is operating, school transport seems to be less of a problem.



## Obstacles

Transport raises the cost of service delivery by up to four times if provided as part of a public outreach programme and has also implications for older and disabled people in particular. It also has to be remembered that the time care personnel spend with people tends to decrease because the care workers have long distances to travel.

The transport issue is acute with regard to more complex health care provision, such as x-rays. In the Portuguese case, people have to travel to the central hospital ninety kilometres away but the bus service runs only once a day and travel expenses (taxis in most cases) are since 2005 no longer reimbursed. The school bus, jointly organised by the local authority and a private company, will shortly stop services as it is regarded as unprofitable. The Scottish and Irish rural population examined has the additional problem of living on islands from which transport is only possible by plane or ferry. These difficulties in accessing and using services have prompted the growth of community development associations which aim to provide services. Among those already organised are clubs for young and older people and mother and toddler groups.

In the Scottish Isles, for older people and those with disabilities, the journey to the mainland is complicated and long. There are, however, patient care coordinators working with the Red Cross to enlist trained volunteers to ease the journey. In Finland the taxi to school is only free of charge if it is less than five kilometres from home. Transport to doctors and hospitals is also mainly organised by taxi for which a part of the cost has to be paid. In response to this problem, municipalities have started to organise transport services for older people which again, are provided mainly by taxis but also by using group transport. People pay the same fee as for public transport. In this respect, the Hungarian caretaker system is potentially in a good position to respond to any needs that may arise in the settlement.

The EU project ARTS – Actions on the Integration of Rural Transport Services - a project within the fifth framework programme of the European Union - competitive and sustainable growth, has tested and also demonstrated effective ways of providing rural transport in Austria, Finland, Greece, Hungary, Ireland, Spain, Sweden and the UK. The project web page provides country studies and demonstrations, newsletters and also a Rural Transport Handbook for Operators and Transport Providers, available in several languages. In Hungary, the



main barriers for providing transport in remote, low-density areas were great distances between settlements, making it difficult to provide economically viable services and the limited willingness to pay for expensive transport. The bibliography at the end of this document will provide web address and contact details.

### *C 3 Evaluation and arguments*

Across Europe, there is a growing trend towards using a variety of service providers and contracting services to non-profit, and private organisations.

In Finland it is commonly agreed that because of the changing demographic situation, new solutions to service provision are needed. At the moment, the public sector is the main provider of services but new approaches should also involve neighbours, friends, families, NGOs and private companies. Public financial resources are strained, making it necessary to resolve the 'finance responsibility triangle' – citizen – local authority – state.

The Finnish government has already started a process this year in which the municipal and service structure is being reorganised. The recently started study programme in household services, the new strength of the village organisation in this matter and the trend to establish care companies in villages indicates that ordinary people have recognised that there is a need for change and an opportunity to provide services that are tailored to the individual.

In contrast to Germany which has a diversity of care providers, Hungary, Iceland and Norway, have service provision that is overwhelmingly in public hands. The Red Cross operating in rural Iceland is one of the few non-governmental organisations outside Reykjavik. As already indicated above, universal public service provision becomes too expensive in remote areas and the most vulnerable can 'fall through the net', if public outreach services cover vast distances with strained human and financial resources. Local solutions, such as home care entrepreneurs, perhaps partly financed by the public purse, empower users in remote areas and are likely to be tailored to the needs of the individual.

The people on the Irish Western Isles also desire more flexibility in home care provision. Available home help services are considered inadequate by people because payments are not made to careers who are relatives. This is in spite of



the fact that the majority of older people on the islands live with their families. In 1997, the Irish Western Health Board, which is responsible for most of the islands, has carried out a user satisfaction survey. The overall result showed that approximately 70% of the island population was satisfied with the services but a further breakdown also revealed severe service shortages in areas such as social work. Evaluations are common and required in Scotland. Both health and social care services are regularly inspected and the annual performance data must be presented to the government. Scotland also has five regulatory agencies which cover both health and social services.

Nordic countries tend to use locally based quality standard systems and Portugal has launched in 2000 the Social Network Programme in which nearly all municipalities now participate. One of the characteristics of the programme is that each municipality has to regulate and evaluate their social strategies. These evaluations are intended to inform future National Action Plans.

The Portuguese local authority of Pampilhosa has expressed unease about projects by charities because, as is their nature, once completed, the absence of services provided during the project is felt more keenly and there are rarely mechanisms to ensure that a project lives on. In Pampilhosa, a project that trains volunteers to provide everyday care to older people which is soon to end without continuity of service.

#### *C.4 Transferability and Policy Issues to consider*

##### **Transferability**

The Hungarian caretaker system presents an apparently unique approach to tackling social exclusion in small villages and homesteads, especially with regard to transport. It is a cheaper solution and firmly rooted within the locality. It appears to have succeeded in meeting a need for basic community social maintenance by ensuring that in the absence of mainstream personal social services, children can get to school, the sick have access to a doctor, the elderly have a hot meal and medicines are collected.

To those who live in remote areas, the caretaker will be a local person, known and hopefully trusted by the village, contactable, practical and probably the only social welfare personnel they will usually see and the only service they



will get. Where there was a gap in basic service provision, there is now a simple and relatively inexpensive point of contact and a link to the outside world. This development has been promoted and largely financed by government and supported by caretaker associations.

At the same time, there appears (until the current survey) to be very little known about the actual activities carried out by caretakers, their profile and relationship with the mayor and the village inhabitants and, critically, the extent to which they are aware of and respond effectively to local need and priorities.

This poses a problem when talking about transferability as we do not really know what works and what may not. We do not know the views of the stakeholders, in particular, those of service users, i.e. the village and homestead inhabitants. This, however, is not a problem restricted to Hungary. As we have seen in the previous section, there are very few countries that have carried out evaluations and surveys of this type.

What we can perhaps suggest is that here is a model which seems to have a number of strengths and which, for less economically developed regions and countries, may offer a useful building block upon which elements of mainstream personal social and other (eg. transport and health) services might be grafted.

Our visit to 'Bokor' village provided an example of this. As the caretaker spends a large part of the day driving the minibus and there is little time to develop other services. The village had recently employed a social care assistant whose task it is to hand out meals brought in from larger settlements, and to provide homecare service for older people. The base was a multipurpose centre which would be used for day care, a library, kitchen, public toilets and even bedrooms on the first floor which might generate some income from tourists. This 'may provide a basis for gradually developing the range of sustainable services with a small social economy linked to nearby villages.

The experience of other countries reflects the problems faced by poor and remote areas although those with stronger economies are able to afford what is essentially a mainstream service provided in an outreach manner. Even in these countries, however, the tensions are being felt around an increasingly aging society, strained transport systems, increased costs and diminished supply of trained professionals.



This becomes particularly obvious in the case of Portugal where the school bus service is under threat. There, the transport services of a caretaker would be an alternative if there is a possibility of implementing such a scheme in a cost effective manner. Even in countries such as Ireland, which has expressed interest in Hungarian policy; Scotland, Iceland, Finland and Norway, such services could potentially be of benefit to the dispersed population where mainly taxis are used to drive children to school (in the latter two countries).

Data from more Eastern European countries has not been forthcoming, reflecting perhaps the lack of service provision and information on this issue. It is very possible that the Hungarian caretaker model, not only in relation to transport, has real applicability for remote settlements with a similar structure.

As a consequence of financial and human resources constraints and the difficulty of accessing services, new approaches to meeting the needs of rural communities are beginning to emerge. These include the greater involvement of local people and the development of self help or small service associations, the imaginative use of new technology, public/private transport solutions and the growth of social enterprise networks.

The invitation by the Hungarian government to share their experience of the village caretaker model provides a timely opportunity for a wider consideration of the importance of addressing rural poverty and exclusion and the need to develop creative and adapted social services solutions within economic constraints.

### **Issues for developing and improving service provision**

- *Effective monitoring, evaluation and sharing of best practice.* It is difficult to underestimate the importance of these issues because they provide the foundation for the future development of services on a regional, national and European level. With respect to rural social services, very little material is available, making it a neglected policy issue in spite of its importance to social inclusion. This lack of evaluation is especially visible at a European level. User input is necessary and invaluable in service provision. What is important overall is developing simple and regular data transfer linked to service planning, cost and evaluation. This appears to take hold now in Hungary with the introduction of the new regulations.



- *Creating a learning environment.* Training for professionals and volunteers is an investment that ensures low staff turnover and a quality service provision. Service users should also be consulted in the design and content of training; it furthers social inclusion through user empowerment and will lead to well-tailored and individual services. Training does not need to be expensive. Voluntary groups or non-governmental organisation, like in Scotland, could be involved, thereby also creating a cross-sectoral approach to training and the provision of services. While the training of village care takers is adequate for the tasks carried out, e.g. transport of school children, delivering medicine, etc., there is no information on whether the care taker programme was formulated with the involvement of the village population and/or target groups. It is also not known if local people have channels for suggesting improvements, changes or complaints. With regard to the other tasks stipulated in the care taker's job description, such as child welfare, the training received does not seem to cover this aspect.
- *Communications systems.* Two levels need to be distinguished here: communication with the village caretaker associations and communication with the authority by which they are operated, be it the local authority, an institution of the local authority or a civil society organisation. Communication with the former would provide the caretaker with support and networking opportunities to compare experiences, consequently enriching her/his work and the service they provide. This could be done via intra or Internet and a website specifically designed to provide information and space for the exchange of ideas.
- *Management.* The experience of the caretaker service has highlighted the dangers of professional and organisational isolation and the need for an appropriate management framework. This would need to avoid creating a tier of bureaucracy which constrained local independence and initiative but rather a mechanism for support, priority setting and development which would be key to future capacity building. Given the rural location and the premium on time and cost, this might mean looking to non-traditional styles with a 'hands on approach'.
- *Building local and strategic partnerships.* Combating social exclusion is a multi-faceted problem requiring partnership and co-operation especially between those with responsibility for providing different services within a remote community. In both a local village level and in government there can be benefits from partnership working across services and sectors, no-



tably those of concern to rural communities namely, transport, education, health and social services. Consideration might be given, for example, to joint working between professional and the sharing of buildings for multi-purpose use. The role of non-government agencies appears underdeveloped in Hungary and may merit consideration in building social capital in rural communities. This appears to have been an important building block in other countries.

### **Some suggested questions for the peer review meeting**

- How might the different levels of government and different professional sectors (health, education, transport, social services) together address the needs of declining rural communities?
- How might the Hungarian caretaker service work in partnership with local authority to provide a comprehensive framework of social services within which there is recognition and support for the different and complementary roles of caretaker and social professional?
- Could other countries benefit from a caretaker solution to their own local social transport needs?
- What is the scope and potential of developing local partnerships involving, NGOs and social enterprise or even commercial companies together with local communities to find local solutions adapted to local need which builds on the caretaker role?

### **References**

- CEC. (2001). Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the "open method of coordination". [http://europa.eu.int/comm/employment\\_social/soc-prot/healthcare/com\\_04\\_304\\_en.pdf](http://europa.eu.int/comm/employment_social/soc-prot/healthcare/com_04_304_en.pdf)
- EC. (2000). Agenda 2000. [http://europa.eu.int/comm/agenda2000/index\\_en.htm](http://europa.eu.int/comm/agenda2000/index_en.htm)
- EC. (1999). Treaty of Amsterdam. <http://europa.eu.int/eur-lex/en/treaties/dat/amsterdam.html>



- EC. (1996). Cork Declaration. [http://europa.eu.int/comm/agriculture/rur/cork\\_en.htm](http://europa.eu.int/comm/agriculture/rur/cork_en.htm).
- EC. (1993). Green Paper on European Social Policy.
- EC. (2001). <http://europa.eu.int/scadplus/leg/en/cha/c11310.htm>
- EC. (2005). Report on Social Inclusion in the 10 new Member States. [http://europa.eu.int/comm/employment\\_social/social\\_inclusion/jrep\\_en.htm](http://europa.eu.int/comm/employment_social/social_inclusion/jrep_en.htm)
- EC. (2005). Joint Report on Social Protection and Social Inclusion. EU25. [http://europa.eu.int/comm/employment\\_social/social\\_inclusion/jrep\\_en.htm](http://europa.eu.int/comm/employment_social/social_inclusion/jrep_en.htm)
- EC. (2004). The Future of Rural Areas in the CEE New Member States. Network of Independent Agricultural Experts in the CEE Candidate Countries. [http://europa.eu.int/comm/agriculture/publi/reports/ccrurdev/text\\_en.pdf](http://europa.eu.int/comm/agriculture/publi/reports/ccrurdev/text_en.pdf)
- Finland Statistics. [http://www.stat.fi/index\\_en.html](http://www.stat.fi/index_en.html)
- Irish Western Health Board. (1992). Health Needs Assessment of Residents on Islands served by the Western Health Board.
- Pillinger, J. (2001). Quality in social public services. European Foundation for the Improvement of Living and Working Conditions.
- Orkney's Community Care Plan 2003-2006. (2003). [http://www.orkney.gov.uk/media/articles\\_media/pdf/CommunityCarePlan.pdf](http://www.orkney.gov.uk/media/articles_media/pdf/CommunityCarePlan.pdf)
- United Nations Statistics Division/OECD. (2005). Indicators on Human Settlements. <http://unstats.un.org/unsd/demographic/products/socind/hum-sets.htm>

### Further references

**Rural Transport.** This website was set up by the EC funded ARTS project and offers valuable information on rural transport systems in Europe. There is also a Good Practice Handbook.

<http://www.rural-transport.net/>

**Rural Development.** The Arkleton Centre for Rural Development offers research reports on migration, service provision, young and older people in rural areas, transport and much more. There is also material dealing with the European situation.

<http://www.abdn.ac.uk/arkleton/publications/index.shtml>

**The Northern Periphery Project.** This website has more detailed information on the project and its background.

<http://www.northernperiphery.net/main-projects.asp?intent=details&theid=100>