Chapter 17
Ageing and Caring in Rural Environments: Cross-National Insights from Central Europe

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17.1 Introduction

In this chapter we discuss how difficulties in receiving undisrupted, good quality care can be understood as place-based social exclusion. We concentrate on the provision of broadly defined care services in rural areas, combining knowledge from three neighbouring European countries: Czechia, Germany and Poland [this and related topics have been addressed in section IV within Cholat and Dacanto, and Széman et al. this volume from the perspective of service exclusion]. Although these countries differ in size, degree of rurality, and in the ways older adult care services are organised, all three nations identify the social inclusion of older rural dwellers as a particular policy and practice concern.

Spatial exclusion can be located at the intersection of exclusion from social relationships, services, and the cultural and identity aspects of place in later life (Vidovićová and Tournier this section). Here, we understand place and space as an essential condition for the realisation of all social interactions, including the provision of care as a special type of both formal and informal interaction. As such, spatial factors can represent a significant set of mechanisms of social exclusion, leading to unintended and unwanted outcomes, such as reductions in mobility, community engagement and social participation (Buffel et al. 2013).

We adopt Walsh's (2018) approach and recognise embedded services, amenities and the built environment as encompassing exclusion from services embedded in

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and delivered into place as a dimension of exclusionary processes. Recognising the multifaceted nature of social exclusion (Moffatt and Glasgow 2009) helps us to see how rural places per se are often perceived as marginal (Hooks et al. 2016), and how living (and caring) in rural areas is thus often understood as yet another minority status intersecting older-age (Vidovićová 2018). Evidence from various countries has demonstrated that professional services in rural areas are often less accessible, less specialised and more expensive than in urban settings (Kaye and Butler 2004; Goins et al. 2011), producing a form of spatial ageism or geographical injustice (Schlosberg 2007). However, how these processes operate in the contexts of Central European states has been rarely explored, and this chapter aims to address this gap.

For the cases studied here we employ a broad understanding of "care". Knijn and Kremer (1997, p. 330) suggest that "care includes the provision of daily social, psychological, emotional and physical attention for people". We will refer to care and support services as having various meanings, as this broad definition of care and caring activities include formalised and paid service provision as well as different forms of informal care activities. Thus, care will be understood as any activity, related to older people as primary recipients, undertaken with the goal of supporting their health and well-being and working against their exclusion.

Our approach combines country-level case studies (using aggregate statistical data) with a brief exploratory analysis of a European comparative survey (EU-SILC) to examine urban/rural differences in two arenas: first, we use the take-up of professional home care services as a proxy indicator of the availability of formal services (in the sense that they are provided, affordable, suited to, and actually needed by, older people); second, we compare data on retired people providing informal care or assistance in rural and urban areas, to examine the essential role of informal carers and more generally of volunteerism (Milligan and Conradson 2006) in rural settings.

17.2 Czechia, Germany and Poland – The Country Cases

With reference to Table 17.1, Czechia, Germany and Poland possess slightly different welfare regimes, socio-physical environments and cultures of expectation regarding care and support in later life (Mai et al. 2008), which in turn affect the ways care is provided to older adults within families and communities in rural areas. These three European countries are special cases within the EU, lying on the north-south and east-west divides evident in data on quality of life of rural dwellers (Eurofound 2019). Czechia and Poland have recently recovered from socialist experiments and still have much in common with other Eastern European countries. However, Poles and Czechs living in rural areas, according to the European Quality of Life Survey "EQLS" (Eurofound 2019), are not particularly deprived in terms of financial hardship and life satisfaction, which are problems often found in rural areas of Eastern and South European countries. As Table 17.1 shows, there was a dynamic change in at-risk-of poverty and exclusion rates between 2010 and 2018,

Table 17.1 Physical and population characteristics of Czechia, Germany and Poland (selection)

		CZ	DE	PL
Population (2019)	mio	10.69	83.10	38.38
Land area	km^2	78,668	357,386	321,679
Population density (2018)	pop/km^2	134	232	123
Sectoral contribution to gross value added (2019) % of value added OECD EU Average: Agriculture 1.6%; Industry 18.7%; Services 73.9%	Agriculture 1996	4.0	1.1	5.8
	Agriculture	2.1	0.9	2.3
	Industry	29.6	24.2	25.1
	Services	62.4	69.3	64.9
Employment rate (2016) (%)	Rural	71.3	77.4	62.5
	Town	71.6	75.3	63.1
	City	73.2	72.3	67.9
People at risk of poverty or social exclusion (%) [ilc_peps13]	2010 Rural	16.1	22.8	33.9
	2010 Urban	12.5	20.8	21.1
	2018 Rural	11.6	17.5	25.3
	2018 Urban	12.0	22.4	13.4
At-risk-of-poverty rate (%) [ilc_li43]	2010 Rural	10.2	18.8	23.5
	2010 Urban	8.2	16.2	11.0
	2018 Rural	9.2	15.8	21.2
	2018 Urban	9.5	18.4	9.6
Share of rural population (%) OECD	Rural	21.1	15.7	35.1
	Of which remote	–	2.2	6.4
Share of 65+ in total population (%)	1976	13.2	14.6	11.0
	1996	13.3	15.6	11.2
	2016	18.3	21.1	16.0
	2019	19.6	21.5	17.7
Share of 65+ in rural population (%) OECD 2019	Rural	20.3	22.6	17.0
	Rural and remote	(n.a.)	23.8	16.6
Share of 80+ in rural population (%) OECD 2019 (%) OECD	2019	4.3	6.8	4.3
Life expectancy at 65 (2015) – in years	Women	19.4	21.0	20.1
	Men	15.9	17.9	15.7
Healthy life expectancy at 65 (2015) – in years	Women	8.6	12.3	8.4
	Men	8.0	11.4	7.6
Living alone at 65+ (2015)	%	32.4	28.2	33.7

Sources: Eurostat; At risk poverty – EU-SILC, table [ilc_li43]; OECD 2010; OECD Regional Demography Database; https://stats.oecd.org/Index.aspx?DataSetCode=REGION_DEMOGR#; Agriculture, forestry, fishing, % of value added, 2005–2019; OECD National Accounts Statistics: National Accounts at a Glance (https://data.oecd.org/natincome/value-added-by-activity.htm)

which is important to note as previous research has shown that the national economy contexts actually make a difference in levels of urban vs. rural poverty (Hooks et al. 2016; Shucksmith and Brown 2016). We draw on Table 17.1 and other data to provide a brief contextual description of the three country cases.

Czechia is a midsize European country with more than ten million inhabitants, of which about one-fifth live in rural areas. There are few remote rural areas, especially in the context of international comparisons. The areas with the most challenges are found in so-called inner peripheries, *i.e.* peripheral regions located in the inner parts of the country, mainly along the borders of the administrative regions (*kraje*) (Musil and Müller 2008). While these include some rural parts, they are primarily the peripheral zones of metropolitan areas and regional centres, some of which are characterised by depopulation and difficulties in creating employment and in improving public transport and service access. This means that the problems usually documented in the rural literature are not exclusive to, or most prevalent in, rural Czech settings.

The population of rural areas are generally not declining, especially those with more than 500 inhabitants and outside the inner peripheries (Bernard and Šimon 2017). As a result, the ageing of the population is equally pronounced in big urban centres and small rural settlements. Older adult formal care services are governed by the principle of subsidiarity, with the regional and local governments having the main responsibility to provide services to citizens, including social care (Průša et al. 2015; Bareš and Víšek 2016). Regional governments also operate residential care and nursing homes. Finance is mostly provided to regional governments and/or care and service providers from the national budget. There is a cash benefit for frail people to cover the extra cost of services if needed, but long waiting lists for the required medical assessment for this benefit result in a high rate of non-take-up. Financing and quality are the most common issues in the political debates on care provision, since the regional availability of social services is considered medium to satisfactory, for both urban and rural regions (Průša et al. 2015).

There are also regional networks of charity and not-for-profit professional organisations active in providing various types of service (including care) to older people in rural areas. These networks are usually located in smaller regional centres, administrative districts of municipalities with extended competence (“*obce s rozšířenou působností”* (ORP)), serving older dwellers in surrounding villages (15–25 km). Non-professional care work is done almost exclusively by family members (Galčanová and Staveník 2020), community involvement in older adult support services has only a weak cultural tradition (see Table 17.2).

Germany has almost eight times the population of Czechia and is the most populous country in the EU with almost 83 million inhabitants. Germany also has the highest population density of the three nations, reflecting the fact that only 16% live in rural areas and only 2% of the population live in remote rural areas. While the agricultural sector is contracting, as with the other two countries (Destatis 2016), Germany is one of the few EU nations to actually have higher employment rates in rural places than in towns and cities.

Table 17.2 Czechia: Who helps rural dwellers 60+ with household chores and self-care?

	Help in the household (%)	Help with self-care (%)
Partner	48	6
Daughter	18	5
Son	10	3
Daughter-in-law	5	2
Son-in-law	1	–
Sibling	1	–
Care worker, other paid help	3	2
Friends, neighbours	3	–
Somebody else	3	1
Nobody	28	84

Source: Survey on ageing in rural areas 2016 (N = 1235; representative of people 60+ living in different types of rural settlement). Vidovićová (2018)

Germany has witnessed considerable depopulation in some areas, not limited but especially evident in the eastern rural districts where out-migration, especially by younger people, is most severe and is compounded by the general ageing of the population (Šimon and Mikešová 2013). These shifts within the structures and systems of local contexts peripheralise certain rural areas. Germany is the "oldest" of the three nations, with almost 22% of its population aged 65+, which rises to almost 24% in rural and remote areas.

Since 1996 Germany has had a system of long-term care insurance (divided into statutory and private components) to ensure services and care are provided to the ageing population. In contrast to German health insurance, the system is not meant to cover care needs completely, but to support families in managing the care of people living with disabilities and older people, similar to other conservative welfare states. Services are mainly provided by private enterprises, with a small proportion provided by non-profit organisations (Gerlinger and Röber 2009). Service development and delivery is mainly negotiated between care insurers, provider organisations and government agencies at the state level; regional and local actors (local authorities) have hardly any influence on service decisions, which remains an issue of political debate. Services provided do not cover personal care needs; this has led to significant pressure on families and the employment of a large number of migrant carers (estimates range to more than 400,000, *cf.* Rada 2016, p. 4), mostly from Eastern European countries, as live-in carers.

Poland is a large country of more than 320,000 square kilometres, nearly as big as Germany. However, population density is the lowest of the three nations, with the proportion of people living in rural areas (35%) twice that of Germany. Interestingly, the share of older people is actually a little lower than average in rural areas, which is another feature that sets Poland aside in the country comparison. Poland is also one of the two countries here affected by rural depopulation (Wojewódzka-Wiewiórska 2019).

Formal long-term care provision in Poland is considered to be largely residual (Perek-Białas and Racław 2014). Support in older-age is covered by the social security system (old-age and disability pension benefits), social assistance (care services and attendances), and health care (medical services, including long-term care). Local authorities ("*gmina*") are responsible for organising care services for home/residential care, day care (outpatient), and around-the-clock care. Social assistance centres determine the scope, measures, duration, and places where care is organised (Szczerbińska 2006). The policies which determine the quantity and quality of care services are drafted at the local level, with care allocations based on family and financial situations. By in large, the care needs of older people are mostly met by the immediate family, neighbours and relatives, and in some cases by directly employed migrant carers (Perek-Białas and Slany 2015; Kordasiewicz and Sadura 2017). Non-governmental care organisations for older people are rare in rural areas (Turek and Perek-Białas 2014). Such care arrangements are based on traditions and values still present in Polish society (Bojanowska 2008).

17.3 Comparing Czechia, Poland and Germany: An Urban/Rural Analytical Approach

As the previous paragraphs show, Czechia, Germany and Poland possess some differences and similarities in the care and support of older rural dwellers. In this section, we take advantage of data available from Eurostat and its revised three-category spatial classification. Cities (densely populated areas) equate to settings with at least 50% of the population living in urban centres; and rural areas (thinly populated areas) equate to areas with at least 50% of the population living in rural grid cells of 1 km^2. The third category of towns and suburbs has been omitted here.

17.3.1 The Use of Professional Home care Services

Often disregarding the homogeneity of rural places, it is generally agreed that "the spatial distribution of the population is a geographic feature of rural areas that makes service delivery difficult" (OECD 2010, p. 27). Therefore, while rural and urban citizens may have common needs and preferences, their location may lead to differences in service provision with rural communities often found to be underserved, in comparison with urban areas (Joseph and Cloutier-Fisher 2005). The data for Czechia, Germany, and Poland, however, suggest a more variable picture (Table 17.3).

If we disregard the five-percentage-point difference in the case of Poland, where urban dwellers report lower levels of subjective health than their rural counterparts, there are almost no differences in (subjective) health status between rural and urban

Table 17.3 People 65+ using professional home care services by household type and people 65+ in poor health by degree of urbanisation (%)

	Single household 65+				Two-adult household, at least one 65+				People 65+ in poor or very poor health (rural)	People (rural single household in poor health)
	all areas	urban	rural	r-u diff.	all areas	urban	rural	r-u diff.	%	%
Czechia	8.3	6.8	10.6	−3.8	4.7	3.7	6.1	−2.4	22	48
Germany	1.7	1.6	2.3	−0.7	3.0	2.5	2.7	−0.2	14	16
Poland	2.3	2.7	1.9	0.8	2.4	3.3	1.7	1.6	33	6
EU27	7.5	7.6	8.0	−0.4	5.1	5.0	5.0	0.0	18	44

Source: https://ec.europa.eu/eurostat/web/degree-of-urbanisation/data/database; table [ilc_ats13] (Data from 2016). Subjective health table [ilc_lvhl01] (data 2018). Own calculations
Note: r-u diff. = difference between rural and urban areas

dwellers in any of the three countries studied here. While subjective health status is only indicative of possible (prospective) need for care, it may provide us with an interesting comparison. On one hand a "healthier" country like Germany has a smaller proportion of people using professional home care services, which is what one would expect. On the other hand, people using home care services represent only about half of those who have serious health conditions in Czechia (48%) while in Germany and Poland this is 16% and 6% respectively. The share of home care users is greater in rural Czechia and Germany, but in Poland it is the urbanites who are more frequent users of services, and that holds for single-person households, as well as for couples.

To respond to the limited availability of different services – in Germany, for example – a growing number of rural communities have founded local aid associations to support disadvantaged older people. These self-organised agencies describe their work as "to help each other make life easier, to commit oneself to others, to volunteer to help and to gain from mutual help" (Rosenkranz and Görtler 2013, p. 12). They offer assistance in everyday activities, trying to complement or even compensate for the lack of public services. Local authorities strive to provide them with formal or organisational support. However, it has been shown that such self-organised help is fragile and depends on people who are active in the aid associations. Consequently, volunteers are often overwhelmed by the amount of work, increasing the risk of unsustainable provision (Alisch et al. 2018). In Poland, regional authorities decided to establish "Centers for Supporting Informal Carers" in order to collaborate with and promote voluntary agencies providing older adult services, as well as to support informal caregivers. However, despite the original plan to spread these centres across regions, most are located in urban areas. Thus, rural areas, which are more in need of such support, are left behind.

17.3.2 Informal Care and Assistance

Unsatisfactory, underperforming state-funded services often create a need to mobilise voluntary-sector organisations and volunteers to provide caring services. But the care provided by family and friends is not included in the usual measurement of voluntary sector activity (Skinner and Hanlon 2016). Yet, the person-hours spent by family and friends in acts of care represent a considerable share of the care services provided to older people [as is the case in Hungary and Russia, as outlined in Széman et al. this volume].

Here, we look specifically at older people's involvement in the provision of this type of care and support. As we have seen already in this chapter, partners are an especially important source of this type of help. Providing that there is a strong age homogamy in marriages we may assume that the partners of those being cared for are themselves older. This greater age of the carer hypothesis holds also in the case of adult children (60+) taking care of their very old parents (80+).

There are at least two reasons to expect that the level of informal care will be higher in rural regions than in urban areas: closer social relationships in rural areas, including family co-residence, and less availability of formal care and services, which then need to be supplemented by informal help. Figure 17.1 supports this expectation and provides an overview of the involvement of retirees in providing informal care or assistance as recorded by the EU-SILC database.

While, on average, there seems to be little difference between rural and urban areas in the EU27, we can see quite a notable variation in our three nation cases. The differences are both across countries and across rural/urban settings. Comparatively

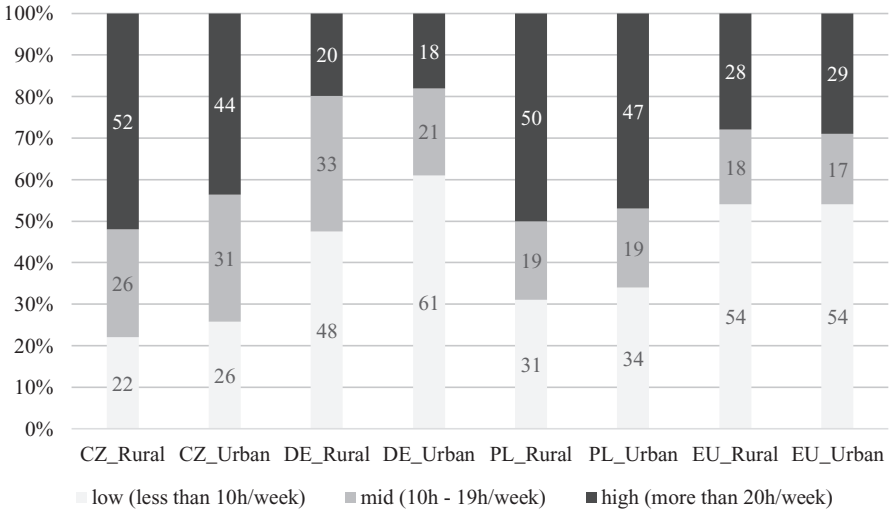

Fig. 17.1 Retirees providing informal care or assistance by degree of urbanisation and intensity of care measured as hours per week (in %)

Source: Ad hoc module EU-SILC 2016; table [ilc_ats18]; https://ec.europa.eu/eurostat/web/degree-of-urbanisation/data/database

speaking, older people in rural Czechia have the greatest involvement in providing care, followed by Polish rural older adults (inter-country comparison). Although a smaller proportion, German rural carers are still considerably more involved than German urbanites. An additional dynamic can be brought to light by applying a gender perspective. Despite the EU averages for rural and urban women being the same, women in cities provided less of the most intensive care (20 h+/week) than their rural counterparts in all three countries.

A qualitative research project in the Małopolska region found that informal caregivers were often left with minimal or no support, and without adequate information about other caring options. These results from Poland (Stypińska and Perek-Białas 2014) and elsewhere, direct our attention to the multidimensional risk of social exclusion for caregivers in rural areas (Racław 2012), including but not limited to financial hardship, lost status and relationships, isolation and constrained involvement in social and community activities (Keating and Eales 2017).

17.4 Discussion

As Walsh (2018, p. 254) summarises, there are two approaches to how place interacts with the processes of exclusion: first, the characteristics of place, and the factors that shape those characteristics, shape the exclusionary experiences of place (place as a domain of exclusion); and second, place functions as a fundamental determinant of exclusionary experiences in old-age, both in relation to place and to various other aspects of life in older-age (place as a mediator of exclusion). The provision of care to an ageing population is an interesting example of how different dimensions can inform the inclusion-exclusion continuum.

In the previous paragraphs we presented three case studies on the Czech Republic, Germany and Poland, the main goal of which was to try to evaluate possible interconnections between social exclusion from services and community/spatial exclusion. Care constitutes the principal element in welfare provision and the welfare state institutional network and also highlights the importance of care activities for the social integration of those working in and receiving care (Geissler and Pfau-Effinger 2005). The embeddedness of (delivering) care activities in a particular place seems to be at least two-fold: service/care delivery is: (a) a special kind of social interaction that is hindered or supported by the appropriates of the place; and (b) enabled and/or hindered by the policies which usually originate at the level of the nation and move down the spatially categorised levels of government, policy making and practice delivery. Both of these features seem to be specifically challenged in rural areas.

> ‘Very few national governments explicitly guarantee that public services should be uniformly available across their territory; there remains a growing perception […] that spatial equality of access should be part of the statutory rights of citizens.’ (OECD 2010, p. 24)

Many of the services seniors consume are considered to be core entitlements, so it is difficult or even impossible to restrict availability; just maintaining the traditional service infrastructure of these areas, ignoring the service implications of depopulation, may in the future not be enough to address the increasing demand for care in ageing populations. The low number of the working-age population entering the care profession and the need to recognise that the wages for these carers might be under threat are another two factors that may add to an increase in the overall costs, which are already high in rural settings. Asthana et al. (2003) specifies the following characteristics of rural areas that impact the costs of service delivery: economies of scale; additional travel costs, high levels of unproductive time; additional communication costs; and poorer access to training, consultancy and other support services to local providers.

While voluntary and grass-roots organisations are often relied upon to cover blind spots, our case studies show that this strategy may be threatened by prevailing cultures and customs. Shucksmith and Brown (2016) collected examples from various countries of how governmental strategies to address rural vulnerability had fed on narratives of community self-help to pass responsibility to local citizens, which involved both rescaling responsibility and shifting it from the state to the market and civil society. Skinner and Hanlon (2016, p. 4) make a similar point when they identify a gap "within prevailing discourses on ageing that emphasise the involvement of voluntary sector organisations and their volunteers (*i.e.* the "voluntary turn"), but do not take into account the crucial differences place makes to explain the uneven landscapes of volunteerism".

The situation of non-existent (Czechia), unstable (Germany), or dysfunctional (Poland) self-organised groups has been also described by Cloutier-Fisher and Joseph (2000) in Canada. The authors see this situation as one of the steps in more general processes of exclusion embedded in vulnerable places, resulting in significant service gaps, including deficiencies in sheltered housing, transport and mobility services, respite care, palliative care and mental health services. If attempts are made to address such gaps, there is a tendency to leave out the voluntary sector, both financially, and in terms of providing coordination and support. This reinforces:

> 'the reliance on voluntary-sector agencies and local governments for the provision of an important sub-set of community support services, and thereby perpetuates the systemic bias against rural communities exemplified by small over-burdened volunteer networks and limited tax bases.' (Joseph and Cloutier-Fisher 2005, p. 136)

Our case studies show that, regardless of the size of the country or its proportion of remote or depopulating areas, there can be similar discourses on care in rural areas. But the data, sometimes counter-intuitively, show that there is a lot of variation. For example, a lot of informal caring is provided both in the family-oriented Polish countryside and in Czechia, a country with a midsize rural population and comparatively common use of professional home care services, indicating a promising belt-and-braces approach to securing care provision. This pattern confirms spatiality as a useful, if not crucial, lens for evaluating social exclusion from services. The country level contexts may give additional information on the heterogenous results obtained at the community level and underline the importance of a culturally sensitive approach. The processes of policy making would greatly benefit from

recognising these interconnections between different levels of places and spaces and how they exercise influence over social exclusion outcomes in terms of service and care delivery and use. That may also include the rehabilitation of rural areas as those "on average worse off".

17.5 Conclusion

The analysis presented in this chapter is exploratory and as such faces many limitations. We were limited by the comparability of available data and with this data originally collected for a different purpose. Further, we decided to use the often rightly criticised urban/rural duality in our analytical approach, and to leave out the middle category of towns, as this category deals with yet another set of issues related to its sometimes "hybrid" character. By limiting ourselves to these two distinct categories we recognise we have lost depth and explanatory power, but we hope we have gained a simplicity, and clarity in our exploration. While emphasising the "importance of place in determining the experience of rural ageing" (Joseph and Cloutier-Fisher 2005, p. 146), we should not ignore the intertwining double heterogeneity of rural contexts and their, often increasingly, heterogeneous older populations (Scharf et al. 2016; Skinner and Winterton 2018). The scope of this study and datasets available didn't allow us to tackle these important intersections in any great breadth or depth, but instead illustrate the extensive set of questions that are left to be addressed in future work.

Editors' Postscript

Please note, like other contributions to this book, this chapter was written before the COVID-19 pandemic of 2020. The book's introductory chapter (Chap. 1) and conclusion (Chap. 34) consider some of the key ways in which the pandemic relates to issues concerning social exclusion and ageing.

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