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ELDERLY PEOPLE AS KEY ACTORS BEHIND SOCIAL INNOVATIONS IN RURAL AREAS: EXAMPLES OF CARE COOPERATIVES IN THE NETHERLANDS

Abstract
The article explores the potential of elderly people living in rural areas in terms of implementing social innovations related to care provision. It is argued that seniors should receive greater recognition as important actors organizing care at the local level. Two examples of care cooperatives recently established in Dutch rural communities are used to illustrate the argument. The article is based on a literature review and in-depth interviews conducted in the Netherlands in February 2017. The challenges involved in transferring this model to Poland are also discussed.

Key words
elderly people, social innovations, care cooperatives

Introduction

This article discusses the potential for elderly people to implement social innovations in rural areas by examining two care cooperatives recently established in the Netherlands. The goal of such cooperatives is to provide better, more personal and flexible care, and to increase awareness of this approach in comparison with traditional care providers, such as day care centres and nursing homes. Care cooperatives offer a network of support under conditions of weakening family and neighbourhood ties. The support is often provided by elderly people themselves, such as when younger and healthier residents help older neighbours in need. Care cooperatives are community-based social innovations that emerged in the Netherlands under conditions of economic austerity and a shrinking welfare state [1]. Under these conditions, it is not surprising that citizens implement solutions to problems in care without waiting for state initiatives. Both care cooperatives were founded by retirees living in rural localities, and most members and volunteers are elderly rural residents. It is argued that older people should be recognized as significant contributors in transforming the existing inefficient system of healthcare provision [2]. They are not just passive care receivers, but often undertake the role of carers and even social innovators introducing novel care solutions.

The article contributes to on-going discussions of the consequences of population ageing and decline observed in many rural areas of Western and Eastern Europe [3, 4]. The demand for care services is rapidly growing, especially in rural areas where the cost of delivering services is usually higher due to greater spatial distances and lower population densities. The recent economic crisis sped up the progressive reduction of state service provision. At the same time, social ties in rural communities are loosening due to the out-migration of younger generations, in-migration of newcomers from cities and socio-cultural changes triggered by globalization and individualization characterizing modern societies. Diversity of rural areas in European countries, as well as that in rural populations, makes the issue even more complex. Therefore, there is a need for innovative and flexible small-scale solutions. The article contributes also to the highly insufficient literature on rural ageing and of the elderly in community engagement and mutual support, especially in terms of care. [2, 5].

Firstly, there is a brief review of the literature on current tendencies in dealing with ageing and community engagement of the elderly in rural areas, followed by an overview of the Dutch context. Two conceptually innovative care cooperatives established in the rural Netherlands will be examined in detail. Finally, concluding remarks will be provided. Also, possibilities and challenges in transferring this innovation to rural Poland will be discussed. The Netherlands and Poland are obviously very different in terms of scale in rural populations, agricultural production, farm size and welfare systems. Nevertheless, innovative solutions tested in the West could be inspiring for Eastern European countries.

The article is based on a review of literature and in-depth interviews with the founders of selected cooperatives ([I.1] and [I.2]) and academic experts on the subject [I.3].[1] The empirical material was collected in February 2017 during my research stay at the University of Wageningen. While the examples of care cooperatives studied cannot be seen as representative for such initiatives in the Netherlands, the analysis presented is a starting point for further, more in depth investigation.

Elderly rural residents as support providers – a literature review

As O'Shea states [6: 279], the literature depicts elderly rural residents as passive recipients of support rather than contributors to the local cohesion: "*There is sometimes a stigmatizing view that older people are dependent and therefore unwilling and/or unable to contribute to local communities. Indeed it is easier to find evidence of what older people living in rural communities lack or need rather than what they contribute to the society.*" However, many older people remain active and are willing to work and engage locally. They often recognize local needs and problems much better than younger people or professionals from outside. They may be able to address problems more effectively as they often have better insight into the community. According to the author cited, such potential of elderly rural residents tends to be overlooked [6: 279].

Indeed, existing research focused on the active involvement of elderly rural residents in the community is quite limited. However, data collected from various projects in a few western countries (Australia, Canada, the Netherlands, Ireland and Northern Ireland) support the thesis that the rural elderly are important actors in the social and political life at the local level. The rates of their participation in social activities, civic organizations and volunteering are higher in comparison with their counterparts living in cities [2, 5, 7, 8, 9]. In Poland, there is some evidence that elderly rural residents often engage in local government, especially by attaining the position of village representative *(sołtys)*, as well as various types of local organizations and informal groups [10]. In the USA, existing research on retirees migrating to rural areas describes them as "grey gold" [11]. They stimulate the demand for housing, commercial goods and services. Elder in-migrants tend to boost the development of social capital at the local level due to their willingness to volunteer and lead civic activities in the community. They contribute to local government and other public structures by providing professional and technical assistance free of charge [11].

The existing research on the involvement of elderly rural residents in providing care within the community is even more limited. What was found is that older people's activities are often based on reciprocity – helping others and receiving support from them, such as assisting with domestic duties, shopping or simply visiting [5, 9]. Type and level of their engagement varies according to their origin and length of residence, gender, age and level of education [5, 9, 10]. It is important to note that, according to Dutch research, rural women more often than men help others with personal care, housekeeping, childcare and by visiting older and disabled people. They are also more active than men in community centres, women's and elderly organizations and do more voluntary work in hospitals and nursing homes [8: 386-387].

The recognition and analysis of the potential of elderly rural residents in terms of providing care is crucial in today's ageing societies, especially in rural areas. The main responsibility for providing services is being transferred from the national level to the local one. Moreover, the available public support is shrinking due to growing economic austerity. As a result, the concept of "community care" is gaining popularity. It encompasses a mixture of formal and informal health and social care services and support provided by institutions, professionals, non-profit organizations (NPOs), volunteers, as well as family members, friends and neighbours [12]. Often, it seems to be taken as guaranteed that rural communities are "well equipped" to fit in this model. Indeed, regarding care provision, rural communities are often described as deprived in terms of accessibility to institutional services but rich in informal networks encompassing family members, neighbours and friends [13].

However, such a view on rural communities is highly oversimplified. Walsh et al. [9] point out that the demographic structure of rural communities is undergoing dynamic change. On the one hand, out-migration of the younger generation leads to reduced services provided locally and fewer support networks for older

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people. Interpersonal relationships in rural communities are changing in that people are not used to calling at each other's homes anymore, and casual visits among neighbours are much less frequent. On the other hand, the processes of counter-urbanization, retirement and foreign migration are contributing to greater diversity in rural communities. These changes shape the contexts of ageing in rural areas and lead to increasing demand for flexible solutions addressing different needs in different local contexts.

Context of dealing with ageing in rural areas in the Netherlands

The Netherlands is highly urbanized and densely populated. There are no predominantly rural regions in the country when the OECD definition is applied at the NUTS-3 level. Still, some areas, like the northern part of the country, are socially perceived as rural. According to the definition of a rural area based on address density (fewer than 500 addresses/km²), the three northern provinces of Friesland, Drenthe and Groningen are the most rural, together with Zeeland, which goes in line with the social perception [14: 25-26].

It is expected that the Dutch population will start to decline from 2040. However, this can already be observed in some rural and peripheral regions such the northeast of Groningen, Zeeuwsch-Vlaanderen and de Achterhoek [15]. This process is caused by population ageing and out-migration of young people to the cities. In general, in regions where the population is already declining, it is expected that by 2030-2040 more than 1/3 of the population will be over the age of 65. Also, the share of people over 80 will grow significantly [16].

The tendency to concentrate and reduce healthcare institutions and other public services in rural areas, especially those affected by population decline, is also observed in the Netherlands. This concentration means large-scale, less personal services, often deteriorated in quality. The state is also seen to be withdrawing from direct healthcare services preferring to support citizen-led initiatives and decentralized distribution of public funds for healthcare and other services. In 2007, the Social Support Act was introduced in the Netherlands, which stresses the importance of active citizenship and volunteering. As Verhoeven and Tonkens state [17: 1], "Active citizens are expected to take personal responsibility for their employability, health and finances as well as for the social cohesion, safety and 'liveability' of their communities. Through volunteering, citizens are expected to shoulder tasks formerly performed by the state, such as providing care and support to disadvantaged and vulnerable groups." In these circumstances, the focus is on solutions that are smaller scale but also personal, of good quality and cheaper.

Care cooperatives as social innovations in rural areas in the Netherlands

Social innovations can be defined as new ideas (products, services and models) that simultaneously meet social needs (more effectively than alternatives) and create new social relationships or collaborations [18]. Bock points out novel elements of rural initiatives for social innovation [1: 566]: context of welfare state reform/austerity, new importance of self-reliance and self-organization, less trust in state support, collaboration with large and distant partners, use of ICT for self-organization, and developing alternatives with relevance beyond the local, positive re-labelling of "the rural". Care cooperatives recently established in rural areas in the Netherlands meet all these requirements [1: 566].

The first one was established in Hogeloon in 2005 as part of a movement in rural areas aiming to maintain local care facilities enabling elderly and disabled residents to stay in their villages. It is run by 25 professionals and 50 volunteers and offers care to 230 elderly people – members may live at their own homes or in one of the care villas located in the village. Care cooperatives are highly promoted by Dutch policymakers as good examples of active citizenship. Currently, there are about 50 such initiatives in the Netherlands [1: 561]. Care cooperatives are based on a mixture of professional and voluntary care, rooted in the concept of mutual help and solidarity: "You may also be not only a patient, but also offering some help, so that you exchange – you help somebody with something and the other person help you to do shopping. This is the important point of the discussion how elderly people could help each other." [I.3]

Care cooperative A: providing healthcare services at home

Care cooperative A was established in 2005 in the Province of North Brabant. It covers the municipality of L. which consists of four villages with a total population of 22,000 people. The cooperative is focused on delivering care at home, as the enlargement and concentration of healthcare institutions means that services

are more distant and care givers from institutions change constantly. The services include medical care provided by nurses, including palliative care, and assistance with one's daily tasks at home, like help in moving around your apartment or house, daily hygiene, and cooking. [I.1] The cooperative is managed by a board consisting of volunteers.

There are currently about 300 members in the cooperative. Single members pay only 16 euros per year, couples 22, as such affordability ensures access for everyone. Most members are already retired but not all join to receive services, some sign to show solidarity and some are anticipating future needs.

At the beginning, the initiative received financial support from local government, and local cooperative banking associations. Currently, cooperative care services are financed from different sources, including private money from care recipients or their families, municipal funds and public funds for re-integration on the labour market for healthcare workers who lost their jobs due to economic reforms and cutbacks.

Care cooperative B: connecting care seekers with care providers

Care cooperative B was established in 2015 and covers rural areas in three municipalities of Achterhoek, which is highly affected by population decline. The aim is to connect care seekers with care providers via an on-line platform: "The care seekers can find a care provider by themselves. (...) According to the profile, the care seeker can make his/her choice, look for the best price." [I.2] Available services include domestic help and companionship (doing shopping, taking care of pets, cooking, playing games, help with transportation, walking or doing sports together), taking care of the garden (cutting grass, watering plants), help with managing finances (e.g. paying the bills, taking care of the invoices), carpentry, painting and many others. The care cooperative is managed by a board of five volunteers who facilitate collaboration between care seekers and care providers.

Currently, there are almost 150 members (care seekers and care providers) in the cooperative. Most (about 70-75%) are elderly middle class people, independent and with a proper source of income. They perceive the cooperative as a good opportunity of getting support at home. The interviewee calculated that about 20-25% of the members are younger. The cooperative is also a good solution for people busy with professional commitments who don't have time for domestic duties [I.2].

At the beginning, the cooperative received start up financial support from the municipality. The cooperative's maintenance costs are not very high (renting rooms for meetings, maintenance of the on-line platform, publicity), but they still depend on subsidies from public institutions and private sponsors. The goal is to have enough care seekers and providers registered to be break even.

Establishing care cooperatives: older people as social innovators

Both examined care cooperatives were initiated by local retirees. In the case of cooperative A, one of its founders was a former director of the large local healthcare institution: "I retired when I was 65 and it was a pity to overthrow all the knowledge and expertise that we accumulated. That is what you often see in projects: no one continues with it when they are completed, so all gained and acquainted knowledge is lost." [I.1] Apart from that, his wife suffered from dementia, so he also had extensive personal experience as a family caregiver. The direct sources of inspiration were care cooperatives observed in rural areas in Sweden during a study visit organized for representatives of local government and public institutions. The 'care cooperative' model fit very well into local traditions of the cooperative movement in the region. Eventually, he managed to mobilize a group of local leaders concerned with the issues of healthcare and ageing.

Care cooperative B was established by an anthropologist who used to work for international TSOs (third sector organizations) such as Doctors without Borders and International Red Cross. He was inspired by the idea of two Dutch social entrepreneurs who developed such an on-line platform in 2013 in Zoetermeer, a city located close to The Hague. He heard their story on the radio and thought about the difficult situation of his own grandparents and parents when they had become older and decided to establish a similar platform in his region.

Elderly rural residents as active actors of service provision

Both care cooperatives examined engage elderly people not only as recipients of services but also as care providers. In care cooperative B, the share of retirees among registered care providers is substantial. According to the interviewee, many of them are retired employees of healthcare institutions who still want to use their professional experience and, at the same time, gain some money for doing that. Self-employed professional care providers are the minority [I.2] It is also worth mentioning that, in general, most care providers are women. However, it depends on services offered. For example, male care providers offer help with the garden, carpentry and electrical installations. Help with managing finances is also usually offered by men, whereas domestic help is provided by women.

In care cooperative A, some services and labour for the cooperative are provided by local volunteers, many of whom are already retired. Currently, there are 15 volunteers in the cooperative, but they can also count on the volunteers who are members of 360 associations and civic initiatives in different villages in the municipality. They include mainly senior people with a diverse set of skills, willing to share their knowledge and expertise by getting involved in local initiatives. The cooperative is supported by groups of women providing meals, but also specialists (women and men) who used to work at Phillips or made their careers in the ICT sector [I.1]

Apart from that, the care cooperatives empower care seekers by letting them co-organize the care provided. The cooperative formula guarantees the members a voice and voting rights on assemblies. In cooperative B, care seekers can freely choose care providers: “It’s so important to create a kind of self-management by the care seeker, so that the care seeker is able to find his/her own care provider for a certain amount of money and a certain time of the week. It is a care seeker who is able to organize his own care. It’s an empowerment of the care seeker.” [I.2]

Also, both cooperatives encourage diversification in Dutch healthcare by networking with other citizen-led initiatives in the field. Structures created by these initiatives negotiate with public institutions to make their perspective more visible and recognized. Both care cooperatives also take part in organizing on-line platforms connecting similar initiatives operating in different regions of the country. Apart from that, care cooperative A, together with a few other care cooperatives and local associations from Northern Brabant and Limburg, established a supra-local entity, which is a kind of an umbrella structure. Through this entity, they try to sensitize the representatives of the Ministry of Health, Welfare and Sport to differences between small-scale care providers and large healthcare institutions. They were asked by the Ministry to present some recommendations in terms of addressing difficulties care cooperatives face and to participate in a round table discussion.

Care cooperatives as flexible solutions creating social capital

Care cooperatives address needs related to the dissatisfaction with the quality of care services provided by large-scale healthcare institutions. They provide more flexible services tailored to individual situations based on a personal relationship between care seeker and care provider. First, care seekers are usually attended by one care provider who provides various services according to personal needs. For example, the same person can clean your house, do the shopping, walk your dog and cook your meal in the afternoon. When medical assistance is needed, you are visited by the same nurse every day. It would not be possible within the professional healthcare system, where care provision is organized into tasks coded as separate and provided by different people. Secondly, care providers in care cooperatives are often people from the same community as care seekers or live relatively nearby. Therefore, care providers are rarely alien and anonymous for care seekers [I.2].

By creating personal relationships between care seekers and care providers who usually live in the same area, care cooperatives address changing social ties observed in rural communities. They cover the vacuum left by family care providers who don’t live in the village anymore or don’t have time to take care of elderly relatives. Apart from that, relationships between neighbours are not as intense as they used to be. On the one hand, people feel less obliged to help. On the other, elderly people don’t like to feel dependent on the good will of others. Care cooperatives then fill the gaps left by shrinking resources for bonding social capital based on close family, kinship and neighbourhood ties. Referring to the types of social capital distinguished by Putnam [19], care cooperatives create, on the one hand, other resources of bonding social capital in the neighbourhood by connecting people of similar age and backgrounds who don’t know each other so well. On the other, care

cooperatives produce bridging social capital as similar age and professional experiences of care providers and care seekers, as well as their common area of residency are not always the case. It is important to emphasize that the care cooperatives established mechanisms to reduce risks in collaboration between people. For example, in care cooperative B, people who want to register as care seekers or care providers are visited and carefully checked by the board members.

Concluding remarks

The care cooperatives examined are interesting examples of social innovations initiated and implemented in rural areas by elderly residents. They address mainly the needs of older people related to healthcare services and assistance with various household duties as well as companionship. Such cooperatives clearly enable rural residents to “age in place”, i.e. continue living in their own houses while becoming less physically fit [20]. The initiatives studied show the importance of the engagement of elderly people themselves in organizing care in rural communities. These initiatives should receive greater recognition and support from local authorities and policymakers [5, 9].

However, the shortcomings of care cooperatives also need to be raised. According to Bock [1], their dependency on voluntary work makes them vulnerable and puts their sustainability under serious risk. Also, as my expert interviewee emphasized, the situation of non-members remains unclear: “(…) there is a problem of exclusion. Because you privatize the right to care. Because there are always outsiders in villages. And what about them?” [I.3] Therefore, there is a need for more elaborate research, including other care cooperatives and the opinions of their members and local non-members.

Discussion: lessons for Poland

According to projections, the Polish population will become one of the oldest in Europe in the next fifty years [21]. Unlike most Western and Eastern European countries, the most dynamic processes of population ageing are characterized in urban areas, but this trend is highly visible in rural areas as well [22]. It is worth pointing out that older people living in Polish rural areas are getting more diverse as a social category. First, existing studies of recent migration from urban to rural areas show that most newcomers are young adults and families with children, but a part of this influx, though smaller, consists of retirees. Secondly, due to the advancing disagrarization of employment, the category of retired farmers is shrinking, whereas the share of various professional experiences gained outside agriculture is increasing among the rural elderly [22]. All these processes create new challenges regarding rural ageing in Poland. A longer life expectancy means an increasing exposure of elderly people to chronic diseases, which may often remain unattended due to looser family ties and declining social relations in rural communities. Apart from that, older people living in rural areas will become more diversified in terms of their needs and expectations concerning types of support. The Polish welfare system, like those in other European countries, is experiencing great political, economic and social pressures [4].

The model of care cooperatives could be attractive as there are quite strong traditions of the cooperative movement in Poland, also in rural areas, as well as recent experiences with establishing so-called social cooperatives supported by EU policy [23]. However, there are serious doubts about care cooperatives’ funding of care services. Would people be interested in spending their own money in such an experiment, especially retirees whose pensions are often rather low? In cases applying for EU funds, how would the sustainability of initiatives be ensured when the funding is over? Apart from that, there are important cultural differences between Poland and the Netherlands. First, due to the complicated history and the experiences with the communist regime, Poles rarely trust institutions and people they don’t know. Apart from that, people in Poland, especially those in rural areas, are more willing to organize themselves in an ad hoc manner to solve a problem than engage in formal associations or volunteer on a regular basis [10]. Last, there is a problem of digital exclusion of elderly people in Poland. In 2016, only 26% of people aged 65 or over used the Internet at least once a week. The share of Internet users among people aged 55-64 was 43% [24]. Also, despite the lack of specific data, it can be assumed internet access is more restricted for the rural elderly than the urban.

References

[1] B. Bock, Rural Marginalization and the Role of Social Innovation: A Turn Towards Nexogenous Development and Rural Reconnection, Sociologia Ruralis 56:4 (2016) 552-573.

[2] A. E. Joseph, W. Skinner, Voluntarism as a mediator of the experience of growing old in evolving rural spaces and changing rural places, J. of Rural Studies 28 (2012) 380-388.

[3] T. Scharf, K. Walsh, E. O'Shea, Ageing in Rural Places, in: M. Shucksmith, D. L. Brown (Eds.), Routledge International Handbook of Rural Studies, Routledge, New York, 2016, pp. 101-124.

[4] A. Cerami, Aging and the politics of pension reforms in Central Europe, South-Eastern Europe and the Baltic States, Int. J. of Social Welfare 20 (2011) 331-343.

[5] S. Davis, N. Crothers, J. Grant, S. Young, K. Smith, Being involved in the country: Productive ageing in different types of rural communities, J. of Rural Studies 28 (2012) 338-346.

[6] E. O'Shea, Rural Ageing and Public Policy in Ireland, in: . McDonagh, T. Varley, S. Shortall (Eds.), A Living Countryside? The Politics of Sustainable Development in Rural Ireland, Ashgate, Farnham, 2009, pp. 269-285.

[7] J. Fast, J. De Jong Gierveld, Ageing, disability and participation, in: N. Keating (Ed.), Rural Ageing. A good place to grow old?, The Policy Press, Bristol, 2008, pp. 63-73.

[8] J. D. Fortuijn, M. van der Meer, Gender and voluntary work in rural communities in the Netherlands, GeoJournal 65 (2006) 381-392.

[9] K. Walsh, E. O'Shea, T. Sharf, M. Murray, Ageing in changing community contexts: Cross-border perspectives from rural Ireland and Northern Ireland, J. of Rural Studies 28 (2012) 347-357.

[10] I. Matysiak, Rola sołtysów we współczesnych społecznościach wiejskich. Płeć jako czynnik różnicujący kapitał społeczny, Wydawnictwo Naukowe Scholar, Warszawa, 2014.

[11] D. L. Brown, N. Glasgow, Rural Retirement Migration, Springer, Dordrecht, 2008.

[12] C. Milligan, Geographies of Care: Space, Place and the Voluntary Sector, Ashgate, Aldershot, 2001.

[13] G. C. Wenger, Myths and realities of ageing in rural Britain, Ageing & Society 21 (2001) 117-130.

[14] H. Delfman, Understanding entrepreneurship in the local context. Population decline, ageing and density, Ph.D. thesis defended at the University of Gronigen, 23rd of April, 2015.

[15] T. Haartsen, V. Venhorst, Planning for decline: anticipating on population decline in the Netherlands, Tijdschrift voor Economische en Sociale Geografie 101:2 (2010), 218-227.

[16] OECD, Demographic Change in the Netherlands: Strategies for resilient labour markets, Local Economic and Employment Development (LEED) Working Paper Series, 2013.

[17] I. Verhoeven, E. Tonkens, Talking Active Citizenship: Framing Welfare State Reform in England and the Netherlands, Social Policy and Society (2013) 1-12.

[18] B. Bosworth, F. Rizzo, D. Marquardt, D. Strijker, T. Haartsen, A. A. Theusen, Identifying social innovations in European local rural development initiatives, Innovation: The European J. of Social Science Research 29:4 (2016) 442-461.

[19] R. D. Putnam, Bowling alone: The collapse and revival of American community, Simon and Schuster, 2001.

[20] J. Sims-Gould, A. Martin-Matthews, Distance, privacy and independence: rural homecare, in: N. Keating (Ed.), Rural Ageing. A good place to grow old?, The Policy Press, Bristol, 2008, pp. 43-51.

[21] P. Błędowski, A. Wilmowska-Pietruszyńska, Organizacja opieki długoterminowej w Polsce – problemy i propozycje rozwiązań, Polityka Społeczna 7 (2009) 9-13.

[22] I. Matysiak, S. Michalska, Social farming: a new model of dealing with ageing in rural areas in Poland?, Sociologia e Politische Sociali 19:3 (2016) 65-82.

[23] T. Kaźmierczak, M. Rymsza, (Eds.), Kapitał społeczny. Ekonomia społeczna, Instytut Spraw Publicznych, Warszawa, 2007.

[24] CBOS, Korzystanie z Internetu, komunikat z badań 92/2016.