



Peer Review in the Field of Social Inclusion Policies

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



Synthesis Report

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1. Executive summary

1.1 Context

The Peer Review *Basic social services in rural settlements – Village and remote homestead community care-giving* took place in Miskolc, Hungary on 27-28 June 2005. It examined the Hungarian caretaker model from the national and European perspectives, analysed the policy's transferability to other EU Member States and undertook three site visits to Sajógalgóc and Hét, Sajósenye and Zilfz and Gesztely-Ujharangód and Szegi.

The meeting was hosted by the Hungarian Ministry of Youth, Family, Social Affairs and Equal Opportunities and attended by representatives from Slovenia, Lithuania, Greece, Portugal and Finland, along with stakeholder participants from Caritas Romania and the European Social Insurance Platform (ESIP). Hugues Feltesse represented the European Commission's Directorate General for Employment, Social Affairs and Equal Opportunities.

1.2 The good practice

The Hungarian village and remote homestead community care-giving policy is a special element of the Hungarian social service system. There are 828 village and homestead caretaker services, comprising 215 homestead caretakers and 613 village caretakers. Their goal is to assist those living in settlements with a population of fewer than 600 people and in satellite settlements far removed from densely populated locations. The village caretaker is usually a local person who is provided with a minimum eight-seat minibus and whose task is to meet the needs of the settlement's inhabitants. Since small settlements lack even basic services such as post offices, schools, shops, pharmacies or medical centres, the village caretaker's most frequent service is to transport people to these facilities.

However, the potential service capability is broader than that: it can link up with the existing social services, such as meals on wheels, school transport, transport to medical centres and pharmacies and transport to railway stations for those who work outside the village or to further education centres. The service can also be used to promote cultural events.



The village or homestead caretaker, who is usually elected by the village assembly and has to undergo special training organised by the Hungarian Association of Village and Homestead Caretakers, is the settlement's 'factotum' and plays a central role in its life, knows the community and its problems, has information about potential solutions and services and about how to access them. This complex and broad task list enables him or her to react to a wide range of situations and needs right where and when they arise. This is a considerable advantage compared with the conventional social services, which tend to be less all-encompassing and may be too bureaucratic.

The service became particularly popular and important because the Social Act stipulated that the local authority could provide basic services with the help of the village caretaker, thereby saving the costs of obligatory provision which also includes home care, family support and child welfare. However this has seriously overburdened village caretakers because their training programme does not cover these specialised elements. The Act was therefore amended in 2004 and now stipulates that village and homestead caretakers can assist in providing basic services, but cannot be exclusively responsible for them.

In spite of these challenges, these services are strengthening the development of local democracy, and the caretaker plays a special mediator role between the leaders of the local authority and the population. He or she signals the needs arising among the population and is able to give information about the opportunities and possible services offered by the authorities.

This multi-sectorial operation, the complex structure of activities and the low cost – compared to other services – makes this policy very popular both in small settlements and among villages that have satellite settlements around them. Although most of the existing services are sponsored by the local authorities, the associations of village caretakers form county-wide unions, making them major civil stakeholders in the counties.

1.3 Transferability

The Hungarian caretaker system presents a unique approach to tackling social exclusion in small villages and homesteads, especially with regard to transport. It is a low-cost solution and firmly rooted within the locality. It has succeeded in meeting the 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 possibly 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.

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 a diminished supply of trained professionals.

Among the peer countries – Finland, Greece, Lithuania, Portugal, Romania (participating country), and Slovenia – this is particularly relevant in some remote areas of Portugal where the school bus service is under threat. There, the transport services of a caretaker would be an alternative if such a scheme could be implemented cost-effectively. 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 (in the latter two countries taxis are mainly used to drive children to school). All participating countries have found the caretaker system highly relevant and elements of it are thought to be viable solutions to rural social exclusion in their own countries.



2. The issue: rural social service provision

2.1 Definitions

Before tackling the issue of rural social service provision it is necessary to examine available definitions of the terms used. For the purpose of this peer review, the term social services has to be considered in its widest possible sense to accommodate the range of caretaker activities. Both the village and homestead 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." (Pillinger, 2001, p. 3)

Hungary's choice of good practice – the provision of basic social services in remote rural areas – also makes it necessary to have a closer look at what are 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 EU definition, but 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. However the classifications are not applied consistently: for example Lithuania uses the OECD definition while Slovenia uses that of EUROSTAT. Estonia neither has a national definition, nor does it use one of the above and Hungary only makes selective use of the OECD definition.

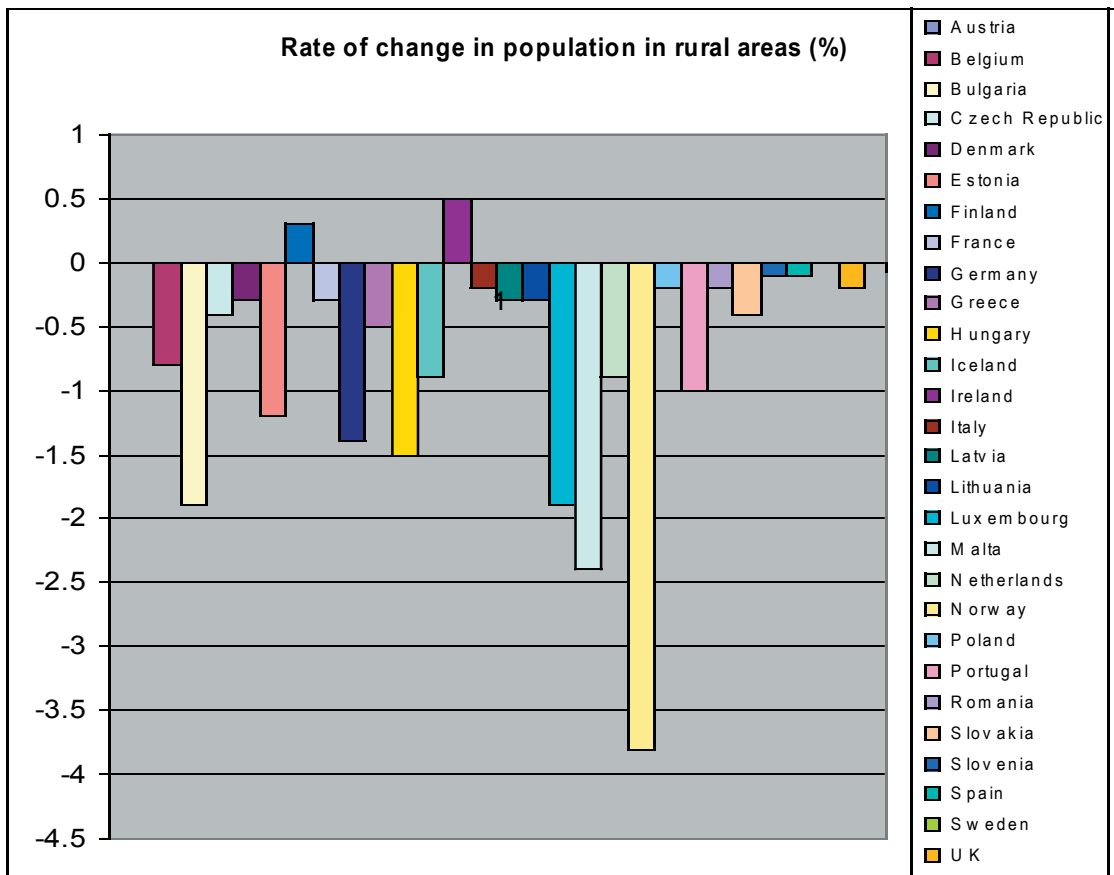
Consistent definitions, however, are necessary in order to develop much-needed indicators and also to formulate social policies that can deliver and adapt service provision to the needs of the population. National indicators which measure the well being of the total population overall are of little use 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 Inclusion 2005 and was further emphasised at the peer review meeting by the European Commission.

2.2 Summary of issues affecting social service provision in rural areas

Social services and infrastructure, especially transport, 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, as the following chart shows:





With the exception of Finland and Ireland, where the rural population is growing slightly, European countries are experiencing a falling or stable rural population. According to a EUROSTAT news release (2005), the overall projected population decline until 2050, especially in the new Member States, 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. As pointed out by ESIP, however, it is necessary to take into account the diversity of rural areas. According to ESIP, seven types of rural areas can be distinguished:

- rural areas with structural weaknesses
- rural industrial towns with a significant rented housing sector
- rural industrial areas with a recent growth in rented housing
- small industrial towns
- traditional, attractive rural areas
- tourist rural areas
- peri-urban rural areas

Infrastructure and service delivery solutions must be adapted to each different area individually since there are major distinctions between areas that are primarily dedicated to agriculture and those that live off tourism. The latter will in most circumstances have service delivery systems that outperform those in less dynamic areas. Also, out-migration does not affect all rural areas equally; it is mostly concentrated in rural areas with structural weaknesses.

The lack of vital social infrastructure, such as schools, also has grave consequences for the local economy, since job opportunities and incomes depend on it. In Finland the last 14 years have witnessed the closure of over a thousand schools in rural areas. Public outreach services are also affected, as long distances have to be covered by care personnel. In Iceland driving 200 km to reach users is not unusual. Social service staff in western Ireland and the Western Isles of Scotland routinely use planes and ferries. Transport is therefore intrinsically linked to the quality and access of services in rural areas, making it necessary to find integrated solutions.



3. The European context

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, social inclusion policy. References to the former areas of action will necessarily be kept brief, with the main focus on the EU's social inclusion policy since the peer review programme forms part of it.

3.1 Rural and regional policy

The EU's 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's 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.

3.2 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 states 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 of eradicating poverty in the European Union by the year 2010 using the Open Method of Co-ordination, which consists of the common objectives adopted by the Council, the National Action Plans for Social Inclusion, 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 Union must aim to reduce dispari-



ties between the levels of development of the different regions and reduce the backwardness of the most vulnerable regions, including islands and rural areas. Implicit in this statement is that people should not be disadvantaged, wherever they happen to live or work in the Union. The **European 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 studies to develop regional indicators on access to public social services and on regional capacity to address rural deficits. The National Action Plans for Social Inclusion are also a vital instrument that could be used to draw attention to rural social exclusion.

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 the 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. Greece, Ireland, Portugal and the UK, underline the issue of marginal rural areas with declining populations and poor service delivery.

In the New Member States, the Report identifies a serious deficit in terms of key social services at a community level, linking this to 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 root 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 providing training for professionals working in social services. Hungary has also emphasised these issues.

3.3 Care services for older and disabled people

One of the most important issues in 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 European rural areas and their numbers are



growing across Europe owing 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 provision for older and disabled people exists, although to varying degrees. The least developed areas can probably be found in Romania, where social services in remote areas are almost non-existent. Where they are available, the initiative stems from the mayor, who organises for example hot meals and basic care. Other services do not exist and, similarly 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 in 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 2,695 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 remote areas in Iceland, Finland, Norway and Portugal although the situation is changing in those countries.

In Finland, people in remote areas (especially in the east of the country) have started to lobby for and also to provide services to 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. Private companies, often consisting only of one or two people, also 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 and escort services. Hungary's system of providing care for older people also seems to be organised by the government; the caretaker is locally based and therefore likely to respond to the needs of the individual. In Portugal, in contrast, public services for older people are almost non-existent. For this population group, services (hot meals, hygiene and cleaning) are mainly organised by charities and a small contribution needs to be paid.



3.4 Training of care staff

- In Finland, home care provider training 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.
- In 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 training (counselling, substance abuse) is required. The voluntary sector also provides training.

3.5 Other services

Most countries concentrate on basic service provision in remote areas and specialist services are often not available locally. As regards children's welfare, the Pampilhosa region in Portugal is the exception among the remote areas examined, with one of the most developed services for children. 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 co-ordination with education and health services provided by local government. Children's needs are served by a home for those who cannot remain with their family (death of parent, violence, etc.), two nurseries, three kindergartens, a children-at-risk service, out-of-hours activities (such as lunch, for which parents pay according to their income) and social care services located in schools. NGOs also organise activities during school holidays. For a comparison with Hungary, a map of Pampilhosa da Serra can be found in the annex.

3.6 Education

In Finland, according to STAKES, approximately 1,000 small village schools have been closed in the last 14 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 they serve only 10-20 pupils. Children who are 11 years and older have to use school hostels on the mainland. Access to education is less of a problem in 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 in 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.

3.7 Obstacles

Transport raises the cost of service delivery by up to four times if provided as part of a public outreach programme and has implications for older and disabled people. 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 providing more complex health care services, such as x-rays. In Portugal, people have to travel to the central hospital 90 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 service, jointly organised by the local authority and a private company, will shortly cease, as it is regarded as unprofitable. The Scottish and Irish rural population examined has the additional problem of living on islands which can only be reached 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 co-ordinators 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 by taxi, for which 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 taxi but also by group transport. People pay the same fee as for public transport. A system similar to that of the Hungarian caretaker might alleviate the transport problem in these countries.



4. The good practice example

4.1 *The context*

Hungary has for many years experienced a declining remote rural population with consequent challenges in delivering social services for a socially and economically excluded and increasingly aging population. With 32% of all communities (total 1,020) 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. A recent survey showed that 98% of villages lack a crèche, 45% a kindergarten, 55% an elementary school, 56% a police presence, 69% a veterinary surgeon, 42% a district nurse, 75% a pharmacy, 60% a post office and 61% a club for the elderly.

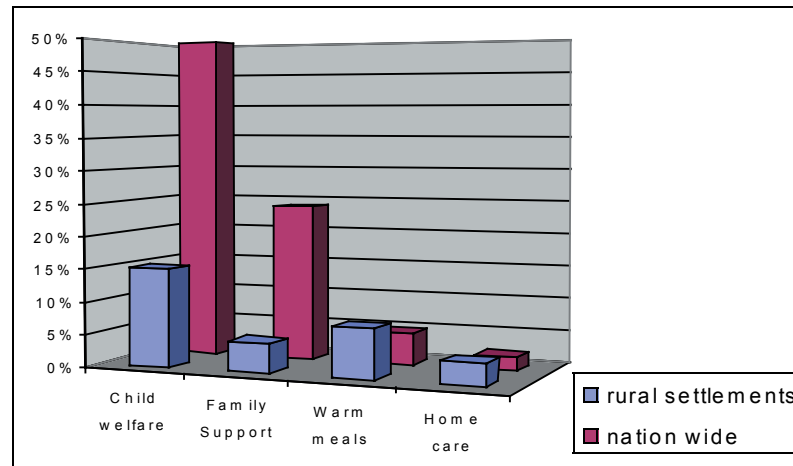
The Social Act requires local authorities nationwide to provide basic social services and also enables them optionally to provide day care social services in all communities, small as well as large. These are:

- **Child welfare service:** the Child Protection Act directs child welfare services to promote children's physical and psychological well being, to support their families and to monitor risks etc.;
- **Family support service:** 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 2,000 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 only 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 are 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 on 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 Association of Village and Homestead 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 established 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 in finding 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 founded the Hungarian Association of Village and Homestead Caretakers in 2000.

According to the Association, there is scope for up to 2,291 village caretaker services serving 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 caretakers in only 2% of villages while in others up to 74% of villages have caretakers. The most underprovided region is North Hungary.

4.2 Objectives and target groups

The Social Act states that: *"The village and homestead community caretaker service has the task of reducing the service deficit in disadvantaged small villages, satellite areas and remote areas and settlements by securing access to basic care and public services and meeting 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 training curriculum of the village and homestead community caretaker services must include the aims and objectives of the service and the target population."*

The overall objectives and targeting are therefore determined locally. Eligibility for the caretaker's help is mainly decided by the mayor (in 78% of cases), but also by the caretaker himself (56%), the elected village council (41%) and the village clerk (24%). Other regulations emphasise specific service goals and target groups (in brackets) for all caretakers, namely:

- providing basic social services (local authority to decide which)
- access to health care (for sick and needy)
- transport of children of kindergarten and school age (3-18 years)
- purchasing goods (for local authority institutions)
- managing public utility workers (long-term unemployed people receiving social assistance, who undertake paid work, typically in public areas (e.g. parks))



There is some ambiguity as to which 'basic' service aims might be addressed because according to law, local authorities are legally required to provide a range of identifiable basic services to all citizens (child welfare, family support, warm meals, home care, day care etc.). In practice however, caretakers' responsibilities are essentially restricted to school transport and meals on wheels.

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

4.3 The legal environment

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 services can be provided by the village caretaker service in 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 600 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 that raises the quality of life of the community can be covered. According to the Social and Family Ministry Regulations the village caretaker service should fulfil individual and community needs, in addition to those mandatory basic services listed above. 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 driving workers to the station or bus stop, shopping trips, repair of home appliances, procuring animal feed and crop seed, managing administrative matters;
- buying goods for local authority institutions, managing public utility workers, providing information and assisting people and the local authority in handling official tasks.



The regulations stipulate that the measurement and range of tasks be regulated by the local authority. The tasks of the caretaker therefore vary from village to village but are often, as the peer review meeting revealed, surprisingly uniform. The daily routine consists mostly of providing transport and meals for older people. It is clear, however, that the needs of the population in different settlements vary significantly. In spite of this, the current regulatory framework of the service takes a universalist approach. Because of this, the National Methodology Department of the Village Caretaker Service Network started directing the expert co-ordination work, and has now reached consensus on areas of reform:

- **Prioritising of services listed in the Act:** services will now be categorised as direct personal services or indirect services to the local authority;
- **Documentation and itemisation of the different services:** services will also be categorised by content and frequency (daily, weekly or monthly);
- **Quantifying the productivity of the village caretakers.**

The above changes will substantially reform the village caretaker service. When the regulation is enforced, services will be better structured and more objectively measured, 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 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 better integration of services into the general social service system.

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 relevant settlement. It requires local authority 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 if any permits have been withdrawn.



4.4 Financing the village and homestead service

Establishing a caretaker service involves an initial investment in 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 variation in the density of caretaker provision across the country. Since 2004 resources have become even more constrained. Between 1991 and 2004 the Social Affairs Ministry provided approximately 2.6 billion HUF (€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 2,120,000 HUF (€8,600). The financial environment of the caretaker policy will be further regulated and in the near future, the funding of services will be based on output, rather than on input, as is the case now.

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.

4.5 Human resources

A village caretaker area is served by one person, but several settlements may belong to the same area. In 2003 there were 707 village caretakers, and according to the Hungarian Association of Village and Homestead Caretakers there are services in 828 settlements, but it is unclear how many caretakers cover several settlements. According to the research carried out by the country expert, 87% of caretakers are men and almost all live in the settlement they serve. They are typically around 45 years old and have a vocational qualification. Approximately one-fifth have a background in farming while only 6% have previously worked in social services.

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 have completed the necessary caretaker training. However,



there is also some 'guidance', which may become a legal requirement in the near future:

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

Caretakers should also have good communication and co-operation skills, be trusted by the people and be multi-skilled. A study into the local caretaker network in Bács-Kiskun County identified four qualities and roles a caretaker plays and which often determine how successful a caretaker service is in assisting the local population:

- *A good communicator:* the caretaker builds links and is aware of the wider network of assistance. This role is present in 98% of cases.
- *A sensitive listener and active participant:* the caretaker is aware that his or her competencies are limited and that it is possible to turn to other professionals in order to resolve problems. This role is present in 83% of cases.
- *The absolute helper:* the caretaker is the person everyone – including social workers – turn to in order to solve problems. This is the case in 30% of caretakers examined.
- *A constructive co-operator:* this can increase the quality of services as the caretaker can initiate change, taking into account factors which possibly only he or she understands or knows of. This role is present in 51% of cases.

4.6 Training of caretakers

The training of caretakers has developed over the last 13 years from 2-day to 1-week to 2-week courses, and today there is a basic training course of 260 hours which comprises 60% theory and 40% local practice.

The professional training curriculum of the village caretaking service (article 5 of the Social Act), is organised by the Hungarian Association of Village and Homestead Caretakers and 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

4.7 Institutional arrangements

The key institutional arrangement for the caretaker service is the Ministry of Social Affairs who is responsible for funding the service, the local authority as employer and the caretaker associations which are established on a county basis and provide the training and professional support for individual caretakers. The association's role within the overall policy is vital for the further development and extension of the caretaker system. Four key roles identified by the Association of Village and Homestead Caretakers of Borsod-Abaúj-Zemplén at the peer review meeting underline its importance. The association sees itself first and foremost as a *link* that offers the caretakers a chance to meet each other. It also forms the county-level link between the villages and the ministry and stimulates co-operation with other professions. The association believes that it is vital to *maintain the personal nature of the services* provided to the population and it therefore strives to put in place local caretakers.

Another important role is *capacity building* among the caretakers who are usually lay people. Capacity building takes the form of obligatory training and offering further training courses at the county or sub-regional level. *Maintaining identity* is also seen as a cornerstone of the policy, and expresses itself mainly in the non-professional nature of the service provision. This reduces the distance to the local population and forms a counterweight to the social work profession which is mainly seen as an 'urban institution'.

As indicated earlier, local institutional arrangements vary from county to county and from village to village and depend on the number of institutions in the area and the initiative of the caretaker and mayor and the relationship between them. There is no overall, uniform 'way of doing things', reflecting both the widely differing local circumstances and the lack of a clear administrative framework.



There are stark differences between settlements in organisational and practical capacities and circumstances. Research carried out by the Hungarian Association of Village and Homestead Caretakers, for example, revealed that there are settlements where the only source of social care is the caretaker along with very occasional visits from a family care assistant – in one case the care assistant has to cover 20 other villages. On the other hand, there are villages in which the caretaker has an extensive network of contacts and assistance. One such example is the local network in Bács-Kiskun county where the caretaker is in regular contact with approximately 20 actors.

Of particular importance for the smooth running of the caretaking services is the relationship between the caretaker and the village mayor as employer. Again, the lack of clear guidelines stipulating the type of relationship means that there is a multiplicity of different situations in the villages and settlements of Hungary. Site visits organised for the peer review meeting revealed many factors that influence this special, often political, relationship and consequently the services provided.

One of the main questions here concerns the independence of the caretaker. In some villages, it is said that the mayor might constitute an obstacle to the caretaker's work, leading to marked contrasts in priority setting. In other villages, the mayor is not employed full-time and the caretaker consequently assumes a much larger and influential role in the village life, as is the case in the settlement of Zilíz.

4.8 Challenges and the way forward

From the information gained, both from the country expert and the peer review meeting, on the structure and dynamics 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:

- 1 Co-operation between different professions, services and sectors is not widespread and this inhibits development in areas requiring a collaborative approach, e.g. involving caretakers and centrally-based specialists.
- 2 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



and overworked, and the community with a poor service and without redress.

- 3 The lack of a framework for ongoing learning and development, which could involve caretakers in sharing good practice and adding to their basic initial training, would seem to be an obstacle to service development.
- 4 According to the national expert there is ignorance of the caretaker service amongst the general public and service users, particularly those who are less empowered, such 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 in many cases be detrimental to the mission of public service, the most efficient use of resources and the opportunity for service growth and increased quality. 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 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, for instance the Western Isles of Scotland and Finland, highlights the opportunity for such 'non professional' low-cost low-tech services to be provided locally, and this can very much be the strength of small organised communities, to bring together local needs with available local supply.

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

The peer review arrived at several conclusions as to how the caretaker service might be improved and further developed. It was suggested that co-ordination between the services needed to be intensified and further training at several levels, both for mayors and for other service providers, would be a very positive development. With regard to the issue of the independence of the caretaker, the meeting indicated that depoliticising the caretaking service and moving it away



from the power of the mayor and towards the administrative system would contribute to a more efficient and individually tailored service. Furthermore, there is a need to extend the village caretaking service with each service being tailored to the characteristics of its host settlement. At the same time, qualitative improvement must also be a priority as standards are being developed.

On the other hand, the caretaker policy is without doubt a major achievement by the Hungarian government and the caretaker associations, who 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, 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 counties show in developing this service must be a testament to the values ascribed to this initiative and its potential to meet local need. The mayor of Tornaszentandrás village, Dénes Frajnyák, succinctly summarises the increasingly important role of the service:

“The village caretaking system has become indispensable in the village. The minibuss is indispensable, and the villagers think of it as their own. I can say that now the people who live in these small settlements cannot imagine life without the caretaker service.”



5. Relevance for and transferability to other national contexts

5.1 Assessment of relevance

The comment papers and the peer review meeting indicate that the village and homestead caretaker service is relevant to all peer countries. All countries have large rural areas characterised by the issues already mentioned in the discussion paper: out-migration, shortage and inaccessibility of services, a large and growing percentage of older people. The peer countries, of course, experience these challenges to different degrees because each has a different level of service provision, individual legislation and often markedly different areas that are classified as rural. In Slovenia for example, 31% of all country dwellers live in areas where access to services is relatively unproblematic because of an extensive transport network. Areas of concern include the so-called 'depopulated areas' (the highlands, the Karst and border regions) in which 15% of the population have witnessed economic and social decline.

Greece has, in addition to mountainous areas, over 2,000 islands where service provision is often scarce and Lithuania, although it has a well developed road infrastructure, also finds basic service provision in the growing number of homesteads to be difficult. In Romania, the problems relating to service provision are deep-seated and wide-ranging: approximately 48% of the population lives in rural areas where the poverty rate is twice as high as in urban areas and where even basic social services are almost non-existent. Finland considers the issue extremely relevant because in recent years it has become obvious that social well being in terms of geography is very fragmented with the eastern, more rural part of the country having a very low index of well being. The Portuguese situation is more pronounced with the distribution of resources and people skewed in favour of the heavily populated coastal urban centres where the poverty rate is 13%, as opposed to 30% in rural areas. Older people are especially vulnerable. Statistics concerning social service coverage for children and older people do not distinguish between urban and rural areas but it is supposed that the latter are generally worse covered.

The Caritas representative from Romania, the participating country that would perhaps be the chief beneficiary of implementing a policy such as the village and homestead caretaker service, stated that this or a similar policy would definitely improve rural health and the general standard of living. Social ex-



clusion could be addressed quite effectively, especially with regard to school transport, which is very problematic in the country's rural areas. The institution of a caretaker as a 'bridge' position could also ensure access to other, at the moment very scarce, basic social services in rural areas.

5.2 Assessment of transferability

Finland

The peer review topic is highly relevant for Finland because, like Hungary, the country has large rural areas, especially in the north and east, with scattered settlements where the accessibility of the social service system is patchy. A recent national study confirmed this picture.

Finland emphasised that local services would need to be adapted very carefully because there can be no single pattern to delivering services. The caretaker policy is therefore considered useful since it allows tailor-made solutions to differing needs. On the other hand, Finland would produce and make use of local knowledge and expertise in order to deliver appropriate services:

"If we are evaluating or setting quality standards, we need information. There are three windows to the picture of regional welfare – statistics, experience and expertise – and we need all three windows. We have to listen to what the people who use the service say, and here we need the perspective of experience – the citizen's experiences of everyday life, as expressed through biographies, narratives, memory, local histories. We need to use the information people produce in their everyday life." (Harri Jokiranta, peer review meeting)

However, a transfer of elements of the caretaker policy would be possible. The transport aspect is of particular interest because Finland strongly supports older and disabled people who wish to live at home. Organising transport to health care centres and schools would be a priority. The question of the roles of caregivers and professionals in social services is also very important and has transferability to the questions of how to use and promote social capital (e.g. village house activities, village associations, everyday help given by neighbours and families) as part of the local social security system.



Greece

Recent changes in the framework for health and social care policies which aim to integrate and decentralise the national social and health care system by creating 17 Regional Health and Welfare Authorities represent an important policy shift in Greece and pave the way for accessible services. The creation of a local, tailor-made solution, both for localities and individuals, is therefore an attractive option for Greece. According to the comment paper however, the policy approach and the financing of services may not permit a transfer. Similarly to other countries, at the moment Greece does not have an integrated and cohesive policy on service provision in rural areas. More importantly, Greek policy towards vulnerable people tends to stress income support and does not focus sufficiently on access to social rights, goods and services by households and individuals. This type of intervention is available on an ad hoc basis through programmes elaborated at the regional or national level and is mainly implemented with EU funding. A transfer would also depend on the motivation and political will of local authorities as they have the expertise and competence to implement such a service.

There is also still a large gap between aspiration and reality. Although Greece has undergone a significant policy change, which empowers municipalities, most services, such as home care, child welfare and family support are still provided centrally and are therefore often difficult to access. In this respect, the Hungarian village caretaker model is an interesting policy.

Lithuania

Lithuania would consider a transfer of the village caretaker model on a temporary or modified basis. Some of the issues that are pressing in Hungary, such as school transport, care for older people and transport to doctors, already exist or are in the process of being developed. As part of the State Education Strategy for example, school buses (on the state budget) are used to provide transport for children living in inaccessible areas. There is, however, a lack of staff which makes implementation difficult and patchy. Lithuania is also in the process of developing a network of primary health care services and is promoting a policy that would ensure the permanent presence of general medical practitioners in rural areas. They would be provided with the necessary equipment and cars. Older people in remote areas, as specified in Lithuania's Catalogue of Social Services, are entitled to direct payments, which they can



use to pay for home care provided by friends or relatives. However, at the moment, health care centres are still mainly situated in regional centres and public transport, although available, is not frequent. The Hungarian model could fit in there until a more comprehensive service provision is in place.

A service comparable to that of the village caretaker (in relation to transport) is the minibus for disabled people. At the initiative of the Ministry of Social Security and Labour, all municipalities have received a minibus to provide services for people with disabilities, but many municipalities find the funds available insufficient to maintain the buses and pay the drivers.

Similarly to Hungary's division of regions into settlements, Lithuania divides rural areas into neighbourhoods, of which there are 500. Each neighbourhood must have a social work organiser, who is responsible for collecting information about problems and needs, and one visiting care worker per 1,000 people. The care worker also supports families and children at risk, making it necessary for the care worker to be a professional. Lithuania uses some elements of the village caretaker model, but those are provided separately and by different institutions and are not co-ordinated. Lithuania also emphasised that it would be important to give local authorities the sole responsibility for such a policy since 'state intervention' might weaken local authorities' resolve and sense of responsibility toward their excluded citizens. With respect to caretakers' educational level, Lithuania stressed that non-professional caretakers would only be able to provide very basic services.

Portugal

Under certain circumstances, Portugal considers it possible to transfer the caretaker model. The comment paper cites as facilitating elements the low cost of the policy and the simplicity of implementation. It is also seen as a very flexible approach that permits tailor-made solutions and is based on the informal solidarity that is still strong in rural Portugal. There is also the possibility of creating more jobs, although the numbers will be limited. A transfer, however, would only be possible if the need for an initial and continuous training process and an institutional framework with supervision is considered. According to Portugal, it would also be necessary to incorporate the policy into a local partnership network, of which there are now many in the country. The implementation of an evaluation system, including user assessments, is also considered vital. Points that may prevent a transfer include the following issues:



- Who might employ these caretakers, given the fact that Portuguese local authorities do not have specific competences regarding the direct provision of social services?
- The private non-profit institutions of social solidarity, which are the major providers of social services in rural areas, tend to have a closed organisational culture, a difficult approach to innovation and flexibility, and a lack of qualified staff (who should play an important role in terms of institutional support and supervision).
- These institutions, even if they wished to employ the caretakers, would always need state financial support to cover salary costs and other expenses. This would only be possible via the establishment of 'atypical agreements' with the social security system, which is proving to be more and more difficult given the financial difficulties currently faced in terms of the state budget.

Slovenia

Slovenia states that the most important prerequisite for enabling a transfer of the Hungarian model would be a recognition that remote rural areas are actually in need of such a service. Although research points to the fact that people in rural areas are vulnerable to social exclusion, no needs assessment has been carried out either by the Ministry for Agriculture, Forestry and Food or by the Agency for Regional Development. According to the comment paper, this issue urgently needs to be discussed by these two departments and the Ministry of Labour, Family and Social Affairs. There is however an element of transferability which would probably need to be modified. In Slovenia, service providers have to be professionally qualified and need to have completed at least secondary education. Professionals who have a licence from the Social Chamber would then supervise their work. The caretaker system is nevertheless attractive to Slovenia because it delivers services irrespective of where the user lives.

Caritas Romania

Romania has witnessed a rise in its retired population and out-migration of the younger generation. Forty-eight per cent of the population lives in rural areas, and the country has no tradition of providing social services, whether in rural or urban areas, since the communist system did not train social workers, therapists or psychologists. Romania is therefore in a particularly difficult, but also slowly improving, situation.



Romania's law referring to the social assistance system would allow a transfer of the policy since it also permits a transfer of competencies to the local and regional authorities. Indeed, the Hungarian village caretaker model is already being implemented by Caritas in two homestead communities in the county of Harghita. Caritas sees a possibility to extend the village caretaker system further within their home care network pilot programme, which is currently being implemented in the county of Harghita with financial and methodological support from Caritas Germany. According to Caritas, the advantage of this would be that the model would be integrated within a pre-existing service provider system, allowing well co-ordinated actions and documentation of the caretakers' actions.

However, it is not clear which institution would finance the policy since the state (from which the initiative stems in the Hungarian case) or interested local authorities, who work in partnership with Caritas, have not commented on the discussion paper. As in other countries, Romania also has difficulties in accepting and fostering a bottom-up approach to solving problems.



6. Conclusions and lessons learnt

This peer review has highlighted the challenges faced by national and local government, voluntary organisations and villages in delivering accessible high-quality services in rural areas. These challenges are not limited to Hungary or the Eastern European Member States; they can be encountered across the European Union in all countries with a significant rural population. This report contains many examples of policies designed to bring about social inclusion in rural and remote areas without failing to mention that service delivery in these areas can be problematic and often patchy. The main barrier to delivering services appears to be the lack of transport and service infrastructure, a problem identified in every country examined. This issue affects the quality of services and the availability of staff necessary to deliver them. As mentioned in the earlier sections, the scarcity of services and physical, financial and human infrastructure is exacerbated by out-migration which is especially high in rural areas with few resources.

Responses to the challenges of rural service provision vary from country to country and from village to village, reflecting different service delivery systems and national and local priorities and traditions. This peer review was therefore a valuable opportunity for participating countries to stand back, compare and evaluate their own policies in the light of the good practice presented by Hungary. The host country benefited from the opportunity to present the caretaker policy to other countries with similar conditions, making comparisons, highlighting the issues at the local, national and European levels, bringing together many concerned actors and last, but not least, bringing about a focused discussion from which many ideas to improve and extend the system emerged.

There can be no doubt that the village and homestead caretaker policy represents innovative good practice on which rural communities have started to depend and now consider to be their own. Local ownership is indeed one of the most outstanding features of the policy. Although the system is mainly financed by national government, it is entirely in the hands of the local community it serves. The result is a tailor-made service which takes account of and respects local circumstances. Its flexibility is its strength and often translates into the only assistance local people can rely on. Without the caretaker, local social and also often economic life would stagnate and probably fuel further out-migration. It is therefore important that Hungary proceeds with the extension of the model.



In spite of its strength, Hungarian research and the peer review have identified several points that have to be taken into account for the future development of the village caretaker system. These points also serve as lessons for other countries in a similar situation:

- There is a need for a sound information base on which services are planned and implemented. This includes better knowledge and understanding of the population's needs, not just in terms of socio-economic data, but by asking citizens and users what they require.
- When developing the caretaker system or any other rural (or urban) service, it is necessary to follow an integrated approach between health, housing, employment, social services and the community. Local networking and co-operation are the most important factors for delivering quality and accessible services.
- Education and particularly further training is vital for delivering services and empowering caretakers.
- Appropriate legislation should refer explicitly to social exclusion and clarify the exact role of the caretaker and people's rights to services, so that the population is aware of their entitlement and which services should be delivered.
- Rural social exclusion needs to be linked more strongly to the National Action Plans and the general growth and employment agenda within the European Union. Mainstreaming and especially the streamlining of the social protection system will help to develop more integrated services.

A final important lesson is to highlight the issue of rural service provision at a European level and to promote its visible inclusion in all aspects of European social inclusion policy. At the moment, rural policies are mainly found in the agricultural policy and exist at the margin or are non-existent in policy instruments that combat social exclusion. Rural social exclusion, together with scarce services, is a widespread problem in the European Union countries and therefore needs a higher profile than it currently has.



7. Annexes and statistical information

7.1 References and internet sources

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7.2 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>