Arrangements in Europe

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Interest in Green Care arrangements is increasing among scientists, politicians, health professionals and farmers, as well as among potential clients. There is a widely-held belief in the positive interaction between 'green' and 'care' (or nature and health), although it is difficult to explain and scientifically prove the relationship (De Bruin 2009; Pinder et al. 2009; Bokkers 2006; Fjeldavli 2006). Further, no agreement exists on the exact meaning of 'Green Care' - what kind of 'green environment' is meant and what kind of 'care'? This is reflected in the variety of names used for describing Green Care activities by referring to 'Green Care', 'care farms' or 'social farming' or more specific terms as 'gardening therapy' or 'animal assisted therapy'. Recognising the wide variation in arrangements and combinations of 'green' and 'care' has not led to agreement about what 'Green Care arrangements' have in common and what distinguishes them from other 'care' or 'green' arrangements.

This study is based on the work done in Working Group #2 of COST Action 866. The objective of that working group is to coordinate research and develop new research on the economics and management of Green Care farming. More specifically, we aim to develop a methodology to assess the economic benefits of Green Care services for farmers, for other parts of the agricultural sector and for the health and social care sectors, as well as to assess the more general social returns of such services. This methodology should allow us to compare the benefits generated for various groups and sectors, as well as at various levels of analysis. Ideally, it will also allow for a comparison of benefits across arrangements and countries. We therefore need to understand and structure the meaning of the various concepts used to describe Green Care activities. Once we do, we will be able to develop a classification of the characteristics of European Green Care Arrangements (GCAs). The classification would be built on the characteristics most relevant for the functioning of the various arrangements, as these characteristics capture the core of the different arrangements.

Research and earlier COST meetings have demonstrated the wide variety in GCAs (di Iacovo 2008; di Iacovo and O'Connor 2009).We try to

understand which differences are relevant for understanding and analysing the functioning of Green Care and what could serve as the basis of a classification system. The classification is based on literature research as well as on our discussions during COST Action meetings and Community of Practice meetings. In addition, we made use of the public reports of the SOFAR project (www.sofar.unipi.it; di Iacovo and O'Connor 2009) which inventoried, analysed and compared social/care farming arrangements in Italy, France, Germany, Ireland, Slovenia, the Netherlands and Belgium.

2.1 Three discourses of Green Care: multifunctional agriculture, public health and social inclusion

The Dutch model of Green Care often serves as an example of a 'professional' Green Care arrangement. It has many participants, it is well organised, officially recognized and registered, and is well-paid through official fees (Roest 2005 and 2007; Elings & Hassink 2006; Hassink et al. 2007). We therefore began our study by using the Dutch model as a point of departure to develop a classification system. However, when comparing green arrangements across Europe, it became obvious that the Dutch model is far from common. In many countries Green Care arrangements develop in different ways and follow a different logic (di Iacovo and O'Connor 2009). The variety of GCAs cannot be covered by the Dutch model. Moreover, taking the Dutch model as a point of reference gives the impression that it represents the most desirable model that others may not have fully achieved. As a result, the (socio-economic) value of other types of GCAs will not be understood and may possibly be underestimated.

When comparing the different ways in which Green Care is presented and discussed throughout Europe, the different ways in which it is organised, and the different parties involved, three main models come to the fore. These three European 'discourses' about Green Care are: 1) the model of multifunctional agriculture, 2) the model of public health and 3) the model of social inclusion.

In sociology, the concept of 'discourse' is used to conceptualise the basic premises on which social practices are built. They typically include the public representation of how something is and ought to be (the meaning), as well as the public organization of phenomena (Edgar and Sedgwick 2003).

Discourses are ideal-types, which means that discourse research focuses on and extrapolates differences and correspondences in order to understand the particularity of different systems. In practice, differences can be less clear and organisational forms can overlap. The same is true for the three main discourses of Green Care presented in this chapter. In describing them, we aim to understand which different frames of reference are guiding Green Care arrangements and explain why Green Care is defined, perceived and regulated differently in different countries. Not all arrangements will fit perfectly into these categories and we may find multiple systems and discourses in each country. Furthermore, the situation will most probably become more mixed in the future as ideas from other countries and systems are adopted. However, without clearly perceiving the differences, it is difficult to understand and acknowledge the core substance and value of different arrangements. This is necessary to model and calculate both economic and social costs and benefits in a meaningful way.

The discourse of multifunctional agriculture

Most research in the Netherlands views Green Care activities as one of many forms of producing extra income. Researchers calculate the amount of income generated through this activity and analyse its relative contribution to the farm's function of costs and benefits (Hassink et al. 2007; Oltmer and Venema 2008; Roest 2005 and 2007; Van der Ploeg and Roep 2003; Van der Ploeg et al. 2002). Within this frame of reference, Green Care is perceived as part of the agricultural sector and one of the new sources of farm income. At the same time, Green Care is presented as one of the multiple new functions that agriculture can fulfil in an urbanising society (Wiskerke 2007 and 2009). Green Care is typically represented as 'care farming', which highlights the importance of the setting within the farm sector. Economic studies aim to demonstrate that Green Care now constitutes one of the most important sources of income for multifunctional farmers (Hassink et al. 2007).

The farm-focused discourse is reflected in the description of the Dutch Green Care *philosophy*, which portrays the green and natural environment as healthy and curative. But great importance is also attached to the immersion in an 'ordinary' farm context, the involvement in 'normal' and hence relevant and useful work and the social interaction with 'normal' farmers and a 'normal' family or family-like group of clients and farmer

(Elings and Hassink 2008; Hassink and Ketelaars 2003). Farmers should of course know how to deal with their clients/patients, but they should not become health professionals and they should not engage in explicit therapeutic interaction. They should remain themselves, 'real' farmers (Enders-Slegers 2008; Elings 2004). Ferwerda-Van Zonneveld et al. (2008) described how important the farmer is for autistic children as role model and attachment figure. They also concluded that farmers are important in the care chain i.e., as personal intermediary between care institutions and parents and for monitoring and evaluating the behaviour and performance of clients in a non-institutional setting. Care farmers aim to provide 'care' in a new way, namely, on a small scale, with personal attention and individual care. This approach differs from institutional care and other forms of health care. Although care farming is an economic activity and often an indispensable source of income, farmers often mention social motives as the most important driver to initiate care activities on their farm (Roest 2005).

Placing 'Green Care' in the context of multifunctional agriculture makes sense if one examines the *organisation* of Green Care activities in the Netherlands. Most Green Care activities take place on private farms under supervision of the farmer (which can be male or female). Traditionally, farmers have engaged in care activities on a voluntary basis, motivated by feelings of social responsibility. In the course of the 1990's, a growing number of farmers started care as a commercial activity as one of several diversifying strategies (Van der Ploeg 2003). In most cases, farmwomen initiated such activities in order to create their own employment, as many of them had experience working in the health care sector (Bock 2004). Care farmers are paid for their activities by health care institutions, which send their clients to the farm as an alternative location for 'daily activation programmes' (occupational activity). They may also be paid by health insurance (AWBZ) or directly by a customer using his/her personal health care budget (PGB) (Elings and Hassink 2006). In all these cases, the payment originates directly or indirectly from health insurance. Some farmers also earn money out of Green Care activities by positioning their care engagement as an added value to their agricultural products. In this way, they can justify and receive a higher price. Care farming was institutionally stimulated and supported by the Ministry of Agriculture, Nature and Food Quality and the Ministry of Health, which (among others) subsidised the foundation of a National Support Centre for Agriculture

and Care, in existence from 1998-2008 (Elings and Hassink 2006). During that period, care farming has not only grown but also become more professionalised. This has resulted in the development of certification systems and education programmes, among others. A new national association has now taken over their work (http://www.landbouwzorg.nl). In addition, various regional associations have been set up.

The Dutch situation is unique in the European context. Based on the SOFAR inventory and COST meetings, we may expect that the situation to be similar only to Flanders (Goris et al. 2008) and Norway (Haugan et al. 2006) and potentially Slovenia (di Iacovo and O'Connor 2009). In Flanders, most green-care activities take place at 'ordinary' farms. The payments are low, but regulated and fixed (40 euro per day) and paid for by the Ministry of Agriculture. The payment for Green Care services is considered as a compensation for loss in production (income). The Flemish Ministry of Agriculture promotes Green Care but there are no institutional arrangements with the health sector that take care of the financial organisation (Goris et al. 2008). In Norway, farmers offer a wide range of care services that include health care, child care, and educational and recreational activities. Farmers are paid by the relevant public-sector departments and are encouraged to sign an agreement with the local authorities (Haugan et al. 2006). When the farmers have no health care related education, they cooperate with health professionals. However, there is also a growing number of Green Care oriented training courses developed for farmers. In Slovenia, new rural development policies recently started to offer some support for care farming as part of the promotion of multifunctional agriculture and diversification (di Iacovo and O'Connor 2009).

The discourse of public health

Other European countries frame 'Green Care' within the discourse of public health and as being part of health promotion activities. This is the case in Germany (Neuberger et al. 2006) and Austria (Wiesinger et al. 2006), and probably also the UK, although Green Care in the UK demonstrates characteristics of all three discourses (Hine 2008). The immersion in nature and green labour is considered of therapeutic value and is part of a medical plan of treatment. Green Care is one of many activities that should warrant caring and curing, or in other words health restoration and protection,

disease prevention and health promotion (Hine 2008; Hine, Peacock and Pretty 2008). Farmers may be involved as providers of the green (farm) environment but are not perceived as important actors in the therapeutic process. Green Care arrangements may take place at various locations but always under the responsibility of health professionals.

Green Care is often part of holistic health care approaches, which attach importance to recognising how health is embedded in specific physical and/or socio-cultural contexts. This *philosophy* gives most importance to the restorative effect of being in a natural environment (De Bruin et al. 2010; Verheij et al. 2008; Kaplan 1995; Sempik and Aldridge 2006). Various studies have been done which try to prove the health effectiveness of Green Care. For example, they have shown how being on a farm stimulates physical activity among elderly clients (De Bruin et al. 2009), which in turn stimulates their appetite (De Bruin et al. 2010b). But some also consider the mental and emotional benefits that results from caring for living objects – be it animals (Ferwerda-van Zonneveld et al. 2008; Berget et al. 2008; Berget and Braadstad 2008a/b; Bokkers 2006) or plants (Putz 2006; Ziwich et al. 2008; Elings 2006). Some also underline the beneficial effects of 'healthy' landscapes (Van Elsen and Schuler 2008) and the importance of the (physical and spiritual) experience of growth and change in natural cycles and seasons (De Vries 2006). Losing contact with the earthly basis of our existence may also be seen as a cause of illness; re-establishing this context is perceived as restoring physical and mental well-being. In Germany and Austria, this philosophy stems from the anthroposophist movement but has also spread into conventional health care institutions.

In Austria and Germany, Green Care activities are generally located at health care institutions and *organised* through hospital gardens and institutional farms (Wiesinger et al. 2006; Neuberger et al. 2006). There are few 'ordinary' farms involved in Green Care activities at their farm; most of them are anthroposophist or organic farms. Given the relation to innovative or 'alternative' health care paradigms, this is not surprising. In the UK, Green Care activities are often part of institutional health care arrangements but are increasingly also offered by private providers, including farmers (see chapter 4.6).

How do these arrangements function economically? In many cases, Green Care activities are paid for from institutional budgets just like any other therapeutic activity. They may be financed by the Ministries of Health,

health insurance, private health associations, and directly by clients. The professionals involved are formally employed and receive wages. Some of them may work as independent professionals that are paid official fees. Institutional farms are part of the health care institution and financed through regular budgets. In cases where a farmer is involved, he or she is most probably also formally employed by the institution and paid for according official wages. The primary farm products may be sold or used in the institution. In both cases, the 'profit' (in cash or kind) is generally property of the institution and not the farmer, even when reinvested into the farm.

It remains to be seen if there are also more entrepreneurial arrangements where (self-employed) farmers are paid for the delivery of 'care products' and function economically separate from the health care institution (similar to the Dutch model). In the UK the 'social entrepreneurship' model seems to enable such a provision of Green Care by private farmers within a public health discourse (see chapter 4.6).

The discourse of social inclusion

A third discourse can be described as the discourse of social inclusion. In most European countries, Green Care involves not only the caring and curing of clients who are in 'ill health'. Other activities such as school visits, involvement of unemployed persons, prisoners or former drug addicts are also grouped under Green Care (di Iacovo 2003). Some of these activities, such as school visits, may also be grouped under the discourse of public health as they provide education about healthy food and nutrition and stimulate physical exercise and the experience of nature as part of health promotion (Schuler 2008). Other activities explicitly mention social (re)integration and social justice as their main objective.

Social inclusion is the main discourse of Green Care in Italy (di Iacovo 2008; di Iacovo et al. 2006; di Iacovo et al. 2009). Italian Green Care is often organised by cooperatives, which engage in such activities as part of their voluntary civic and political engagement. In addition, the increasingly popular engagement in urban agriculture in the UK and the Netherlands may be classified under the discourse of social inclusion. They promote the participation in food production and experience of nature as contributing to individual health and well-being, but also social cohesion and inclusion

of marginal groups especially in the poorer metropolitan districts (Jarosz 2008; Stobbelaar et al. 2006; Wiskerke 2009). Also in France and Ireland, civic and voluntary engagement is an important driving force for the provision of Green Care, which is organised by individual farmers and civic associations generally without institutional support and in the absence of formal regulations (di Iacovo and O'Connor 2009).

The engagement of long-time unemployed persons, former drug-addicts and/or ex-prisoners in farm labour are part of a *philosophy* of social reintegration, participation and social inclusion. The goal is to re-establish the habit of working, build up knowledge and skills and build self-esteem. These aspects should eventually enable them to find employment in the regular labour market and re-integrate into society. Part of the philosophy is also the belief that manual physical labour generates well-being as well as the capacity for work (Hine 2008). Agriculture offers the type of manual, unskilled labour that is running low on regular labour markets. Again, the immersion in 'normal' work and working hours as well as the interaction with 'normal' people are important values of Green Care arrangements. Looking at those activities from the viewpoint of the providers of care, social justice and an ethic of care are important elements of the philosophy. They feel motivated and responsible for rendering modern society more inclusive and offering a home and sense of belonging to those living on the margins of society (di Iacovo 2008; Hine 2008).

The *organisation* and payment of such activities takes many forms. Some Green Care is organised by formally recognised organizations, e.g., rehabilitation centres, prisons or social services. In this case, public social services budgets pay for the activities in question. The clients may also receive compensation for their labour as part of the reintegration process. This is the case in institutional farms that belong to a prison or are set up for the purpose of social integration. When inmates work for 'ordinary' farmers, the farmers may also pay them for their labour. Farmers can receive payment from social services as an encouragement (or compensation) for employing 'difficult' labourers. The commoditisation of 'care' in the sale of ethical products also provides a kind of payment to the farmer (Carbone, Gaito and Senni 2007). In many cases where Green Care activities are part of the voluntary sector and organised as part of the civic engagement of individuals, groups or social movements. In these cases, there is no formal payment and monetary costs and benefits are not considered to be important (di Iacovo 2008).

2.2 Conclusion

These three discourses structure the wide variety of Green Care arrangements into three major streams based on organisation and philosophy. They also differ in financial arrangements and recognition of costs and benefits, which we have shown to the extent possible based on the limited information available. Chapter 4 contains a more detailed analysis, with a discussion of the costs and benefits of specific Green Care arrangements representing the three main discourses. Again, this classification is ideal-typical. It describes Green Care arrangements as belonging to one of three discourses. In practice, of course, Green Care arrangements share characteristics of different discourses. Normally, however, one discourse is prominent, as in the example of defining organisation and payment. We have also described certain discourses as dominant in certain countries. This does not exclude the presence of different arrangements and it does certainly not exclude the possibility of change. The main purpose of the classification is to analyse and clarify the wide variety in Green Care arrangements in Europe in terms of organisation and philosophy. Understanding how and why the different arrangements function differently allows us to learn more about each one. Each way of providing Green Care has different costs and benefits. One best solution does not exist.

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