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Older people and care networks in rural areas: An exploratory study in Italy

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Abstract

A care crisis concept has been introduced in the literature to describe the growing decoupling process between the expanding care needs of older people and the difficulties of informal and family networks in coping. These changes happened in rural areas quicker and with greater intensity than in urban areas.Against this background, the article investigates older people living in rural areas in Italy and focuses on care networks. The analysis draws on an exploratory study conducted in three rural areas, based on 48 interviews with older people living alone at home and with different degrees of functional limitations and care needs.The research findings highlight the emergence of a complex scenario characterised by different configurations of care networks and coping strategies of adaptation and reorganisation. At the same, the research suggests further research lines to capture the multifaceted dimensions and multiple inequalities related to the care crisis in rural areas.

KEYWORDS
ageing population, care crisis, care networks, coping strategies, Italy, rural areas

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INTRODUCTION

It is well known that European societies are facing significant socio-demographic and socioeconomic changes.

Among these changes, population ageing has become a prominent social issue (Colombo et al., 2011; OECD, 2021). This phenomenon may be seen as a virtuous evolution of societies explained by the progressive increase in life expectancy.

However, the number of older people suffering from chronic diseases and functional limitations has increased, causing critical care pressure consequences.

It is important to note that the automatic association between advanced age, functional limitations and need for care has been strongly criticised in the literature. It reproduces and reinforces stereotypical assumptions that neglect ageing process complexity and the differentiation of old age (Lambotte et al., 2019; Walsh et al., 2021).

However, care coverage for older people has become a crucial issue for other significant socioeconomic and socio-demographic changes that have taken place alongside population ageing.

While there are considerable differences between European countries, dependent older people have been traditionally cared for by informal family networks, particularly women (spouses, daughters and daughters-in-law; Haberkern et al., 2015; Lyon & Glucksmann, 2008; Saraceno, 2010). This is due to gender inequality in intergenerational care relations.

However, informal family network support has been increasingly eroded due to changes in family structures (e.g., smaller families and greater instability due to separation/divorce), the rise of new social values and women's labour market participation. While, on the one hand, these processes have represented crucial conditions, which have undermined the organisation and functioning of care arrangements, often shaped by patriarchal assumptions and traditional forms of oppression (Hankivsky, 2014; Mingione, 2017; Williams, 2021), on the other hand, they have also entailed a growing reduction of informal resources, which traditionally supported the care needs of older people.

A care crisis concept has been introduced in the literature to describe the growing decoupling process between the expanding care needs of older people and the difficulties of informal and family networks in coping (Hodgkin et al., 2022; Kröger, 2022). A combined dynamic of population ageing, the de-structuring of family networks and the tensions associated with such processes have particularly affected rural areas. These changes happened in these areas quicker and with greater intensity than in urban areas (Jones & Heley, 2015; Maclaren, 2017; Skinner & Winterton, 2018; Warburton et al., 2016).

For that reason, research studies conducted in several countries investigated the care crisis in rural areas, shedding light on the emergence of processes of care network reorganisation and coping strategies adopted by older rural people, with important similarities but also differences across countries (Anderson et al., 2020; Brooks & Meçe, 2023; Conkova et al., 2018; Elizalde-San Miguel & Díaz-Gandasegui, 2016; Hodgkin et al., 2022).

While several studies have already analysed the living conditions of older people in rural Italy (Lucchetti et al., 2008; Marcellini et al., 2007), to our knowledge, the terms in which the transformations determined by the care crisis have impacted rural areas remain unexplored so far, despite the care crisis tensions being salient and critical in this country.

Against this background, this article investigates the organisation of care networks in rural Italy from an explorative perspective.

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The article contributes to the emerging literature about the care crisis in rural areas and fills the literature gap for Italy.

The article is organised as follows. The next section presents the theoretical debate about ageing and care networks in rural areas. Then, the research design and empirical findings are presented. The empirical results are discussed within the thereotical debate. The article concludes with some considerations about policy implications based on the empirical results.

THEORETICAL FRAMEWORK

Care is a complex and relational concept entailing multiple dimensions (Finch, 1989; Knijn & Kremer, 1997).

When looking at the specific types of care needs, different domains crucially shaping the living conditions of people can be considered, ranging from personal care, practical care and socio-emotional support (Finch, 1989; Kröger, 2022).

The literature on rural ageing shows how the care needs of older people were traditionally embedded within strong family and informal networks (Coward & Cutler, 1989).

In rural areas, the large presence of residential proximity, based on forms of family co-residence and of multi-generational households, has facilitated strong intergenerational exchange and family support for older people in conditions of need (Anderson et al., 2020; Elizalde-San Miguel & Díaz-Gandasegui, 2016; King & Vullnetari, 2006; Walsh & O'Shea, 2008; Whal, 2005).

The presence of cohesive local communities, rich with social capital and informal networks, was a crucial factor for supporting older people (O'Shea et al., 2012; Petersen et al., 2022; Skinner & Winterton, 2018; Urbaniak et al., 2020).

This social configuration was embedded in the persistence of traditional values and normative expectations of family roles and informal networks in rural areas (O'Shea et al., 2012; Skinner & Winterton, 2018; Urbaniak et al., 2020). However, normative expectations have been shaped by structural care service availability limitations too. Specific contextual features, for example, low population density and long travel distances have traditionally made organising rural service delivery difficult (Hodgkin et al., 2022; Kröger, 2022; Volckaert et al., 2021).

Yet, the central role of family and informal networks has been radically undermined by important processes of demographic change that affected rural areas over the years.

The emergence of a care crisis in rural areas is related to the fact that population ageing has been coupled with a structural transformation of family and informal networks, affecting the traditional forms of protection existing in rural areas (Elizalde-San Miguel & Díaz-Gandasegui, 2016; Hodgkin et al., 2022).

Demographic change has contracted and verticalised family structures, with a negative implication on the provision of informal care (Brooks & Meçe, 2023; Elizalde-San Miguel & Díaz-Gandasegui, 2016; Hodgkin et al., 2022). 'Survival' migration (Brooks & Meçe, 2023) with growing dynamics of out-migration, particularly for young family members looking for better living and working conditions, have undermined family proximity and extended families (Klärner & Knabe, 2019; Walsh et al., 2020). Many older people have started to live alone in rural areas (Conkova et al., 2018). Furthermore, geographical distance has fragmented family solidarity and made intergenerational interactions and assistance more difficult (Brooks & Meçe, 2023), critically affecting the resource availability of rural older people in dealing with their care needs (Anderson et al., 2020).

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The critical impact of these demographic changes has been further exacerbated by the progressive macroeconomic transformation of the public regulation from models of spatial Keynesianism contrasting socio-spatial inequalities to neoliberal models, centred on austerity with few redistributive spatial goals (Brenner, 2004; Martinelli et al., 2017). Meanwhile, regional rationalisation and centralisation of public services have become strategic. This regulative shift has strongly penalised public investments and the expansion of formal care services in less developed and rural areas (Burholt & Dobbs, 2012; Klärner & Knabe, 2019; Milbourne, 2012; O'Shea et al., 2012).

Against this background, several studies investigated the effect of the care crisis in rural areas, by looking at the organisation of care networks, and how older rural people manage their care needs in conditions of structural change (Anderson et al., 2020; Conkova et al., 2018; Hodgkin et al., 2022; Petersen et al., 2022).

Empirical analyses conducted in several countries shed light on the emergence of a complex scenario in terms of care networks and coping strategies adopted by older people living in rural areas to deal with the coverage of their care needs.

There is not a singular experience, but a variety of experiences and adaptations, characterised by different interactions between informal and formal care, shaped by multiple factors such as the complexity of care needs, the presence of close family ties and the informal resources available (Petersen et al., 2022; Urbaniak et al., 2020).

Despite demographic changes and the spatial fragmentation of family networks discussed previously, several studies noted how family networks play a crucial role, with support and assistance to older parents taking place even at a distance.

Geographical distance and the absence of a strict spatial proximity between generations do not totally displace intergenerational solidarities. It is possible to identify the emergence of new forms of intergenerational care networks, based on different forms of functional specialisation. For example, these forms take place as intermittent support provided by family members (such as support that is activated only when necessary) or support that is functionally and temporarily focused, with family members providing assistance and support largely for specific activities (e.g., shopping and cleaning) combined with regular weekly visits or during the weekend (when allowed by geographical distance) while neighbours playing a more crucial role in emotional support and daily companionship (Hodgkin et al., 2022; King & Vullnetari, 2006).

Furthermore, also the diversity of rural places and in particular the embeddedness within different macro-contextual conditions in terms of normative expectations and institutional resources (Walsh et al., 2021) represent crucial factors in shaping the experiences and adaptations of care networks.

In general, in countries where traditional familialistic values are stronger, a certain orientation in terms of familial (female) care provision has been dominant, coupled with a more central role played by private and social networks (Walsh et al., 2021).

Similarly, the emergence of additional care strategies in these countries, including temporary co-residence for specific conditions of needs of older parents or when seasonal adverse conditions are critical in rural areas (like in winter), has been identified too (Elizalde-San Miguel & Díaz-Gandasegui, 2016).

Several studies point out older people are not passive in the organisation of their care networks but play a crucial proactive role in the capacity and adoption of specific coping strategies (Anderson et al., 2020; Conkova et al., 2018).

By adopting the Lazarus and Folkam (1984) framework, it is possible to identify two main coping strategies that, according to the literature, older people in rural areas may develop in dealing

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with the coverage of their care needs. These are mainly problem- and emotion-focused coping strategies.

The first strategy concerns efforts actively developed by older people to solve the problem or change stress conditions, modifying the problematic circumstances related to their situation.

For example, a care coping strategy to handle weakened support provided by family networks might lead to a growing reliance on the instrumental and social support provided by non-kin ties, especially neighbours, given the presence of cohesive rural communities (Elizalde-San Miguel & Díaz-Gandasegui, 2016; Urbaniak et al., 2020).

The second strategy refers to a different type of effort that may involve the older person's emotional and cognitive dimensions. This includes emotional disclosure or dynamics of adjustment or reduction of the expectations about the satisfaction of care needs and the support provided by family and non-kin networks (Milbourne & Doheny, 2012; Urbaniak et al., 2020; Walsh et al., 2020). In this case, older people contrast their emotional stress through a reality normalisation, which, however, is not in line with their expectations.

Empirical analyses have identified commonalities but also important differences across countries that can be interpreted in the light of a differentiated embeddedness of coping strategies within macro-contextual conditions. For instance, in countries where normative expectations about the family's role in covering care needs are stronger, studies have highlighted how the fragmentation of family networks in rural areas has increased the difficulties for older people to match such expectations (Conkova et al., 2018). This entails the activation of coping strategies to deal with the emotional stress deriving from such condition, such as lowered expectations about family member relationships. In other countries, with limited expectations about the family's role, studies noted a greater reliance on the state or the market for welfare support rather than family members (Anderson et al., 2020; Walsh et al., 2021) or self-limitation, where critical living conditions are more accepted by older rural people as part of their life, relying on a strong sense of self-sufficiency, which is traditionally embedded in rural areas and on a strong sense of attachment and belonging to where they live (Milbourne & Doheny, 2012; O'Shea et al., 2012; Walsh et al., 2020).

In summary, the care crisis is a crucial rural phenomenon, where a population ages alongside the progressive erosion of traditional protection systems, such as family structures. In the wake of such transformations, many older people live alone, facing significant uncertainties and difficulties in coping with their care needs. Despite spatial fragmentation, several studies highlight how family networks and intergenerational solidarities still play a crucial role but based on changed care arrangements, which may be integrated with informal networks embedded within neighbourhood communities. Coping strategies adopted by older people are a complementary factor.

Overall, these aspects are key conditions in supporting older people in rural areas, even when they live alone and have care needs that affect their autonomy. However, the redefinition and reorganisation of care networks may be strongly shaped by the embeddedness of rural ageing within different macro-contextual conditions, in terms of institutional resources and normative expectations: not all rural areas are similar (Warburton et al., 2016). The challenge of the care crisis in rural areas requires its features and implications to be carefully scrutinised.

RESEARCH DESIGN

Starting from the theoretical debate illustrated in the previous section, this exploratory study considers the organisation of care networks as a research focus.

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TABLE 1 Structural indicators, several years and last year available.

	Absolute number of municipalities, 2017	Resident population, 2017	% population change 1971-2011	% population. aged 65+, 2017	% population 65+ integrated home care assistance users, 2015
Oltrepò Pavese	15	10,784	−33.6	37.8	1.9
Appennino Basso Pesarese e Anconetano	9	33,146	−10.1	27.9	2.4
Area Grecanica	11	17,994	−39.4	27	0.9
Italy	7998	60,589,445	9.8	22.3	4.1

Source: Agenzia per la coesione territoriale (2022).

More specifically, it expands the existing knowledge about rural ageing, given the variety of experiences that older adults may have in different rural situations (Maclaren, 2017) by analysing the organisation of care networks of older people living in Italian rural areas. This is a phenomenon that was unexplored in the international and national literature.

The research adopted a specific focus on personal and practical care for the operationalisation of care needs (Hjälm, 2012; Kröger, 2022; Lambotte et al., 2019). This included the support needed for activities of daily living (ADLs), such as getting dressed and showering, and instrumental activities of daily living (IADLs), such as cleaning, paying bills, shopping and cooking.

To provide empirical evidence, this study draws from data gathered through 48 interviews with older people living alone at home and with different degrees of functional limitations preventing them from fully performing daily and instrumental activities in three Italian rural areas: Oltrepò Pavese (Lombardy region), Appennino Basso Pesarese e Anconetano (Marche region), Area Grecanica (Calabria region). Data were collected within the IN-AGE research project (INclusive AGEing in place: Contrasting isolation and abandonment of frail older people living at home) aimed to analyse conditions and impacts of ageing in place in Italy.

In the absence of a clear international definition of a rural area (Neville et al., 2021; Scharf et al., 2016), the Italian definition of inner areas (*aree interne*) was used as a reference standard for identifying the rural areas analysed in this study. Inner areas are rural areas characterised by strong marginalisation, decline and distance from essential services. This aspect represents a distinctive feature of Italian rural areas as recognised by the literature (Osti, 2016).

Table 1 shows a series of structural indicators concerning the main socio-demographic and socioeconomic features of the three rural areas considered in this analysis, compared to the national average. Even though some differences exist, the three rural areas show similar structural conditions in terms of care crisis. All three areas have been strongly affected by demographic decline coupled with population ageing over the years (as shown by the two indicators concerning the change in resident population between 1971 and 2011 and the percentage of people aged more than 65 years in 2017). Despite the ageing population, these three areas show a residual availability of care services for older people (as shown in Table 1 by the last indicator concerning the coverage rate of the integrated home care assistance).

Interviews were carried out between May and December 2019 (16 in each rural area) and were undertaken at home (lasting 60–90 min, and audio was recorded when permitted). The

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interviews covered several topics, including attitudes and perceptions regarding the organisation of care networks and the coverage of care needs. Structured and open-ended questions were considered in the interview guide to better capture the older people's experiences (Walsh et al., 2020) and collect quantitative and qualitative information.

Local key informants supported the interviewees' recruitment. The recruitment was not based on a probabilistic sample but open purposive sampling. This involved older people with particular features (such as different degrees of functional limitations and absence of family members living in the same building) to have sample diversity and collect rich and pertinent data according to the research focus (Tong et al., 2007; Warmoth et al., 2016). Using this research strategy, the data collected through the interviews was only illustrative and not generalised for all older rural Italians.

All interviews were anonymised, transcribed verbatim and analysed.

Quantitative data were analysed through descriptive statistics and hierarchical cluster analysis (HCA). HCA is a specific statistical technique identifying distinctive homogeneous clusters of cases, based on a set of selected variables (Sharkh & Gough, 2010).

This technique does not predefine cluster numbers at the analysis beginning. The procedure follows a step-by-step agglomeration process, where a case is merged with other similar cases until the final clustering is completed.

In this analysis, HCA was performed to explore the main care network configurations.

Several distance metrics and linkage criteria were initially considered to assess the agglomeration process stability. The final configuration was achieved using Euclidean distance and complete linkage method.

The analysis of qualitative data followed a thematic approach (Neville et al., 2021; Urbaniak et al., 2020), based on the identification of main recurrent themes, through deductive (theory-driven) and inductive (data-driven) strategies (Cho & Lee, 2014; Conkova et al., 2018) to illustrate the coping strategies developed within the main care network configurations identified according to the results of HCA.

EMPIRICAL RESULTS

Care network configurations: Overall picture

As a first step, this section provides a descriptive and analytical reconstruction of the care networks emerging from the interviews with the older people living alone in the three rural areas considered in the analysis.

Table 2 shows the characteristics of the older people interviewed by considering their main socio-demographic individual features.

To a large extent, the older people interviewed were women, aged over 80 and widowed. These features are typical of the profile of older Italian people living alone (Istat, 2020). Other types of marital status were more marginal. This is a distinctive feature of Italian and other Southern European countries (Wagner & Weiß, 2006), where divorce was introduced only in the 1970s and traditionally encountered cultural resistance, particularly among older generations.

As discussed in the previous section, the research focus was on the organisation of care networks, for older people living alone. Care needs were operationalised by considering the specific functional limitations in performing activities of daily living.

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TABLE 2 Characteristics of the older people interviewed ($N = 48$).

Characteristics	*N*
Gender	
Female	36
Male	12
Age	
65–74	5
75–79	9
80–84	13
85 and over	21
Marital status	
Never married	5
Widowed	39
Separated/Divorced	3
Other	1

Source: Author's elaborations.

Assessing such limitations was conducted through 16 ad hoc questions to detect the potential individual difficulties in carrying out basic ADLs and IADLs.

During the interviews, in addition to conditions of functional limitations, other types of information were collected to analyse the family network, including the degree of geographical proximity, and the care network structure. Attention was given to who practically provided care support, by considering the role of family members, and other actors who might be involved (e.g., public operators, private operators and neighbours). This information was further investigated by considering the care support frequency (such as daily, weekly and monthly) and the degree of spatial proximity for family members.

The information collected was codified and grouped into three main analytical dimensions: *(i)* functional limitations, *(ii)* family structure and *(iii)* care networks.

In terms of operationalisation, the first dimension considered as a variable the number of ADLs/IADLs, which the older person could not perform autonomously. This was a proxy of care needs.

The second dimension included two variables concerning the family structure—the number of family members alive and their degree of spatial proximity with the older person. In this case, the fact that the family member and the older person lived in the same city was considered.

Finally, the third dimension concerned the care network reconstruction and included three variables. These variables referred to: the number of people supporting the older person in carrying out basic ADLs and IADLs; the number of people providing this support daily; and the number of family members providing support and living in the same city of the older person as a proxy of spatial proximity.

A detail concerning who concretely provided the care support to the older person was considered for the two first variables.

The combination of these dimensions, and corresponding variables, was investigated empirically by performing HCA.

The dendrogram in Figure 1 shows the agglomeration process of the 48 older people interviewed based on their features and how they fit into the three analytical dimensions investigated.

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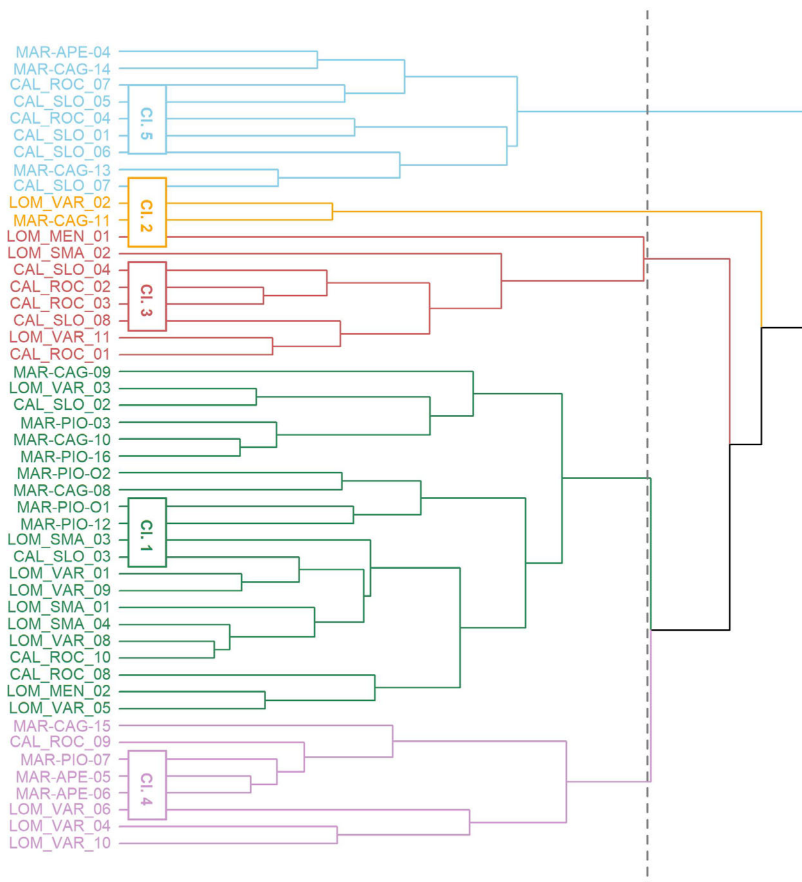

FIGURE 1 Cluster analysis: dendrogram. *Source*: Author's elaborations.

It visually supports the analysis of the degree of cohesiveness of the clusters emerging from the agglomeration process and for identifying the final numbers of clusters—a decision that is under the researcher's responsibility (Sharkh & Gough, 2010).

In the same diagram, the dashed line indicates the dendrogram's height in which a good level of cluster cohesiveness can be seen based on the agglomeration process. Five main clusters were identified. These include individual cases that were transversal to the three rural areas where the interviews were carried out.

Table 3 shows the clusters' main features. For each variable included in the three analytical dimensions analysed, the mean value within each cluster is reported. To provide a more direct interpretation of the main distinctive features of each cluster in comparison with the results emerging from the interviewees, the same table shows symbols indicating the intensity of the phenomenon investigated, ranging from low (–) to high intensity (++).

Care network configurations: Main features and coping strategies

After having identified the main care networks configurations, this section aims to further expand the empirical analysis. The description of the main features of each cluster will be combined with

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TABLE 3 Data and characteristics of the five clusters, mean values within cluster and total mean value ($N = 48$).

	Cluster					
	1	**2**	**3**	**4**	**5**	**Total**
N	*21*	*2*	*8*	*8*	*9*	*48*
Functional limitations						
N. ADLs/IADLs unable to perform autonomously	3.0 (*)	1.5 (-)	7.3 (++)	0.5 (-)	2.0 (*)	3.0
Family structure						
N. family members	4.7 (-)	7.0 (*)	8.4 (+)	3.5 (--)	7.8 (+)	5.8
N. family members living in the same city	0.2 (--)	1 (*)	1.4 (*)	1 (*)	3.1 (++)	1.1
Care network						
Family						
N. family members	1.4 (*)	0.0 (--)	1.4 (*)	1.5 (*)	3.6 (++)	1.8
N. family members living in the same city	0.2 (-)		0.5 (*)	0.8 (*)	2.6 (++)	0.9
N. family members daily	0.1 (--)		1 (*)	0.5 (*)	1.7 (++)	0.7
Personal care assistants						
N. personal care assistants	0.2 (*)	0.0 (--)	0.5 (++)	0.1 (-)	0.3 (*)	0.3
N. personal care assistants daily	1.0 (*)		1.0 (*)	1.0 (*)	1.0 (*)	1.0
Public operators						
N. public operators	0.4 (++)	0.0 (*)	0.0 (*)	0.0 (*)	0.0 (*)	0.2
N. public operators daily	0.1					0.1
Private operators						
N. private operators	0.3 (*)	0.0 (--)	0.3 (*)	0.8 (++)	0.2 (*)	0.4
N. private operators daily	0.3 (*)		2.0 (++)	0.3 (*)	0.0 (-)	0.4
Neighbors/friends						
N. neighbors/friends	1.2 (*)	4.5 (++)	0.0 (-)	0.4 (*)	0.1 (-)	0.8
N. neighbors/friends daily	0.3 (*)	3.5 (++)		0.3 (*)	0.0 (-)	0.6

Note: The following symbols were assigned for each mean value within clusters by considering row-wise z-score points:-- (less than −1), - (between −1 and −0.5), * (between −0.5 and 0.5), + (between 0.5 and 1), ++ (more than 1). Scores were calculated by subtracting the mean values within the cluster with the corresponding total mean values and dividing by the corresponding standard deviation.

Abbreviations: ADLs, activities of daily living; IADLs, instrumental activities of daily living.

Source: Author's elaborations.

a presentation of the main coping strategies developed according to the analysis of the qualitative content of the interviews with older people in the three local contexts. Brief direct quotes from interviewees will illustrate the analytical features of the identified coping strategy.

Cluster 1: The spatial distance of family members

The first cluster (Cluster 1) was the predominant one (see Table 3). It includes 21 older people out of the 48 interviewed. By looking at the mean value within the cluster, older people had

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an intermediate level of functional limitations. This means that they were not fully dependent: Despite being affected by some limitations in their activities of daily living, older people were not passive actors but actively involved in the organisation of their care network through the adoption of specific problem-focused coping strategies.

By looking at how care needs were covered, functional limitations involved a request for support, provided by an articulated care network (see Table 3). This care network included different actors, like family members, personal care assistants, public and private operators (the former with a mean value higher than the total mean value), neighbours and friends. The mean value concerning the number of those providing daily support for these actors is in line with the total mean value. Some interesting internal differentiations emerge when the difference between the mean values in terms of number and their mean value for daily support for each actor are considered. Daily support was higher in the case of personal care assistants, neighbours and friends, while lower for private operators and, particularly, public operators and family members. This aspect confirms a marginality of public care services. Even when provided, this support was limited and unable to cover care and daily needs. In the case of family members, limited daily support was closely related to the conditions of spatial distance as indicated by the low mean value of the number of family members providing care support who lived in the same city as the older person.

Despite the distance from family members (mainly adult children) living far away from their parents' rural areas, older people included in this cluster described a continuous relationship with their families. This represents a clear example of problem-focused coping. For instance, several interviews clarified that, despite the distance, older people often relied on regular visits from family members (particularly when the distance was not excessive), and this provided fundamental support. This support included help in performing activities of daily living, such as shopping, accompaniment to medical visits or help with paperwork.

> *Now for the shopping, my son comes up every…Before, he came up every week, but I told him 'But no, leave it alone!'. Now he comes up every 10 days, and we do a big shop*. (Interview: LOM_VAR_01, F, 88)
>
> *My children are the closest to me for shopping, money management, etc… When I need to go somewhere or carry out some activities, they help me. Even when I don't need them, they visit to keep me company and have lunch with me*. (Interview: MAR_PIO_12, F, 79)
>
> *My son visits when he can. He came here 2 days ago. Today he accompanied me to the hospital.. He's gone now because he must pick up his daughter from school. Tomorrow morning, he will be back because I have to go to the hospital*. (Interview: CAL_SLO_03, F, 82)

In a few cases, the temporary establishment of a closest spatial proximity between the older person and a family member was identified in the interviews as an additional problem-focused coping strategy. In particular, the establishment of a closer spatial proximity with a family member (like temporarily living in the same building) was linked to a seasonal cycle due to the critical conditions in rural areas during the winter.

> *And in winter I'm here a little. Honestly, I go to XXX (in winter), and the radiator is hot there*. (Interview: LOM_VAR_05, F, 90)

Generally, relationship continuity between the older person and the respective family network was embedded in the persistence of traditional deep-rooted familialistic values where care was assumed as a mutual, family-based, intergenerational obligation despite any spatial distance.

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Most interviewees included in this cluster confirmed high normative expectations concerning the family's role in supporting care needs.

When the support provided by the family networks was limited (even at a distance) and did not meet the individual normative expectations, the adoption of specific emotional-focused coping strategies was identified. Older people adopted such strategies to reduce a potential source of emotional distress, caused by a failure to meet their normative expectations about the family's role in providing care.

For example, several interviews showed a downward re-definition of the individual expectations about the family's role, with a narrative that substantially normalised and justified the mismatch between high normative expectations and limited family care support due to the children's absence. This reality normalisation was framed by referring to the family networks' structural transformation, and the consequent reduction of family carers, or to the need for family members to maintain a constant professional career and pension accumulation.

> *The central role must be for the family, but… They also must work to get a pension*. (Interview: LOM_SMA_04, F, 86)
>
> *Families today cannot always care for older parents, they are very busy, they have work*. (Interview: MAR_PIO_12, F, 79)

Cluster 2: Light care needs supported by neighbours and friends

The second cluster (Cluster 2) represented a residual group. In this group, only two cases were included based on the cluster analysis. The main features that distinguish the two cases were that they featured relatively good conditions in terms of autonomy (even if there were some limitations in performing ADLs and IADLs), and there was no support provided by family members or public and private actors. In this group, the only support was provided by neighbours and friends, who had a high daily relevance (see Table 3). The involvement of neighbours and friends represented an important problem-focused coping strategy. The possibility to develop such a strategy was embedded within reciprocal relations strongly consolidated in rural areas. Neighbours and friends provided important support whether they were asked or not, for practical care needs tasks, or monitoring and control.

> *My neighbours come here several times a day; I can ask them everything if needed … my friends also are very supportive*. (Interview: LOM_VAR_02, M, 73)
>
> *Neighbours help me. I could contact anyone; they come here … if I need to go to the city, I can call them … I've always found them available*. (Interview: MAR_CAG_11, F, 88)

Cluster 3: The migrant-in-the-family model of care

The third cluster (Cluster 3) included eight older people. The cluster's distinctive feature was strong limitations in performing ADLs and IADLs autonomously. The mean value within the cluster for this variable was above the total mean. In this case, there was no support provided by neighbours and friends. Furthermore, the absence of support provided by public services confirms the strong critical conditions affecting the availability of care services in rural areas (see Table 3).

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In this cluster, family members played an important role in supporting older people's care needs. Despite the evident effects of spatial fragmentation on rural family structures in this case (see the difference between the mean value within the cluster of total family members and the mean value of those living in the same city as the older person), the role of family members was associated with the existence of a certain degree of geographical proximity. Such a condition guaranteed a complementary function from family members supporting the care needs of the older person in a care network where a crucial role was also played by personal care assistants.

The recruitment of a personal care assistant, referred to as *badante*, represented an additional problem-focused coping strategy adopted given strong functional limitations. It exemplifies the so-called migrant-in-the-family model of care.

A *badante* was a female migrant care worker, mainly from Eastern Europe. They often lived directly with the older person, guaranteeing around-the-clock assistance, representing a crucial alternative option when the recourse to other resources was limited or the direct support of family networks was more difficult. Despite the adoption of such a strategy required specific material pre-conditions (especially adequate financial resources to sustain the cost of such care option as well adequate housing to host the *badante*), when adopted, it guaranteed a high care intensity.

> *My daughters-in-law can't help me because they work… they can't quit their job to come here. One of them works in the pharmacy, and she doesn't work on Sundays only. Only a badante can care for me because my daughters-in-law cannot help me. I consider that it is right because they have family, their things*. (Interview: CAL_SLO_08, M, 90)
>
> *She stays with me all day and night too. I need assistance more at night because I don't feel like getting up. I can no longer be alone. She is good. She does everything. She cooks because I can't stand for long to do the food. I don't feel like standing. She cooks well. She does everything, laundry, cleaning, housekeeping. She helps me with bath and get dressed. She brings me the medicines and helps me take them. (Interview*: CAL_ROC_01, F, 80)

The *badanti* were recruited largely in an informal and unregulated private care market. This entailed harsh working and living conditions and largely the absence of formal employment contracts.

> *She has been here with me for 6 to 8 months, and she has no contract. Noo, so… under the table. They (the badanti) have no documents*. (Interview: CAL_SLO_08, M, 90)

It is important to note that recruiting a personal care assistant did not mean the total displacement of the role of family networks. Despite the presence of a *badante*, the support provided by family members remained crucial, even at a distance when conditions of strict spatial proximity were absent. The family members' support concerned not only handling specific care activities that were not delegated to the *badante* (such as paperwork) but also financing part of the cost, given the financial limitations that many older people suffered, or the search and direct recruitment of this assistance (which took place mainly informally, through word-of-mouth).

> *Word…Word of mouth! Word, word of mouth! My son, it seems to me!* (Interview: LOM_VAR_11, M, 78)

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Cluster 4: A mixed care network

The fourth cluster (Cluster 4) included eight older people. Unlike the previous cluster, in this group, older people were affected by few ADLs and IADLs limitations. Care needs were mainly covered through individual private operators, representing a specific problem-focused coping strategy adopted by older people (see Table 3). Similarly to the *badanti*, these operators were recruited in the private market, without formal qualifications, and helped the older person with domestic support and assistance. They were informally recruited, sometimes for a few hours a week or on a monthly basis or when specific needs emerged:

> *Sometime come here (a private individual operator) … about two times … a month! I ask her to clean the kitchen well because now I must avoid taking the ladder for cleaning! And the glass…* (Interview: LOM_VAR_06, F, 84)

The support provided by neighbours and friends was also relevant in this cluster, representing a complementary problem-focused strategy adopted by older people in coping with their care needs.

In addition, like the previous cluster, family members were part of the care network. Despite geographical fragmentation, part of the family structure was localised in the same city where the older person included in this cluster lived. This guaranteed strong spatial proximity and continuity in terms of relationship with family members: an important precondition for care support.

> *My son* (living in the same town) … *he comes in here, every night to see if I'm okay, if I need something … to see whether I'm alive or dead* (laughs). (Interview: MAR_APE_5, F, 88)

Cluster 5: The traditional family model of care

The last cluster (Cluster 5) included nine older people. In this cluster, care needs existed but in line with the total mean. Care demand was not in a critical condition, even if older people could not autonomously perform all the ADLs and IADLs considered in the analysis. In this case, family members were the constitutive part of the care network and provided daily support (see Table 3). This was a unique feature of this cluster, which indicates the persistence of traditional forms of support in rural areas, based on strong intergenerational solidarities. This configuration was possible in relation to the strong geographical proximity of family networks, which presented the highest value in this cluster. It was also embedded in the persistence of strong normative expectations about the family's role in supporting older people, given the lack of support provided by public care services:

> *So far, I have not received any care support from the municipalities … In my case, only my children take care of me … my children do not abandon me. The support is provided by the family*. (Interview: CAL_SLO_06, F, 88)

Other forms of support existed (like private care assistants and private operators) but more limited. The role of neighbours and friends was marginal too. So, in this cluster, the configuration of care networks was characterised by the development of problem-focused coping strategy based on a strong internalisation of care support within family networks. However, this reproduced the forms of gender inequalities embodied within the traditional family model of care: daughters,

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daughters-in-law and sisters-in-law, in particular, represented the main source of care for older people in this cluster, both providing support on a daily basis and/or in performing more heavy care tasks (e.g., personal care, domestic works, etc.). The role of sons, instead, when existent was more oriented in performing complementary activities, like monitoring or repairing and maintenance of the house where the older person lived.

> *There are two of my daughters and my son who is far away, but we talk by phone… With my son, we love each other and respect each other. He is very present. My older daughter doesn't always come if she knows her sister is here, my youngest daughter comes two, three times a day*. (Interview: CAL_ROC_04, F, 80)
>
> *Everyone helps me … Mostly there are my daughter and my sister-in-law*. (Interview: CAL_ROC_07, M, 85)
>
> *The most direct help is provided by my daughter who lives here*. (Interview: CAL_SLO_05, F, 95)

In summary, the empirical analysis illustrates a complex scenario, with multiple configurations of emerging care networks and coping strategies.

It is important to note how traditional care networks, characterised by problem-focused coping strategy based on a central involvement of intergenerational solidarities persisted. In several cases, family members represented a crucial condition for supporting the daily care needs of an older person. This happened, particularly when spatial proximity persisted, as emerged from the analysis of Cluster 5 and partly in Clusters 3 and 4.

This confirms the crucial role that the family and intergenerational solidarities continue to play in Italy, where strong familialistic values persist. This is because of the structural limitations affecting the availability of public care services as confirmed in the analysis (the exception to this was Cluster 1 where, however, the relevance of public operators was affected by weak daily support).

The process of spatial fragmentation of family networks is a central feature in the identified clusters, particularly in Cluster 1, which comprises half of the sample of interviewees. The weakening of spatial proximity within the family network entailed the development of problem-focused coping strategy based on a reorganisation of care networks, where informal support (like neighbours and friends) was combined with private care support, such as private operators and personal care assistants providing daily care, coupled with the adoption of an emotional-focused coping strategy to reduce the emotional distress when high normative expectations about the family's role were unmet.

However, the family's role was not completely displaced. Support provided by family networks assumed new configurations within an integrated care network (as emerged from the analysis of Clusters 3 and 4) or a redefinition of support (such as not being provided daily) but with care needs still supported (as in the case of Cluster 1). These configurations redefine the traditional forms of care networks predominant in rural areas.

DISCUSSION

This study investigated the effects of the care crisis in rural areas, focusing on the organisation of care networks of older people in rural Italy, which is yet to be studied in the literature.

The presence of multigenerational families, co-residence and strong informal networks traditionally represented crucial support and assistance resources for care needs. However, these resources have been steadily eroded due to socio-demographic changes alongside population ageing. This has entailed the emergence of new tensions in rural areas.

The analysis was developed in explorative terms based on quantitative and qualitative information gathered from interviews with older people conducted in three Italian rural areas.

The sampling did not attempt to find a representative statistical sample but collected the experiences of older people to develop an explorative analysis.

Given its exploratory perspective, the analysis did not have generalisability ambitions, which could be applied to all Italian rural areas. More research is needed.

Despite these limitations, the empirical evidence presented in this article contributes to the theoretical debate in three main ways.

First, the research confirms the importance to avoid a sort of generalised view in interpreting the impact of the care crisis in rural areas. The fragmentation of family structures represents a critical condition shaping the care networks of older rural people, coupled with the structural residuality of care services. Many of the older people interviewed, were affected by functional limitations and did not have family members living in the same city (sometimes far from them). The spatial fragmentation of family networks due to out-migration dynamics, particularly among younger family members, made providing on-site informal care support difficult.

Despite such spatial fragmentation, this condition did not entail a total displacement of the family networks' traditional role. In some cases, traditional form of family care persisted. In (many) other cases, the analysis highlighted that the family's role has been redefined with distance support or a specialisation of this support, which is focused on IADLs and less sensitive to geographical proximity. The empirical evidence shows an integration of the support provided by family networks with other care actors, based on functional coping strategies adopted by older people to incorporate the resources that characterise rural areas (Anderson et al., 2020; Conkova et al., 2018; Urbaniak et al., 2020; Whal, 2005). This includes support provided by neighbours and friends. All in all, the emergence of a complex scenario characterised by different configurations of care networks and strategies of adaptation and reorganisation represented crucial conditions supporting older people in rural areas, despite the adverse effects of the care crisis.

Second, empirical evidence confirms the importance to adopt a context-sensitive perspective in interpreting the configurations of care networks and strategies of adaptation and reorganisation.

Care networks' organisation in rural Italy continues to be embedded within a normative and institutional context, such as the Italian care regime (Saraceno, 2016). This features a strong persistence among the Italian population of strong shared expectations and social norms regarding the role of family and intergenerational solidarities in care practices (Glaser et al., 2004; Haberkern & Szydlik, 2010). Public policies have reinforced such configuration, by prescribing extensive legal duties and due to limited supply of formal care services. Public cash benefits have been consistently used as a welfare measure to provide some care support but reinforcing the family-based care model and its gendered implications (Da Roit et al., 2007; Ranci & Arlotti, 2019; Saraceno, 2016).

These features could explain the reason why traditional forms of care networks based on the centrality of family and intergenerational solidarities persist, even if they are taking on new forms and configurations. Furthermore, the contextual embeddedness represented by the Italian care regime general features could explain the presence of emotional coping strategies and adds new insights concerning rural ageing and the care network organisation yet to be considered in the

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general literature or research studies conducted in countries with a care regime structure similar to Italy (Elizalde-San Miguel & Díaz-Gandasegui, 2016).

Emotional coping represents an important strategy, adopted by older people to reduce a potential source of emotional distress caused by a failure to meet the normative expectations about the role of the family in providing care. This has been identified in other studies conducted in countries where the persistence of familialistic values is more relevant (Conkova et al., 2018).

The recourse to private markets is a new important feature yet to be analysed in the literature, where the underdevelopment of private markets in rural areas is mostly highlighted (Walsh et al., 2020).

The exploratory analysis has shown how the recourse to private markets, even though largely informal and characterised by low wages and poor working conditions, particularly when recruiting migrant care workers (*badanti*), was an option existent in the three rural areas investigated, under specific conditions (especially availability of spatial conditions in the house and financial resources).

The Italian care regime general features represent an important explanatory dimension in this case. Due to the absence of significant reforms and investment in long-term care policies, the shift to a 'migrant-in-the-family' model (Bettio et al., 2006) represented one of the most important ways to manage the care tensions for many Italian families. These tensions were determined by conditions of reduced capacity to provide care support due to increased female labour market participation, declining fertility and smaller family size.

As previously discussed, this configuration of the care network does not entail a displacement of the family whose role remains crucial. The role of family members is redefined, for example, in terms of less direct care provision but more supervision and support to the older person in the recruitment and payment of migrant care workers and in handling those care activities not delegated to them.

All in all, these aspects show the importance of adopting a nuanced perspective in the study of rural ageing by carefully considering the diversity of rural places and the conditions of rural living (Warburton et al., 2016), avoiding the risks of an over-generalised interpretation of rurality (Phillipson & Scharf, 2005) to grasp cross-national differences that may influence this phenomenon.

Third, the empirical results suggest a need to expand the theoretical reflection about the care crisis in rural areas by considering the multifaceted dimensions and multiple inequalities embodied in such a phenomenon. The intrinsic relationality of care entails considering the perspective of those who provide care and the potential related effects (Saraceno, 2010; Yeandle et al., 2017). These effects may be examined focusing on different analytical levels.

At the individual level, an important issue concerns the persistence and reproduction of gender differences and social inequalities in care responsibilities' allocation and distribution within intergenerational solidarities (Brooks & Meçe, 2023). This is crucial, particularly in familialistic societies such as Italy, where the structural reliance on family solidarity is related to persistent strong gender inequalities and the unpaid work of women (Da Roit et al., 2007; Saraceno, 2016).

In addition, our analysis shows how the tensions deriving from the care crisis in rural areas have been in many cases externalised in the diffusion of care works, largely in the grey market, strongly affected by under-protection and deplorable working conditions, which reproduce the conditions of gendered exploitation and power relations typical of informal care (Da Roit et al., 2007).

Simultaneously, the fact that the *badanti* are largely migrant care workers implies the importance to examine the care implications by looking at care drain dynamics (Williams, 2018). The

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position of rural places, and of rural older people, is deeply embedded within wider networks of power relations requiring the adoption of a scalar and relational perspective (Williams, 2021; Yarker et al., 2023) to critically analyse social effects in poor rural areas due to the emigration of female carers in rural regions located in Western countries (Vullnetari & King, 2008).

CONCLUSION

To conclude, the empirical findings reported in this article indicate the existence of a complex scenario featuring different configurations of care networks and strategies of adaptation and reorganisation. They suggest careful consideration of cross-national differences underlying this phenomenon and the importance of expanding the theoretical reflection and empirical analysis to capture the multifaceted dimensions and inequalities of care in rural areas.

There are some important policy implications worth mentioning. The several forms of analysed adaptations and coping strategies in care networks confirm the resilience of rural areas, despite the care crisis pressures (Elizalde-San Miguel & Díaz-Gandasegui, 2016). However, the empirical findings show the inequalities and tensions embodied in these configurations.

The research results highlight the importance of avoiding a romantic or stereotyped idyllic image of rural ageing (Maclaren, 2017; Petersen et al., 2022) and the risks that certain rhetoric about the resilience of rural settings may have, particularly when mobilised instrumentally for legitimising the shifting of responsibilities from public policies to informal networks and local communities (Walsh et al., 2021).

Public policies can crucially complement the functioning of the family and informal networks. This entails the importance of tackling the issue concerning the limited availability of public care services in rural areas and combining the direct provision of in-kind services with regulative interventions focused on family and informal network roles, alongside that of private care workers, to support the adequacy and sustainability of care networks both for care-receivers and caregivers.

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CONFLICT OF INTEREST STATEMENT

The author declares no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data are not publicly available due to privacy restrictions.

ETHICS STATEMENT

Ethical approval was obtained from the Ethics Committee of the Polytechnic of Milan (Project identification code No. 5/2019 approved 14 March, 2019).

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