International Perspectives on Social Policy, Administration, and Practice

Ian Gillespie Cook
Jamie P. Halsall
Paresh Wankhade

Sociability, Social Capital, and Community Development

A Public Health Perspective

International Perspectives on Social Policy, Administration, and Practice

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A Public Health Perspective

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Liverpool, UK — Ian Gillespie Cook
Huddersfield, UK — Jamie P. Halsall
Lancashire, UK — Paresh Wankhade

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Chapter 1
Introduction: What Is This Volume About?

In these early years of the twenty-first century, it can often seem that across the globe we are living in a world of crisis. When we began this book, there were bombings at the end of the Boston Marathon of 2013, an army coup in Egypt that overthrew the first democratically elected government, an armed conflict in Syria, the President of North Korea made bellicose threats against South Korea and the USA, and the shrinking of the Arctic ice sheet that was implicated in the extreme winter weather that the UK has faced in 2012–2013. 'The war on terror', the age of austerity, global warming and consequent climatic instability, disparities in wealth, and other issues add to the sense that social institutions are unable to cope with the major problems that the world faces. It is certainly the case, on the one hand, that states around the world are under enormous fiscal pressure, in large part brought about by the banking failures of 2008, which heralded the end of a long period of conspicuous consumption and an era of deregulation. On the other hand, the private sector, too, is under pressure, losing once-certain markets to new competitors, and 'fat cat' directors facing angry shareholders and governments seeking to curb their excess salaries and the bonus culture of those in charge of large corporations. Certainly at the moment there is much to be concerned about. However, while we do not seek to minimize the threats which humanity currently has to face, even in a time of crisis we feel that there is much about which to be optimistic. In this, we echo Bill Gates in his 2013 Reith Lecture to the British Broadcasting Corporation (BBC), who also took an optimistic view of the world.

Optimism lies in the following situations. People across the world, for example, are living longer and more productive lives than in the past. Most countries now having increased longevity and pass the 7% level at which they can be said to have an aging society, as Cook and Halsall (2011), for example, noted. Further, despite or even because of the competitiveness that is a key feature of capitalist society, 'sociability' is a concept that has considerable currency in contemporary society. This is evidenced by the role of the voluntary sector, for instance, and the way in which community groups are increasingly willing and able to fill the gap between the private sector provision on the one hand, and the public sector provision on the other (Andrews 2012; Cusack 1999). There is a palpable growth in 'social capital' that is being developed by social entrepreneurs who offer a 'Third Way' to capitalism on

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the one hand or the state on the other. In this book, we draw upon our diverse and rich experience of different societies in order to explore these concepts and discuss the extent to which this sense of optimism is indeed appropriate for today and 'our' tomorrow.

In addition to examining the concepts of sociability, social capital, and community development within the different national chapters, there are several sub-themes. These include:

- Aging
- Governance and institutions
- Emergency services and public health provision
- Community development

These themes are selected because of their contemporary relevance. As noted above, more people are living longer in most societies. However, 'age does not come by itself'; therefore, there are morbidity threats such as dementia or obesity that society must tackle. But this situation is arising as the state increasingly seeks to withdraw, or is being forced to withdraw, from the expense of welfare support for older people; therefore, governance and institutions must be examined in order to determine whether these remain, or can become 'fit for purpose' in different countries. In our chosen sample, for most of the people facing an emergency, they are most likely to require state support via the emergency services or the public health service (Wankhade 2011, 2012). It might be helpful to think about the national variations in performance of the emergency services and health providers on account of the variations in the co-production or social networks within countries/regions (see Andrews and Wankhade, forthcoming for a study of social capital and the UK ambulance service performance; Andrews and Brewer (2010) for social capital and fire service performance in the USA). A recent study (Timmons and Vernon-Evans 2013) has reported that community first responding has been quite successful in the health and pre-hospital care sector with clear implications for other voluntary organisations. But in a time of fiscal constraint, how is this provision being met, and what are the limitations of service provision? Finally, our sense of optimism is born from the growing evidence that 'community', however defined, can help to plug this gap in provision (Putnam 1993, 1995a, b, 2000; Tavits 2006). Who are the activists, what are their traditions, and how can they be nurtured given that current fiscal constraints affect community groups too, not just state providers.

The beginning of the twenty-first century is an exciting era for public health, both from a theoretical and practical standpoint. Improving public health and well-being is a high profile feature of government policies. The realms of public health have become broader in recognising the factors in people's social, economic, and physical environment that have a profound impact on their health and can create inequalities (Orme et al. 2007, p. 8). It now involves a more diverse public health workforce and partnerships between organisations in the public, private, voluntary, and the third sector. Reducing disparities in health as a consequence of social and economic differences is a key government priority across the world (Griffiths and Hunter 2007). This book aims to explore some of these challenges of public health

in the twenty-first century in making sense of the complexities and differences on the chosen themes and subthemes in the selected case studies.

In this exploration, we have decided to use the case study approach to different countries, as used by Cook and Halsall (2011), and have selected the following eight countries to analyse:

Chapter 2:	UK
Chapter 3:	USA
Chapter 4:	China
Chapter 5:	India
Chapter 6:	South Africa
Chapter 7:	Bangladesh
Chapter 8:	Japan
Chapter 9:	The Netherlands

Firstly, the UK is selected because it is our home base and has the National Health Service (NHS) as its major health provider. The concept of aging and the 'Big Society' and the impact on the NHS are discussed in a previous publication in Cook and Halsall (2011) plus Halsall et al. (2013a, b). The US context requires a deeper exploration being the biggest economy in the world plus a society that is highly polarised in terms of an often vicious debate concerning the state role in public sector health (Cook and Halsall 2011). China offers quite a contrast to both these countries, representing not only a one-party dominated government and strong state, but one which since the reform period began in 1978 has moved towards market solutions to its social and economic problems. Again, this country is studied in Cook and Halsall (2011). India is selected because of its pre-eminent position in the South Asian peninsula having a population of more than a billion people along with the familiarity of two authors (Cook and Wankhade). Community governance in the UK and India has also been recently explored by the three authors (Halsall et al. 2013). South Africa is chosen because of the experience gained in researching this fascinating country for Cook and Halsall (2011) and also because of the role of older people as carers in the light of the HIV/AIDS crisis that the country has faced. Bangladesh is a new choice, chosen in part because of Halsall's experience of this country plus complementary knowledge of the other two authors. Japan is selected because it was also in Cook and Halsall's previous book and because the country is the leading 'flying goose' in East Asia. The Netherlands provide a good European case study since the chosen themes are fairly well developed in Dutch society; while in addition is the availability of the academic resources in the English language. The following sections will focus on sociability, social capital, and community development.

Sociability

As Cook and Norcup (2011) illustrate, the concept of sociability comes from the Russian social anarchist Peter Kropotkin in his book *Mutual Aid,* published in 1902. Peter Kropotkin was a fascinating figure, being born into the Russian aristocracy as a prince giving up the privileges of his noble birth due to his growing awareness of the poverty that was endemic to Russian society in the nineteenth century (Cook 1990). He joined a Cossack regiment rather than an elite one and spent time with them stationed in Siberia. Whilst there, he observed the poor levels of governance of the exile communities as well as anarchist ideas from the exiled poet Mikhailov. Despite grinding poverty and deprivation, he was impressed by the spirit of the exiles and the way in which they came together to survive and in some cases, prosper. He also observed this community spirit in animal species in this vast region. Many years later, by which time he was himself in exile from the Russian authorities and had become the 'leading' anarchist of his day, he drew together his observations of different societies, partly to counter the growing tendency towards *Social Darwinism* that was leading many thinkers at the time towards the doctrine of *survival of the fittest* and the eventual horrors of fascism.

Cook (1994) has previously summarised Kropotkin's views of altruism and sociability in one of a series of public lectures at the University of Durham in celebration of Kropotkin's sesquicentenary in 1992, and what follows draws heavily on this source. As Cook (1994, p. 22) explains:

> Kropotkin believed that we were, at root, an altruistic and sociable species, as indeed were most species. Moreover, he contended that the higher up the evolutionary scale, the more rather than less co-operative was each species. This was in flat contradistinction to the prevailing orthodoxy of the Victorian era with its stress on competition and the bastardisation of Darwinian ideas towards 'Survival of the Fittest' at any cost.

While Kropotkin admitted that there was 'an immense amount of warfare and extermination going on amidst various species…there is at the same time, as much, or perhaps even more, of mutual support, mutual aid, and mutual defence amidst animals belonging to the same species, or, at least, to the same society. Sociability is as much a law of nature as mutual struggle' (Kropotkin 1902, p. 5, cited in Cook 1994, p. 22). In his field observations with the zoologist Poliakov, despite the fact that they were influenced by Darwin's *Origin of Species* to actively seek out instances of intraspecies competition, rather than co-operation, they searched in vain. Instead, they found that a whole range of species such as ants, bees, birds, antelopes, and even carnivores all depend on each other for support and survival. Indeed:

> From the smallest species to the biggest ones, sociability is a rule to which we know but a few exceptions. (Kropotkin 1902, pp. 50–51, cited in Cook, p. 22)

Moreover, 'as we ascend the scale of evolution, we see association growing more and more conscious. It loses its purely physical character, it ceases to be simply instinctive, it becomes reasoned' (Kropotkin 1902, p. 53). Reason is closely associated with intelligence, and for higher species, this is an essentially social facility; therefore, to him it was evident that 'language, imitation and accumulated experience

are so many elements of growing intelligence of which the unsociable animal is deprived' (Kropotkin 1902, p. 58, cited in Cook 1994, p. 22).

European society, at the time Kropotkin was assembling his evidence of sociability, was heavily influenced by racist views of non-White societies which were largely portrayed as ignorant savages living a bloodthirsty or aggressive existence in the war of 'each against all', with the European colonisers in contrast being seen as bringing civilisation and enlightenment to these so-called benighted races. Kropotkin criticises such simplistic views via his knowledge of the tribe or clan society in which:

> Wrongs were righted in a community forum for arbitration, and customs and lore were passed down in an oral tradition…The imaginary barbarian—the man who fights and kills at his mere caprice—existed no more than the 'bloodthirsty' savage. The real barbarian was living, on the contrary, under a wide series of institutions, imbued with considerations as to what may be useful or noxious in his tribe or confederation. (Kropotkin 1902, p. 130, cited in Cook 1994, p. 23)

In terms of European society, Kropotkin views the development of the state as the main cause of the undermining of pre-state guilds, brotherhoods, federations, and confederations, but despite the growth of the state, examples could be found of 'voluntary association, communal undertakings and mutual support in a wide range of countries and societies, in Swiss cantons, in Ariege in South France, in Wurttemberg (sic) or Baden in Germany, in Middle Russia and elsewhere one finds rural examples, while urban/industrial ones are found in the Trade Unions, political associations and other voluntary bodies flourishing in sometimes difficult and even dangerous circumstances' (Cook 1994, p. 23); further, the working classes could not survive without mutual aid, and even the rich practised mutual aid among themselves, and would give to charity.

Cook went on to briefly evaluate these views in the context of the time, the early 1990s. Noting that Kropotkin did not seek to duck the issue of the individualistic competitiveness, which is also a feature of human affairs, and that the contemporary dominance of Thatcherism and Reaganism meant that, similar to the Victorians, there was a strong individualist competitive ethos, underpinned by the laissez-faire writings of Friedman, Hayek and others; nevertheless, it was essential to consider Kropotkin's alternative view that we are mutually supportive and cooperative as a species. This serves to

> remind us that there is another way of looking at human affairs and that
> we can search for and seek to develop further, the mutual aid dimension of human society. (Cook 1994, p. 24)

Such a view was recently reflected, for example, in the fact that the United Nations declared 2012 as the International Year of Co-operatives, a milestone that

> marks an important recognition within the international community of the role of co-operatives in promoting the 'fullest possible participation in the economic and social development of all people', including women and peoples of all ages, creeds, ethnicities and disabilities. (Webster et al. (2011, p. 1)

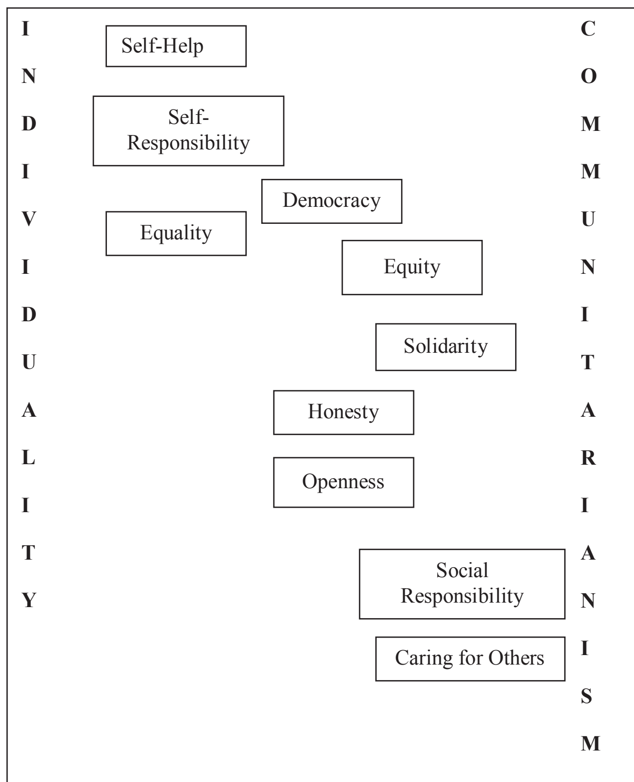

Fig. 1.1 Individuality–communitarianism. (Source: MacPherson 2011, p. 216)

The volume from which this quote is taken, *The Hidden Alternative: Co-operative Values, Past, Present and Future,* provides examples of co-operative practice across the globe, over time and space, and several will be referred to below within this book where they have a public health dimension. Within that volume, MacPherson explores the relationships between individualism on the one hand and what he calls 'Communitarianism' on the other and presents a diagram reproduced here as Fig. 1.1.

The diagram is open to debate, but makes interesting connections. Arguably, democracy is best served with a combination of the best of both of these attributes, rather than the extremes of one or the other. Similarly, the virtues of honesty and openness require elements of each to be realised, as the figure shows. Self-help is another commendable feature of social life, but requires a strong individualist element in order to be attained, while social responsibility and caring for others depend more upon communitarian values.

Social Capital

One surprise omission in *The Hidden Alternative* volume is that there is no mention of the concept of sociability and only one mention of 'social capital'. Interpreted by Battilani (2011, p. 158) in this book as 'sustained group-level co-operative behaviour', he uses this concept to link the concept of culture to the 'non-homogeneous territorial distribution of co-operatives in Italy' and the 'ideal of community happiness' which emanates from the contrasting traditions of liberalism, Catholicism, or socialism in Italy. Rowland (2009 p. 63) takes Battilani's definition further by drawing upon the Organisation for Economic Co-operation and Development (OECD) definition of social capital as 'networks, together with shared norms, values and understandings which facilitate cooperation within or among groups'. Such networks and relationships become an important community resource as social capital, for example in the process of population migration which can have an important impact on patterns of aging around the globe, either because of the loss of young people to other countries, or the more recent phenomenon of migration of older people themselves, either to their original home country or to warmer climes (see Cook and Halsall 2011 for a fuller discussion).

The concept of social capital has been theorized and understood in many different ways (Andrews 2011; MacGillivray 2002), the central core being the notion that the relational resources within a community can be harnessed by certain actors to achieve desired outcomes (Bourdieu 1980). Putnam (1995b, p. 67) defines social capital as 'features of social life—networks, norms, and trust—that enable participants to act together more effectively to pursue shared objectives' referring to the then social connections and the attendant norms and trust. Putnam (2000, p. 290) later argued in his American study that 'social capital makes us smarter, healthier, safer, richer and better able to govern a just and stable democracy' underlining the social and economic resources embodied in social networks.

Further participation in networks prevents social isolation, bringing the social and health benefits of social engagement, as well as better prospects for obtaining additional and compatible forms of assistance when needed. In the social policy field, social capital is seen as having the potential to reduce expenditure on social problems, encourage cooperation and trust and enhance quality of life. It assists in explaining why communities with similar resources may diverge in terms of social cohesion, initiative, mutual support, and adaptability to change. Although causal links are difficult to confirm, social capital in the form of social and civic engagement and cooperation appears to bestow advantages of wellbeing and resilience on communities, as well as on individuals. Some go so far as to say that 'social capital is the most fundamental resource a community requires in the creation of economic, social and political wellbeing' (Winter 2000, p. 9 cited in Rowland 2009, p. 63).

Recent policies to limit government spending have led to a big squeeze on public expenditure. This has been witnessed in several of the chosen case studies except in India, for example, where public spending has not been cut drastically. However, within our sample cases, circumstances involving either welfare budget cuts

or improving citizen participation have necessitated a bigger role by the social networks in the co-production of the services. The concept of social capital, sometimes considered an ambiguous concept, has been drawing attention of political scientists; policy makers and commentators help explain the role and importance of social networks and community groups in improving the public service provision. Robert Putnam (2000) in his classic work, '*Bowling Alone'* identified how the American society has increasingly become disconnected from one another and the various social structures such as church, political parties have disintegrated signifying a significant social change and a decline of generalised reciprocity (Putnam 2000, p. 505). Field (2003 p. 1) argues that social capital can be summed up in two words: 'relationships matter.' Skidmore et al. (2006, p. 8) have noted that there are strong connections 'between the properties of social capital and effectiveness of governance.' Hence the promotion and practice of social capital means better governance (Putnam 1993).

The success of social capital is the development of institutions and opportunities for public engagement and involvement. While acknowledging that the concept of social capital (Navarro 2002; Fine 2010) remains controversial, it nevertheless provides a practical tool to explore the significance of social networks and community engagement within the backdrop of cuts in public spending and efforts to improving citizen participation (Jackson 2011; Jakobsen 2013).

Community Development

The concept of community has fascinated social scientists because it brings a whole host of connotations (Giuffre 2013; Somerville 2011; Delanty 2003). When the term is used in the public domain there is a perception that the word 'community' creates a 'feel good' factor. Bauman (2001, p. 1) has noted that 'company or society can be bad; but not the community. Community, we feel, is always a good thing.' It has become apparent when things go wrong in society; governments want to know why this happened. Furthermore, it has become common practise for governments to examine what went wrong and how problems can be solved. In this sense, a government tends to examine a community when that community is doing well (Campbell and Jovchelovitch 2000). Elias (1974, p. i) has provided a useful definition of community when he says:

> The term community can refer to villages with some characteristics of state in relatively undifferentiated agrarian societies. It can refer to a backwater village of a more or less urbanised nation state. It can be used with reference to a suburban community, a neighbourhood region or an ethnic minority of a large industrial city.

Theoretical debates on the term community have caused much contested debate. For example, famous sociologists, such as Durkheim, Weber, Tönnies, and Simmel, have all commented on the symbolism and boundaries of community. Cohen (1985, p. 11) has noted these scholars would all agree that 'modernity and community are irreconcilable, that the characteristic features of community cannot survive

Table 1.1 Population percentage aged 65 or more over time for top five countries 1950–2050 (10% and 1 million cut-offs). (Source: Rowland 2009, extracted from Table 3.3, pp. 44–45)

1950	1975	2000	2025	2050
France 11.4	Sweden 15.1	Italy 18.1	Japan 28.9	Spain 37.6
Latvia 11.2	Austria 14.9	Greece 17.6	Switzerland 27.1	Japan 36.4
Belgium 11.1	Germany 14.8	Sweden 17.4	Italy 25.7	Italy 35.9
UK 10.7	UK 14.0	Japan 17.2	Sweden 25.4	Slovenia 34.8
Ireland 10.7	Belgium 13.9	Belgium 17.0	Finland 25.2	Greece 34.1

industrialisation and urbanisation'. Modern debates on community have generated much public interest. For example, one of the flagship policies that the British coalition government introduced in May 2010 was the Big Society.

Until recently the terminology associated with community has been somewhat fuzzy and unclear. Moreover, there has been a continual need to produce a satisfactory definition. Mooney and Neal (2009, p. 3) have argued that 'finding one definitive meaning of community is neither possible nor desirable'. Moving on from this argument is the viewpoint that communities have become more complex over time. A recent example of this are issues surrounding migration. With the improvement of transport, people have the opportunity to travel more and thus create new opportunities. Also the impact of migration has brought a contemporary perspective to communities.

As the title suggests, this book is fascinated with the concept of community development. Phillips and Pittman (2009, p. 6) have provided a comprehensive definition of community development:

> A process: developing and enhancing the ability to act collectively, and an outcome: (1) taking collective action and; (2) the result of that action for improvement in a community in any or all realms: physical, environmental, cultural, social, political, economic etc.

Brocklesby and Fisher (2003, p. 193) have argued that the concept of community development is 'not fashionable in the international development circles' because they have created a greater emphasis on 'promoting a sustainable livelihood approach'. This shift has allowed other concepts to be introduced, such as empowerment, people's participation, and stakeholder decision-making.

One area in which sociability, social capital, and community development is so important is with regard to the health and wellbeing of older people, who are increasing rapidly in number across the globe (e.g., Cook and Halsall 2011; Rowland 2009). Here, we utilise parts of two of Rowland's tables to highlight the numbers involved, both now and as this century unfolds.

Table 1.1 shows the top five countries in terms of percentage of people aged over 65 (10% and 1 million cut-offs) from 1950 to 2050 (based on United Nations data). Not only do the top five countries change over time as other nations increase in longevity, but the percentages increase dramatically over time. And so, for example, France leads the way with 11.4% in 1950 but slips out of the top five by 1975 and is replaced by Italy, with 18.1%. By 2050, it is anticipated that Spain will lead the way with a massive 37.6% of its population aged 65 or over. One caveat must be,

Table 1.2 Population numbers aged 65 or more over time for top five countries, in millions (5 million 65 or more cut-offs). (Source: Rowland 2009, extracted and analysed from Table 3.4, p. 47)

1950	1975	2000	2025	2050
China 25	China 41	China 87	China 195	China 332
USA 13	India 24	India 50	India 112	India 233
India 12	USA 23	USA 35	USA 64	USA 84
Germany 7	Russia 12	Japan 22	Japan 36	Indonesia 51
Russia 6	Germany 12	Russia 18	Russia 24	Brazil 44

however, that the current high rates of unemployment and indebtedness that Spain is suffering may have a negative impact on these projections, as may also be the case for Greece and, possibly, for Italy.

Table 1.2 provides the top five countries in terms of numbers rather than percentages; so unsurprisingly, China leads the way throughout, but the numbers increase from 25 million aged 65 or over in 1950 through to 332 million in 2050. In similar vein, India increases its numbers from 12 million in 1950 to 233 million projected by 2050. In all, as Cook and Halsall (2011, p. 5) note:

> The scale of aging is unprecedented. These are projections of course, and we must be careful not to take them too literally, in that there remain considerable threats to the process, such as the environmental threats—increased rate of hurricanes, typhoons, erratic monsoon patterns leading to major floods for example, the struggle against old infectious diseases such as malaria contrasting with the struggle against new forms of infection such as SARS or Avian Flu—associated with such factors as climate change and changing population concentrations and interactions.

One of the major concerns of population aging is the risk of dementia which is currently estimated by the UK Alzheimer's Society as 'affecting one in 14 people over the age of 65 and one in six over the age of 80' (Alzheimer's Society 2011, p. 2). Globally, it was estimated that in 2010, 35.6 million people suffer from this disease, rising to 65.7 million by 2030 (Rogers 2013, p. 260). The cost of this to society was estimated at US$ 604 billion in 2010, with the 'baby-boomers' of the late 1940s/early 1950s being at particular risk. Threats such as this worry decision-makers across the planet, particularly given that, currently, the cause of this disease is unknown (Rogers 2013). However, there does seem to be remedial action that can be taken in terms of such factors as exercise, lifestyle, or 'resistance training' (Rogers 2013, p. 261) that can ameliorate or reduce some of the worst consequences of this dreadful disease. One aspect of our study of community action in different countries will be to discover to what extent community involvement can reduce the risk factors and improve the quality of life for dementia sufferers.

It is useful to briefly summarise some demographic and economic features of our sample countries to facilitate comparisons. Table 1.3 accordingly presents key recent data for the sample. In terms of gross national income per head, therefore, the USA is the wealthiest country in the sample with a gross national income per capita (GNIpc) of US$ 50,120 in 2012, closely followed by the Netherlands at US$ 48,250 and Japan with US$ 47,870 and then the UK at US$ 38,250. There is then a marked

Table 1.3 Key comparative data for our sample countries. (Source: Britannica World Data 2014)

Country:	UK	USA	China	India	South Africa	Bangladesh	Japan	Netherlands
Population in millions	64.2 (2013)	316.5 (2013)	1357.4 (2013)	1255.2 (2013)	53.1 (2013)	154.7 (2013)	127.6 (2013)	16.8 (2013)
Percentage of aged 60 or over	22.7 (2011)	18.5 (2010)	12.3 (2010)	7.9 (2008)	8.0 (2011)	7.1 (2010)	32.2 (2012)	22.2 (2011)
Male life expectancy	78.1 (2008–10)	76.3 (2011)	72.4 (2009)	63.9 (2011)	54.9 (2011)	67.6 (2010)	79.9 (2012)	79.2 (2012)
Female life expectancy	82.1 (2008–10)	81.1 (2011)	76.6 (2009)	67.1 (2011)	59.1 (2011)	71.3 (2010)	86.4 (2012)	82.8 (2012)
Top 3 causes of death per 100,000 population	312.6 diseases of circulatory system 261.8 malignant neoplasms (cancers) 132.4 diseases of respiratory system (2008)	249.8 cardiovascular diseases 184.6 malignant neoplasms (cancers) 79.8 diseases of the respiratory system (2011)	326.7 malignant neoplasms (cancers) 278.4 cerebrovascular diseases 241.7 heart diseases (2009)	420 infectious and parasitic diseases 268 diseases of the circulatory system 100 accidents, homicides, and other violence (2002)	289.4 infectious and parasitic diseases 204.6 circulatory diseases 152.2 respiratory diseases (2009)	97.2 old age 90.6 diseases of the respiratory system 76.2 high blood pressure, heart disease, and stroke (2006)	279.5 malignant neoplasms (cancers) 160.9 heart disease 97.6 pneumonia (2011)	254.3 malignant neoplasms (cancers) 236.8 diseases of the circulatory system 78.1 diseases of the respiratory system (2010)
Gross national income per capita	US$38,250 (2012)	US$50,120 (2012)	US$5,740 (2012)	US$1,530 (2012)	US$7,610 (2012)	US$840 (2012)	US$47,870 (2012)	US$48,250 (2012)
Population per physician	365 (2012)	313 (2010)	618 (2010)	1,696 (2008)	133 (2007)	2,783 (2009)	434 (2011)	349 (2008)
Population per hospital bed	349 (2011)	325 (2009)	337 (2010)	2,449 (2008, Govt. hospitals only)	30 (2007)	1,869 (2009)	75 (2011)	215 (2009)

jump to South Africa, and then the other three countries, with Bangladesh by far the poorest at US$ 840 GNIpc in 2012. Unsurprisingly, there is a strong correlation between GNIpc and the number of population per physician, and to a lesser extent with the population per hospital bed, but South Africa is a strange anomaly with a very low number of people per physician and per hospital bed, far lower than what would be expected in terms of national income. Perhaps this reflects the impact of the HIV/AIDS crisis that has had such a devastating impact on the country. In terms of population, China and India are of course by far the most populous countries, but China does better in terms of a number of criteria, including population per physician and per hospital bed plus life expectancy (72.4 for men in China in 2009 compared to 63.9 for Indian men in 2011 and 76.6 for women in China in 2009 contrasting with 67.1 for Indian women in 2011). This confirms the analysis of Dummer and Cook (2008) who found that China's health record was better than India's on a number of counts. India still has a high rate of infectious and parasitic diseases, for example, whereas China is now more likely to suffer from diseases associated with developed countries, such as cancers or heart diseases for instance. Japan is the longest-lived country in terms of life expectancy, at 79.9 for men and 86.4 for women, both for 2012, but it is South Africa rather than India or Bangladesh that comes out lowest on this data with 54.9 years for men and 59.1 years for women, both in 2011. Further, as Cook and Halsall (2011) have shown, there is a marked discrepancy between rates by ethnicity with Whites outliving Blacks in South Africa by a significant margin. These are the sorts of contrasts that will be discussed further in the country chapters below.

In conclusion, we have selected a range of countries with which we are familiar. They vary by location, level of economic and social development, longevity, and other variables. There is at least one country from each of Europe, North America, Africa, and Asia. Perhaps in the future work, it will become feasible for us to include a South American country. The following chapters will examine eight countries from across the globe. The next chapter explores some of these themes in the UK.

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Chapter 2
United Kingdom

Befitting the UK's status as an advanced capitalist society notwithstanding the current problems of national debt and cost-cutting of public services in particular, there are a wide range of local, regional, and national initiatives from agencies that are rooted in altruistic beliefs (see Table 2.1 which sets out the key social and economic indicators of the UK). We shall consider these in terms of the following themes:

- Aging
- Disability and other health issues
- Community development, governance, and institutions
- Emergency services and public health provision

Aging

Cook and Halsall (2011, p. 4, 29) provide an overview of aging in the UK. As they note, drawing on Rowland's (2009) United Nations (UN) data, the UK has had an aging society for many decades, reaching the commonly accepted 7% cut-off point for the proportion of those aged 65 or over by 1930. By 1950, the UK was 4th globally in the list of countries with an aging population at 10.7%. This percentage rose to 14.0 by 1975, then 15.8 in 2000, with forecasts of 21.9% by 2025, and 27.3% in 2050 when the country is forecast to be 28th in the global list of older populations. It is not just about numbers, however, and Cook and Halsall (2011, p. 29) cite Dorling and Thomas (2004, p. 30) who suggest that the proportion of the UK's oldest residents is likely to increase disproportionately, giving rise to a range of issues including pension provision, pressures on the National Health Service (NHS) and the welfare system in general, as Cook and Halsall (2011) cite. Such issues are exacerbated by public sector cutbacks, including those in the NHS and from 2012, there have been increasing concerns over extraordinary pressures on Accident and Emergency (A&E) services, which began during the long hard winter of 2012–2013. For example, in Wales extra funding was announced for A&E departments on 5 December 2012, due to the fact that:

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Table 2.1 UK summary data. (Britannica World Data 2014)

Population, millions	64.2 (2013)
Percent age of aged 60 or over	22.7 (2011)
Male life expectancy	78.1 (2008–2010)
Female life expectancy	82.1 (2008–2010)
Top three causes of death per 100,000 population	312.6 diseases of circulatory system 261.8 malignant neoplasms (cancers) 132.4 diseases of respiratory system (2008)
Gross national income per capita	US $ 38,250 (2012)
Population per physician	365 (2012)
Population per hospital bed	349 (2011)
Further information	www.ons.gov.uk/ons/index.html

> A bigger than expected increase in emergency hospital admissions for patients aged 85 and over was putting a 'significant strain' on services. (BBC 2012)

In England, A&E services have a target of a 4 h waiting time for patients, but by March 2013, these services were under such a pressure that many were unable to meet this target. For example, in the county of Shropshire, (BBC 2013a) the two main hospitals failed to treat and discharge 95 % of patients within this 4 h period, in part due to high demand, with 290 patients per day since the start of the year seeking treatment in A&E. Two patients were left on trolleys for over 12 h.

Such stories were repeated across the country, and by May the issue had become a full-blown crisis (BBC 2013b) The UK Government stated that there had been an increase in use of A&E services of 1 million patients in the last few years since they came to power. In part, this was attributed to the rising numbers of older people in the population who were seeking out such services, but there were also issues identified over the lack of General Practitioner (GP) visiting out-of-hours at evenings and weekends, a lack of funds for A&E services, which meant a shortfall in staff availability, plus the failure of the NHS helpline service that was originally intended to reduce demand for emergency services. Hospitals received less funding per patient when numbers rose above those for the benchmark year 2008–2009, and as this British Broadcasting Corporation (BBC) link shows, this was estimated to be costing hospital trusts 'millions' in lost revenue, given the deficit between funding per patient and the cost of patient treatment. Further, it was estimated that non-emergency patients accounted for between 15 and 30 % of those attending A&E, and so, ideally, these patients would be directed to local treatment centres such as GP surgeries or 'walk-in' centres.

Negative news stories such as these were compounded by a report by Macmillan Cancer Support (MCS) in June 2013 which forecast that 47 % of the UK population will get cancer by 2020, compared to the level of 44 % in 2010 and 32 % in 1992 (BBC 2013c). The forecast increase was due to people living longer and thus becoming at higher risk of contracting this disease the impact of which is severe in terms of physical health and emotional wellbeing. The chief executive of MCS,

Ciaran Devane, argued that this projected increase meant that the NHS would not be able to cope:

> Without a fundamental shift towards after-care, without more care delivered in the community, and without engaging cancer patients in their own health. (BBC 2013c)

But even within this gloomy prognosis, there were signs of progress because survival rates had increased from 21 % in 1992 to 35 % in 2010 and a forecast of 38 % by 2020. Up to a quarter of cancer cases could be avoided via lifestyle changes including cutting down or stopping smoking, keeping physically active and maintaining a healthy weight.

MCS is one of the longest established charitable organisations involved in cancer amelioration and treatment, famously in the UK via their Macmillan nurses. Their website Macmillan (2013) details their historical development from the founding more than 100 years ago, in 1911, as the Society for the Prevention and Relief of Cancer. Table 2.2 is based on their website, which provides further information concerning their aims and objectives.

As Table 2.2 shows, there can be little doubt about the success of this charity, which has grown to national recognition, partly of course due to the contemporary seriousness of cancer as an illness in the UK. Thus, they appointed their first Macmillan nurse in 1975 and reached their 1000th cancer nurse in 1993, with their 2000th being appointed in 2000. They have been engaged in national fundraising campaigns that have raised millions of pounds sterling, including a major TV campaign in early 2014. Although very much associated with Macmillan nurses who support those with cancer, as Table 2.2 indicates, they now have a multiplicity of activities designed to support not only cancer patients, but their families, who also have to deal with the trauma of this illness.

Another illness that strikes fear into people, due to its dramatic impact, is dementia. ‘Dementia is a word used to describe a range of symptoms. These can include the gradual loss of memory, communication skills and the ability to think and reason clearly’ (Alzheimer’s Research UK n.d., p. 5). One of the main causes of dementia is Alzheimer’s, which causes about two-thirds of dementia cases (Alzheimer’s Research UK n.d., p. 5), but there are others too, including vascular dementia, dementia with Lewy bodies and frontotemporal dementia (Alzheimer’s Research UK n.d., p. 5). In brief, Alzheimer’s (named after the German neurologist Alois Alzheimer) sees ‘plaques’ or ‘tangles’ of proteins build up in the brain; these interfere with normal brain cell activity and kill off brain cells in a progressive deterioration that also involves chemical change in the brain (Alzheimer’s Society 2011). Vascular dementia is caused by reduced blood flow to the brain, after a stroke, for instance, dementia with Lewy bodies is caused by build-up of protein within nerve cells, and frontotemporal dementia is similar in that abnormal proteins develop in specific parts of the brain (Alzheimer’s Research UK n.d., pp. 12–13). Whatever the cause, dementia is an illness that is very much associated with old age, and the vast majority of people with dementia in the UK are aged over 65, about 92 % according to estimates. At particular risk are people aged over 80 with a one in five chance of contracting the disease (Alzheimer’s Society 2008, p. 1). In all, about 820,000

Table 2.2 Macmillan Cancer Support (MCS) historical development (key milestones). (Adapted from Macmillan 2013)

Year	Milestone
1911	Douglas Macmillan establishes the 'Society for the Prevention and Relief of Cancer', providing information on recognising, preventing, and treating cancer to patients, doctors, and members of the public
1924	Becomes a benevolent society and changes name to 'National Society for Cancer Relief', providing practical help to patients and their families
1930	The first paid member of staff is appointed
1969	Begins to support in-patient care, making first contributions towards building hospices.
1975	First Macmillan nurses are appointed, plus first Macmillan cancer care unit established
1980	£ 2.5 million spent to expand Macmillan nursing teams throughout the UK. Educational programme launched to train doctors, nurses and students in advanced pain control and cancer care
1986	First Macmillan doctor is appointed
1989	Name changed to 'Cancer Relief Macmillan Fund'
1993	1000th Macmillan nurse is appointed
1994	'10 minimum standards of care' publicised as part of a nationwide campaign about breast cancer
1997	Name changed again to 'Macmillan Cancer Relief'. Information Line opened in December
1999	Macmillan launches 'a voice for life' to give people with cancer the chance to have their voices heard and successfully lobbies The Oxford English Dictionary to change its inaccurate definition of cancer
2000	2000th Macmillan nurse appointed
2001	Macmillan merges with Cancerlink, a national charity providing support to people affected by cancer, particularly those in cancer self-help and support groups. Founds a mobile Macmillan cancer information centre and completes 100th building project, a day centre at Craigavon in Northern Ireland
2002	Macmillan CancerLine is launched, integrating the existing Macmillan Information Line and Cancerlink's information services

Table 2.2 (continued)

2003
Implements a social care strategy, focusing on supporting carers and helping people financially
2004
Macmillan Benefits Helpline, offering advice by telephone for people with cancer across the UK who need help to access benefits and other kinds of financial support, is established
2005
Number of Macmillan health professionals rises to more than 3,500 and includes nurses, doctors, radiographers, dieticians, occupational therapists, and other specialists to provide more integrated care to people with cancer
2006
Name changed once more to Macmillan Cancer Support to help people better understand what they do
2008
Merged with Cancerbackup, to provide high quality, expertly developed information about cancer, and make it available to everyone who needs it
2009
Integrated phone service is launched, allowing people affected by cancer to call just one number for medical, financial, practical, and emotional support

people in the UK are estimated to have dementia, but it is not necessarily that obvious an illness to identify and can be slow to progress.

Typical symptoms in the early stages of Alzheimer's are shown in Table 2.3 and include memory loss, disorientation, mood swings, and so on. One of the hardest things for relatives and friends to cope with is the fact that patients can completely forget who their relatives or friends are, while the patients themselves can exhibit distressing behaviour. Not surprisingly, therefore, given the social impact of this disease, a major charity has grown to help people deal with the consequences of this condition, namely the Alzheimer's Society (2013).

Related to the Alzheimer's Society is the research organisation whose work is cited here, namely Alzheimer's Research UK which according to their publication *All about dementia* is the UK's leading dementia research charity. Their website is

Table 2.3 Typical symptoms of early Alzheimer's disease. (Alzheimer's Research UK n.d., p. 8)

Regularly forgetting recent events, names and faces
Regularly misplacing items or putting them in odd places
Confusion about the time of day
Disorientation, especially away from your normal surroundings
Getting lost
Problems finding the right words
Reduced judgement, for example, being unaware of danger
Mood or behaviour problems such as apathy, irritability, or losing confidence

Table 2.4 Lifestyle factors that may reduce the risk of dementia. (Alzheimer's Research UK n.d., p. 16)

Lifestyle factors
Regular exercise
Not smoking
Achieving and maintaining a healthy weight
Controlling high blood pressure
Controlling blood glucose level if you have diabetes
Eating a healthy balanced diet with high amounts of fruit and vegetables and low amounts of saturated fat
Only drinking alcohol within recommended limits

www.alzheimersresearchuk.org where more information can be found, but we note here that they have 'funded tens of millions of pounds of pioneering research across the UK to promote the development of new treatments for dementia' (Alzheimer's Research UK n.d., p. 19). Given people's worries about dementia, it is worth noting that their research shows that an active lifestyle that includes a range of interests and hobbies may be beneficial in reducing the risk of dementia, as shown in Table 2.4. They warn, however, that some potential ameliorations such as consumption of oily fish or B vitamins are as yet unproven, as are taking of anti-inflammatory drugs such as aspirin or ibuprofen, or hormone replacement therapy (HRT), while 'There is also no evidence that turmeric, gingko, ginseng, statins or coffee can protect against dementia' (Alzheimer's Research UK n.d., p. 17).

Given the social, sometimes antisocial, nature of dementia, it is clear that the social response will become increasingly important in order to support immediate family members in particular. One charity that performs an important role in this process of providing respite to dementia carers is Personal Social Services (PSS). They have a Dementia Befriending Service in which trained volunteers are paired up with people of similar interests who have dementia, for example, those with an interest in football (soccer), swimming, shopping, or whatever, and then those volunteers (who must obtain police clearance and references in order to prevent abuse of vulnerable people) gradually meet up with their allotted person with dementia with a view to taking them out to various agreed activities. This not only provides friendship to the person with dementia but also acts as a respite for the immediate carer who can have some time off to catch up with essential tasks or just to have some time to themselves without the responsibility of the role of carer as the need arises (see Person Shaped Support 2013).

Disability and Other Health Issues

In the past, in the UK as in other countries, disability was poorly dealt with and the word 'spastic' became a common term used against those who suffered a range of physical disabilities, while 'mad' or 'lunatic' were used for those with mental problems. Today, in the UK, we have come a long way in terms of responding to

disability and the success of those such as Professor Stephen Hawking or the British Paralympic Squad show dramatically how disability can be overcome in a range of ways. But there is much work still to do, and charitable organisations can play a big part in educating people to be more caring in their response to disability. For example, in 1963 a Women's Royal Volunteer Service (WRVS) officer, Joan Brander, saw firsthand the problems faced by those with severe physical disabilities, including their need for a break from regular routine. Further:

> Joan also witnessed the plight of family carers, whose devotion to their loved ones without any kind of support or respite was taking a devastating physical and emotional toll. Joan realised that these families were in desperate need of support—and she set about providing it. (Vitalise 2013, p. 8)

Ms. Brander became the founder trustee of 'The Winged Fellowship' which began to provide holiday breaks for disabled people and their carers. Joan Brander died in 2004 by which time the organisation had gone from strength to strength, and changed its name to Vitalise that same year. Two of the current authors live in Southport, Merseyside, where the Sandpipers centre is one of three major centres run by the charity. The statistics in the Vitalise (2011–2012) annual report are impressive, and include total income of just under £ 8 million which includes £ 1.2 million of fundraising, generating a small surplus of £ 114,000 after 3 years of a deficit (Alzheimer's Research UK n.d., pp. 24–25). In all, Vitalise provided 4,838 weeks of 'life-enhancing breaks' for those with disabilities and their carers, assisted by 4245 weeks of time given by volunteers, 83 % of whom were aged between 16–25 years old (Alzheimer's Research UK n.d., pp. 6–7). As a link to the Alzheimer's topic discussed in the previous section, 133 weeks of breaks were devoted to supporting couples dealing with the impact of Alzheimer's/dementia on their lives. Further information on this worthwhile work is available at Vitalise (2013). But of course, not all charitable activity is without its problems. As noted above, the charity lost money for 3 years from 2008–2009, which we would attribute to the impact of the beginning of the recession. This loss prompted difficult decisions that have included the closure of the Kendal, Cumbria, office when its lease ended in 2012, and consolidation within the London office. Once again the organisation is in surplus and is in a position to realise its revised aims, which include provision of short breaks, non-centre breaks, investment in facilities, and to further develop the volunteering programme, one of whom is the young Philip Bembridge, 18, who volunteered at Sandpipers in order to gain an insight into social care before beginning his degree in medicine and the sprightly Joy Bone, 82, who has devoted an average of 13 weeks per year to volunteering since 1990!

A different type of emphasis on wellbeing is provided by the Reader Organisation, founded by Jane Davis who then lectured in continuing education and English at the University of Liverpool. She is now director of this charity whose mission is to build a 'Reading Revolution…in which everyone has access to literature and in which personal responses to books are freely shared in reading communities in every area of life' (The Reader 2014). A key element in their work is the concept of shared reading, led by reading facilitators trained by the charity. These facilitators lead small reading groups, often with people who have a range of mental problems

or alcohol and drug dependency for instance. The therapeutic dimension of this shared reading is considerable and potentially life transforming. Jane Davis herself has had an interesting and varied life, eventually transformed by her growing love of literature, and more information can be found about her at the Ashoka website linked to the Reader Organisation website itself.

Another important UK charity that deals directly with mental health issues is Mind, whose website is: http://www.mind.org.uk. This charity campaigns against the stigma of mental health, giving a voice to those who suffer from mental ill-health. As their website notes, there are local branches throughout England and Wales, offering support to 250,000 people. 'Their services include supporting housing, crisis helplines, drop-in centres, employment and training schemes, counselling and befriending' (Mind 2014a). The charity has been operating for over 60 years and has had noted successes in promoting more positive attitudes to mental health, including a campaign against two major supermarket chains, Asda and Tesco, that were promoting derogatory Halloween masks mocking mental ill-health in September–October 2013. The masks were withdrawn following public concern, in response to their publicity. Ecotherapy works is one of their major current campaigns, launched in late 2013. Sometimes known as 'green care' or 'green exercise', ecotherapy involves a range of outdoor or indoor green activities such as gardening, conservation, and helping to look after animals. These types of activities are shown to promote good mental and physical wellbeing, aiding recovery from or response to mental problems (Mind 2014b). These charities and many others typify those working voluntarily in the UK, and help explain why David Cameron launched the 'Big Society' campaign in 2010. Such organisations do not, however, operate in a vacuum, and are affected by the same stresses and strains within British society that the 'age of austerity' has brought. And so, for example, some have struggled to ensure that donations keep up with the increased demand for their services at a time when public sector funding has been cut. Many charities have amalgamated over time, and difficult decisions have been made to close branches ('branch plants'?) to ensure survivability. We wonder if such closures are in part an issue of corporate size—is there an optimum size for a charity? In similar vein, is there a point at which the original aims of the charity are professionalised to such an extent that working for such organisations becomes little different to working for public or private sector organisations, i.e. 'our' professionals talk to 'their' professionals? But such questions are related to questions of governance and it is to this that we now turn.

Community Development, Governance and Institutions

Social scientists have had a long fascination with governance and institutions (North 1991). There has been a contemporary fascination with governance. Many scholars have reframed the concept of governance as 'Global Governance'. Sinclair (2012) has noted that global governance has commanded a new authority within the context

of globalisation and this theoretical debate will continue. Interestingly, Weiss (2013, p. 2) has had a critical insight into global governance whereby arguing:

The essence of the problem of global governance is that the evolution of intergovernmental institutions, and the forms of collaborative in which they engage, lags well behind the emergence of collective problems with trans-border, especially global, dimensions.

One of the most prominent scholars on institutions is Anthony Giddens (1987). In his book of 1987, Giddens argues that institutions have two contributing factors which are: (1) agency and (2) structure. As (Halsall et al. 2014, p. 169) have noted, 'Agency is the sense of individuals of making their own choices and structure in the impression of pattern arrangements which influences or limit choices and opportunities available.' Similarly, Dunia (2011, p. 22) has provided a contemporary definition on institutions:

> According to perhaps the most formal approach, institutions are tightly structured entities—such as parliaments, courts, trade unions, firms, and various sorts of associations—whose parts relate to each other in clearly and often officially prescribed ways. We can think of institutions as highly organised spaces.

In the context of the UK, there are two interpretations of institutions. Firstly, institutions can be defined in central and local government and secondly, the voluntary sector. Within the British society, social commentators and scholars have had a profound interest in the welfare state. The origins of the welfare state were born from the Beveridge Report (1942). As Cook and Halsall (2012, p. 21) have noted 'The main aim of the Welfare State is to bring together a number of agencies and institutions to deliver a sustainable social welfare programme.' Since the setting up of the welfare state past governments have been obsessed in changing the system to make sure the most vulnerable people in society are protected (Patton 2006; Klein 1995).

The general election of 1997 saw a significant change in British politics. The election of New Labour saw a new emphasis placed on how communities function at a local level. As Imrie and Raco (2003, p. 4) state 'The Labour government came to power in 1997 with a commitment to regenerate Britain's cities by recourse to social inclusion, neighbourhood renewal and community involvement.' Local communities across the UK experienced a new level of investment and a greater focus on the statutory and voluntary sector. Since this time local communities across the country have encountered a greater level of public participation. One area of policy that New Labour developed when they were in power (1997–2010) was 'Active Citizenship'. The New Labour government of time perceived 'Active Citizenship' as a tool for residents to engage in their local community, thus, creating community empowerment and contributing to 'Civil Renewal' (Recknagel and Holland 2013). In this period of time, communities saw an integrated relationship between different institutions, namely, central/local government and the third sector. However, since the economic downturn from 2008, the level of investment for local communities has declined. Due to the economic downturn and the recession of 2009 onwards, the previous Labour and the current coalition governments have cut back government spending, thus having an impact on local communities (Hastings et al. 2014).

Research carried out by Mayo et al. (2013, p. 234–235) concluded that the success of community development in the UK relies upon:

> Public resources can still make a difference, when provided through democratically accountable partnership, whether these are resources for community-university research, and/or for the promotion of active citizenship and community development more generally.

In recent years, there has been a critical focus with regard to institutions failing people in British society. The most prominent case to date is the Steven Lawrence murder of 1993, which was racially motivated. A public inquiry was undertaken in 1999 'The *Macpherson* Report'. The report was highly critical of the conduct of the police. There are other examples whereby a number of public institutions have failed members of the public. The most contemporary examples to date are the Jimmy Saville and Cyril Smith cases (Furedi 2013; Danczuk and Baker 2014), Asian Grooming (Cockbain 2013), and the murder of *Daniel Pelka* (Coventry Partnership 2014). It is therefore our argument that there needs to be a more critical focus placed on why institutions are failing the British public.

Emergency Services and Public Health Provision

The landscape of pre-hospital care and the health service delivery changed drastically after the coalition government's highly controversial spending review announced in October 2010 which set broad limits on public spending through to 2014–2015. These proposals became part of the Health and Social Care Act 2012. The impact of these cuts has been far reaching given that the total cuts amounted to £ 67 billion and spread across all government departments (HM Treasury 2010). It was estimated that this could lead to cutting 500,000 jobs, costing the government around £ 4.6 billion in lost tax revenues and £ 6.1 billion in extra benefits (UNISON 2010). There were far reaching implications for the design and delivery of the emergency ambulance services. Radical structural reforms initiated by the coalition government have been transforming the architecture of emergency pre-hospital care. These include incorporating the changes into the commissioning structures from abolition of the primary care trusts (PCTs) in 2013 and transferring those responsibilities to the new clinical commissioning groups (CCGs) along with the abolition of the NHS direct service. The scale of these NHS reforms is significant. Radically transforming urgent and emergency care services including ambulance services is central to achieving the government's objectives to improve outcomes delivered by the NHS, alongside delivering greater efficiency and productivity (NHS Confederation 2012).

There have been few notable aspects of these reforms impacting the future direction of travel of the emergency ambulance services. Each of them has been discussed in some detail.

GP Commissioning

The changes incorporated in the Health and Social Care Act 2012 involved abolition of the PCTs and the incorporation of the new GP-led commissioning groups to use the services of individual ambulance services to cover their geographical areas. Since 2005, the PCTs and the GPs have been involved in commissioning in the form of practice-based-commissioning (PBC) but the evidence of transformational shift in the delivery of the health care in the UK is still lacking (Smith et al. 2010; Kings' Fund 2008). The new system replaced the old commissioning structure led by the PCTs. Some fears were expressed (NHS Confederation 2012, p. 2) that till the new structures are fully embedded, any uncertainty and lack of efficiency could damage efforts to meet the efficiencies expected under quality, innovation, productivity, and prevention (QIPP) and also undermine the drive to increase clinical leadership and compromise the quality and safety of patient care. There is also a debate concerning the skills of the new GP consortia, especially in these early years, in handling about £ 70 billion of public funds and subject to similar pressures as the PCTs but with much less management resource and experience. Ham et al. (2011) recently highlighted the difficulties of the PCT commissioners to put providers sufficiently at risk in relation to developing better integrated and more efficient care. The Audit Commission (2009) surveying the evidence of nearly 20 years of primary-care-led commissioning highlighted the fact that the erstwhile PCTs struggled to control expenditure on hospital care.

Promoting Accountability and Commitment to Patients

The NHS medical director, Professor Sir Bruce Keogh, announced in January 2013 a comprehensive review of the NHS urgent and emergency care system in England. The review *Everyone Counts: Planning for NHS Services 2013/14* (NHS Commissioning Board 2013) sets out the priorities in the planning guidance for clinical commissioning groups. The review set up a working group comprising of expert clinicians, patients, and delivery partners from across the urgent and emergency care system to develop an evidence base for change, and a set of principles to underpin that change.

Efforts to reform the sector included examining the pressures on the hospital A&E units which directly impact the ambulance service response times and use of resources. In 2012–13, there were 5.3 million emergency admissions to hospitals which was an increase of about 47 % over the last 15 years costing approximately £ 12.5 billion to the taxpayer (House of Commons Committee of Public Accounts 2014). The media reported stories that the emergency departments are spending an average of £ 600,000 each on locum doctors amounting to a total of £ 120 million a year (Daily Telegraph 2013) and a government bailout plan to spend an extra £ 500 million for the struggling A&Es to deal with the crisis (Guardian 2013). The experience of the new three-digit-telephone number (111) for urgent health

situations to ease out the pressure on the 999 has been rather mixed. The NHS confederation briefing note (2013, p. 3) identified the problems faced by 111 service, particularly the need for improved clinical input in call handling and called for a quick resolution to restore confidence in the service and suggested making the 999 and 111 telephone services co-terminus, so that there were no slippages through the gaps. The involvement of the CCGs in commissioning of the A&E services, overseen by the NHS has also contributed to the lack of clarity about the accountability and responsibility structures and mechanisms for driving the changes needed to improve the emergency A&E services in the UK (House of Commons Committee of Public Accounts 2014, p. 5).

There are also disagreements between the different emergency services in sharing resources and having control of the emergency 999 call facilities. The Ken Knight Report (2013) examining the reform of the fire and rescue services reiterated the earlier proposals from the Chief Fire Officers Association (CFOA)'s proposal to share 999 facilities with the ambulance service (Fire Futures 2010). The ambulance view reflected through the ambulance service network remains that the emergency 999 services must stay with ambulance trusts. Woollard (2010) reiterated the case for an independent ambulance service while refuting some of the key premises put forth by the CFOA's proposals. The Knight Report (2013) alluded to the unified 'Scottish' model for emergency response services consistent with the government's concept of 'Big Society'. The Scottish Fire & Rescue Service was created on 1 April 2013 replacing the country's previous eight regional services. Similarly, Police Scotland was formally established on 1 April 2013 after the merger of the eight former police forces and is now the second largest force in the UK after the Metropolitan Police. The key arguments supporting both the mergers relate to efficiency and savings by pooling resources, therefore, protecting front-line staff and services (Wankhade 2013) and would inform the future debates.

Developing the Ambulance Service Into a Professional Health Care Provider

A significant feature of the 'New Public Management' has been the emphasis it placed on public sector organisations measuring their performance. However, in practice, this has often been carried out in ways which proved dysfunctional; for example, by concentrating on a single dimension of performance, perverse incentives and unintended consequences arise (Heath and Wankhade 2014). The previous performance measurement regime for the English ambulance service was held to be a classic example of this, since it concentrated on response times at the expense of other aspects of performance such as the outcomes of treatment at the scene (Wankhade 2011a, b; Heath and Radcliffe 2010; Radcliffe and Heath 2009; Snooks et al. 2009; Siriwardena et al. 2010). It is further suggested (Wankhade 2012; Wankhade and Brinkman 2014) that it may be culturally ingrained and require significant stimuli to change the perception of the service from being perceived as a 'blue collar trade' (McCann et al. 2013).

Recent changes in the performance management regime have resulted in a 'dashboard', containing a wider range of performance indicators (Cook and Halsall 2011). Moving from a very limited set of indicators to a much broader one, whilst welcome in itself, may also give rise to difficulties. The measures may indeed turn out to be a balanced set of indicators for the ambulance service or they may just make assessment of service performance too complex to be meaningful. It may be that, in practice, some of the indicators will be stressed, simplifying the issues faced, but giving rise to new forms of gaming (Heath and Wankhade 2014). Thus, English ambulance services are faced with two new performance measurement regimes; both of which seem, in principle, an improvement on the old regime, but which, in some respects, seem contradictory in their 'philosophies' (see Heath and Wankhade 2014).

McCann et al. (2013, p. 771) recently argued that the senior level professionalization strategy has so far had limited traction due to power issues and other institutional priorities/pressures. They contend that the College of Paramedics is growing in influence but other powerful organizations (such as the Association of Ambulance Chief Executives) are centrally involved in administering the behaviour of paramedics, and imagining the future directions of travel for the paramedic profession. They conclude that:

Short-term priorities of hitting targets, winning care contracts, and 'keeping the show on the road' are far more important to NHS trusts than any aspirant long-term projects such as paramedic professionalization. Institutional work in such a setting is necessarily less about trying to change organizations and institutions, and more about maintenance. (McCann et al. 2013, p. 772)

Wankhade et al. (forthcoming) argue about a conflict between professional cultures and management objectives with the complexity of culture as an amorphous concept, which is often subject to various local contingencies making it difficult to reform. The contrast between the complexity of culture and the necessarily simple nature of performance measurement is often at the core of cultural transformation process and the ambulance service is no exception.

Concluding Remarks

The aim of this chapter was to critically explore the key contemporary issues that are involved within the UK in respect of sociability, social capital, and community development. At the start of the chapter, an overview of aging in the UK was given. It was argued that people are living longer than ever before and are putting new pressures on the NHS. A historical overview of community development within the context of governance was also provided. The chapter concluded with an analysis of the pre-hospital care settings in the UK and the monumentous changes brought in the NHS through the Health and Social Care Act (2012). The next chapter explores some of these issues in the context of the USA.

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Chapter 3
The United States

Writing at the end of the 1980s, at a time of Thatcherite dominance of state policy in the UK and Reaganite dominance in the USA, Professor David Smith (1989, p. 391) noted that

> While the emphasis in this book is on the British experience, it should be noted that the ideological underpinnings of the Thatcher government's policy orientation bears a strong resemblance to those articulated in the United States. Individual self-reliance, family solidarity, local or small-town community cohesion, and antagonism towards 'socialized' services and state control are central features of the culture and political rhetoric of the United States.

By the late 1990s, Freie (1998, p. 3) similarly noted that despite the fact that

> At least one social analyst has claimed that our longing for community is part of our human nature … [nevertheless] America has clearly moved in the opposite direction, toward individualism and a glorified sense of self as discovered in separateness, away from community and connectedness.

It is this sense of individualism that dominates the frontier ethos of the USA, or perhaps this should be termed the frontier myth, in which the rugged and resolute (white) hero overcomes all obstacles largely via his own resources in order to win his woman, raise a family, buy a ranch, and attain his American dream. The upside of this myth is the 'can do' mentality that values individual freedom and self-reliance rather than federal welfare handouts and big government. The downside can be a lack of fellow-feeling for those who are unable to obtain their share of this dream, not due to some personal fecklessness or inadequacy, but due to the invidious circumstances of lack of opportunity, poverty, or ill-health, for example. Sociability is restricted to those most like oneself, to those of similar age, ethnicity or income, in the same club, or those met via social networks on the Internet. Please see Table 3.1 which sets out the key social and economic indicators of the USA.

Well, that is one perspective. However, we shall show that even if this sense of individualism may well be dominant, there are also many in the USA who have worked selflessly for decades in a voluntary capacity giving of themselves to

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Table 3.1 US summary data. (Source: Britannica World Data 2014)

Country	USA
Population, in millions	316.5 (2013)
Percentage of aged 60 or over	18.5 (2010)
Male life expectancy	76.3 (2011)
Female life expectancy	81.1 (2011)
Top three causes of death per 100,000 population	249.8 cardiovascular diseases (2011)
	184.6 malignant neoplasms (cancers) (2011)
	79.8 diseases of the respiratory system (2011)
Gross national income per capita	US$ 50,120 (2012)
Population per physician	313 (2010)
Population per hospital bed	325 (2009)
Further information	www.census.gov
	www.census.gov/prod/www/abs/statab/html

worthy causes and good works. The drive for community and community values has been theorised by social analysts such as Murray Bookchin (1995, and see Price 2012, for a recent evaluation) or Amitai Etzioni (1995). We shall examine these elements in terms of:

- The development of sociability and voluntarism
- Volunteering today: the evidence
- Community development and philanthropic works
- Community activism and public health
- The emergency services

The Development of Sociability and Voluntarism

To us, it seems very much that a major drive towards sociability and voluntarism in the USA is associated with the rise of the civil rights and women's liberation movements and the counter-culture of the 1960s followed closely by processes of counter-urbanisation and deindustrialisation from the 1970s. The combination of oppositional and alternative perspectives on society, that developed in the 1960s, was quickly followed by the abandonment of inner city areas across the country as an initial period of 'White Flight' from traditional industrial cities of the northern USA. This became known as the 'rustbelt' which was combined with Black Flight as the general loss of manufacturing jobs to the 'sunbelt' of states like California or overseas went to the 'Flying Geese' of Japan followed by countries like Taiwan or South Korea, which hit the traditional industrial cities of the northern USA. As a consequence, northern inner cities became deprived and poverty-stricken areas in which drug addiction and crime were major problems, where skilled working class

or middle class population cohorts left to be replaced by poor Blacks or Hispanics. Thus, a city like Baltimore, for example, saw its adult unemployment rate rise from 7% in 1966 to 17% in 1988 and the 'most common complaint' in the neighborhood had changed from 'housing' in 1966 to 'drugs/crime' in 1988 (Harvey 2000, p. 134). In all:

> … in just one decade between 1970 and 1980, more than 30 million jobs were lost in US manufacturing industry. Unskilled and semi-skilled 'blue collar' workers were especially vulnerable, although now white collar support staff are just as likely to lose their jobs … In the steel industry of the USA, studies show that few workers from the massive plants that have closed in Illinois, Ohio and Pennsylvania found jobs in the new minimills of Colorado, New Mexico or Utah. Workers who were once highly paid have found themselves 'skidding downwards' into piecemeal employment in machine repair shops or as attendants in petrol stations. For those who are middle-aged, the prospect of never working again is very real. (Cook et al. 2000, p. 262)

In the face of such massive social change and restructuring, residents in the residual downtown areas of the inner cities came together in many ways in order to help their communities survive. In part, there was a legacy from the 'War on Poverty' introduced by President Lyndon B. Johnson in the 1960s. A key element of this approach was the community action programme administered by community action agencies. At the time of writing, there has been a 50-year review of the success or failure of these initiatives published by Republican Paul Ryan's House Budget Committee (Wallbank 2014). Ryan is clear that the means of testing that is a feature of federal welfare programmes 'effectively discourages' poor families from trying to make more money. Scholars cited suggest that their work has been misrepresented in this report, however, and that the war on poverty programme had considerable success, especially in the 2 years immediately after its introduction (Hiltzik 2014; Weissman 2014). Those referred to by such commentators argue that poverty levels were reduced and would have been much higher had such welfare programmes not been developed. This debate is not just of academic interest because President Obama's policies also focus on poverty and attempt to reduce economic inequality.

By the early 1990s, a wide range of community initiatives had been tried in the USA. Ian Cook and his colleagues Steve Jackson, Debbie Shepton, and Eddie Tunnah made a research visit to Boston and environs and New York in order to discover lessons and ideas for their work as the Community Strategies Research Team in Liverpool, the UK. This was summarised in a research paper on their return (Community Strategies Research Team 1994). In New York, the late professor Neil Smith kindly facilitated visits to his and Professor Susan Fainstein's community contacts. 10 meetings were held, three in Boston, one in Somerville, MA, one in Lowell, MA, and five in New York where the one at Battery Park City was unfortunately cut short due to the impact of the mayoral election that ushered in a Republican administration and the replacement of the previous Democratic one, necessitating upheaval in the organisation. The full list of those we met is:

- *Boston*: Council for Economic Action; The Massachusetts Land Bank; Bunker Hill Community College
- *Somerville*: Mt Auburn Associates

- *Lowell*: Lowell City, Lowell Housing Authority and Coalition for a Better Acre
- *New York*: Jamaica Business Resource Center, Queens; Battery Park City; Cooper Square Mutual Housing Association, Lower East Side; Phipps Community Development Corporation, West Farms, the Bronx; Harlem Restoration Project, Harlem.

Findings included the fact that community colleges were becoming increasingly important locations for training and business assistance, that private business was more likely to be involved in not-for-profit community initiatives than in the UK, and that there was an increasing role for universities in supporting community initiatives via the varied expertise and experience that the universities could provide. The New York examples were particularly inspirational, with those in the Bronx and Harlem being especially noteworthy. The West Farms area of the Bronx (near the Bronx Zoo), for example, was an area that, *inter alia*, contained a population whose incomes were two-thirds that of the New York City (NYC) rate, had a population of 70 % Hispanic, infant mortality that was 23 % higher than the NYC rate, and a rate of HIV/AIDS that was 2.5 times the NYC rate. The felony arrest rate was one of the highest in NYC while the proportion of 'clean' streets was one of the lowest in the city. In the face of such deep-rooted problems, the West Farms branch of Phipps Community Development Corporation (CDC) was based in the innovative Beacon school, funded by the city but managed by them. This school was the focus for community education, community arts, recreation activities, teen leadership courses, and 'street outreach' workshops and programmes that help teenagers prepare for the demands of adulthood via 'Brothers Ready' and 'Ladies First' for men and women, respectively. Jose Lopez of Phipps CDC showed the team around the neighbourhood and discussed the problems of health provision, the struggle against prostitution, and the improvement of housing facilities. A new half marathon was proposed for teenagers to help leverage funds from the city, state, and the private sector in order to help upgrade the area. To conclude, the Community Strategies Research Team (1994, p. 16) found that

> In all, allied to the activities described in the SNAP (Strategic Neighborhood Action Plan) of May 1994, the West Farms initiatives are impressive in their range and scope in tackling the multifaceted problems of the neighbourhood.

As an update to this analysis, we note that in 2014 this organisation is still going strong:

> At the present time, Phipps CDC serves neighborhoods in West Farms, Melrose and Morrisania in the Bronx, and Bellevue South in Manhattan. Through the combination of affordable housing and human services, the Phipps family of companies continues to help the people of New York City build healthy communities. (Idealist 2014)

Similarly, under the leadership and drive of the redoubtable Marie Runyan, who was then in her late 70s, the Harlem Restoration Project was also achieving considerable results in adverse circumstances by applying a range of innovative approaches to problems, including a drugs and adopt-a-block approach which links to a New York Police Department (NYPD) programme that assigns two officers to the

block in which the project is based in order to reduce drug use. Housing and small business initiatives were also found and the New York Times ran a feature (Slatin 1992) about their restoration of an abandoned industrial site in Harlem with a view to establishing a small-business incubator. As above, this project too continues to inspire today.

Volunteering Today: The Evidence

It is often assumed that voluntary associations are essentially local, based on face-to-face contacts and relationships. In the world of the internet, however, this may no longer be the case, but long before the world wide web was invented, Stocpol et al. (2000) show that historically in the USA voluntary organisations were often federated and could parallel (or as we might say, mimic) state and federal government structures. The heyday of voluntary organisations was, according to their analysis, 1910, when it was at a peak, including, for example, organisations such as the Masons, Oddfellows, temperance movements, and more sinister ones such as the Ku Klux Klan. They show that in a time of exceptional mobility in the founding of the USA, in which the 'all time peak' of inter-state mobility was the mid-1800s (Stocpol et al. 2000, p. 538), migrants would network in their new locations via such federations. These authors suggest that they were

> not bureaucratic because they operated on representative principles and relied on the willingness of ordinary people to join local chapters, attend meetings, pay dues, and elect conscientious officers. (Stocpol et al. 2000, p. 541)

They concluded that the misconception that associations were predominantly local needs to be combated so that Americans can thus 'reimagine their democratic future and look to revitalize shared and representative institutions not just in national politics but in associational life as well' (Stocpol et al. 2000, p. 542).

Today, one example of such a reimagining is found in the data collected by the US bureau of labor statistics on volunteering across the country (Bureau of Labor Statistics 2014). This website shows that (figures extrapolated from a sample of around 60,000 households across the country) although volunteering is at its lowest since their first survey in 2002, and had dropped by 1.1 % since 2012, nonetheless an impressive 62.6 million Americans (just over one in four at 25.4 %) had volunteered at least once to a voluntary organisation in the data collection year October 2012 to September 2013. From their tables, the person most likely to volunteer would be female, White, educated to degree level, in part-time employment, be a mother and aged 35–44, and she would volunteer to assist with food preparation or distribution, fundraising, or tutoring or teaching via a religious organisation. The least likely to volunteer would be a Hispanic male with low education attainment, unemployed and aged 16–24 or 25–34 with no children. In terms of categories, women (28.4 %) volunteer at a higher rate than men (22.2 %), Whites (27.1 %) more than Blacks (18.5 %) more than Asians (19.0 %) more than Hispanics (15.5 %), better educated (nearly 40 %) at a higher rate than poorly educated, parents more than

non-parents, employed more than unemployed, and the highest age category for volunteering was 35–44. In all, 43 % had volunteered through their own initiative, while 40.8 % had been asked, usually by a friend, to do so. Involvement with food was slightly the main activity, at 10.9 %, closely followed by fundraising at 10 % and teaching or tutoring at 9.8 %. The type of voluntary organisation that was most volunteered for was religious (33 %), followed by educational or youth related (25.6 %), and then social or community based at 14.7 %. Perhaps reflecting the impact of the downturn in the USA, the percentage of White volunteers had dropped 0.7 % but Blacks 2.6 % year-on-year 2012–2013. Unsurprisingly, although the oldest age category volunteered less than other age groups apart from those aged 16–24 and 25–34, they volunteered more hours per head than other cohorts. In all, and despite the reduction in percentage volunteering in the last decade or so, we suggest that the level of volunteering is healthy, and a sign that the selfishness of modern US life may be exaggerated.

As people age, most would probably prefer to remain in their own home, even if their spouse has passed away. But, as Blanchard (2013, p. 6) notes:

> While living at home is preferable to life in an institution, it can still feel like a hollow victory when it happens in a home that poses physical, financial, or emotional challenges and makes meaningful connection with others difficult, if not impossible. Without social interaction, meaning, and purpose, advanced aging in one's home, often alone, can result in dwindling choices and mounting levels of loneliness, helplessness, and boredom—the same three plagues of nursing homes (Thomas and Blanchard 2009). Furthermore, loneliness and social isolation in particular can lead to functional decline and hasten death.

Such concerns, allied to the high cost of private care in nursing homes, have led seniors across the USA to increasingly band together to develop communitarian alternatives to either being left alone in one's home or being faced with the high cost of private care. This situation particularly affects older women after what Blanchard calls the impact of the 'Great Recession' that has impacted on communities across the country, and indeed across the globe. Blanchard cites data from Entmacher and colleagues that show that nearly 19 % of single women aged 65 or over were living in poverty, while many retired couples are 'caught in the middle' having too many financial assets to qualify for Medicaid but too few to cover expensive nursing care.

In response, senior self-help groups have sprung up in the following communities:

- Beacon Hill Village, Boston, which provided the first village model
- The 'circle of caring' on Whidbey Island, Washington State
- 'Golden Girl Homes', Minneapolis
- Glacier Circle Senior Community, Davis, California
- Elderspirit Community Cohousing, Abingdon, Virginia

The Beacon Hill Village model has now led to 85 new ones being opened across the USA, and a further 120 under development. The initiatives vary, but they encourage such concepts as the growth of 'pocket neighbourhoods', and 'senior coops'. In all, they

> create intentional communities of mutual support and caring so as to enhance their wellbeing and improve their quality of life. (p. 10)

By such means, new vibrant communities of seniors are emerging that can help avoid the 'social death' of isolation. Blanchard concludes by arguing that while at the moment these models 'remain on the fringe', nonetheless they will increase in the future as more senior citizens cooperate to improve their own situation.

Community Development and Philanthropic Works

> Community Development is a time-honoured tradition in America's response to poverty, but its meaning remains notoriously hard to pin down. The term has come to encompass a large number of different place-targeted interventions that never quite added up to a coherent, comprehensive strategy. (O'Connor 2012, p. 11)

As the above quote argues, community development, within the US context is difficult to place. O'Connor (2012) goes on to argue that community development has been perceived to be a concept that has been obsessed with place targets 'interventions' that have been poorly thought out in strategic terms. DeFlippis and Saegert (2012) have argued that in the USA the term community development has created 'emerging tensions', 'contradictions', and a lack of direction for the future of community development. Moreover, the central issue of community development:

> …is the potentially radical separation of the notion of community from attachment to a place … the development is what the community wants and needs. But in both, the community is transitional. This does not at all delegitimize the needs of the community but it does call for a re-examination of many of the basic assumptions of community development as intervention in places. (DeFlippis and Saegert 2012, p. 380)

Hence, in this sense community development, in the context of the USA, is perceived to be misaligned as the concept does not take into consideration that each 'place' is different in many ways. This misalignment has been affected by the process of globalisation. A similar contention has also been presented by the British geographer Doreen Massey, who has argued that globalisation has created 'a global sense of place'. As Massey (1994, p. 146) notes:

> One of the results of this is an increasing uncertainty about what we mean by 'places' and we relate to them. How, in the face of all this movement and intermixing, can we retain any sense of a local place and its particularity? An (idealized) notion of an era when places were (supposedly) inhabited by coherent and homogeneous communities is set against the current fragmentation and disruption.

As the US population demographics inform us, the country has diverse social and economic challenges. The one social and economic indicator that is most eminent is ethnicity. Social scientists have been fascinated with ethnic segregation across the USA (Wilson and Taub 2006; Maly 2005; Tonkiss 2005; Park and Burgess 1967). Since the establishment of the Community Development Commission (CDC) which was set up by the Chicago City Council in 1992, the commission has been focused

on urban renewal in the city. According to the city of Chicago website (2014) the commission

> … reviews and recommends action to the establishment of new Tax Increment Financing districts, Redevelopment Area designation, and appointment of members to Community Conservation Councils. The CDS also reviews and recommends action on the sale of city-owned property located in TIF districts or redevelopment areas, and the provision of TIF financing to assist private redevelopment projects.

The above example from the CCD in Chicago is an illustration of social capital in practice. Hence, in this sense the main driving force of social capital, in the case of Chicago, is the notion of civic society, economic growth, and democratic government. Amin (2004, p. 56) has summarised social capital as

> … serving to secure many economic benefits, including public sector efficiency in the provision of services; civic autonomy and initiative in all areas of social and economic life; a culture of reciprocity and trust which facilitates the economics of association; containment of the high cost of social breakdown and conflict; and potential for economic innovation and creativity based on social confidence and capability.

One of the good examples of community development is the Bill and Melinda Gates Foundation. The Bill and Melinda Gates Foundation is one of the prevalent private foundations in the world today. Bill Gates, the owner of Microsoft, and his wife Melinda launched the foundation back in 2000. The founding principle of the foundation is to 'help remove barriers' for the most needed people in society. As it states on their website Bill and Melinda Gates Foundation (2014):

> … we fund innovative ideas that could help remove these barriers: new techniques to help farmers in developing countries grow more food and earn more money; new tools to prevent and treat deadly diseases; new methods to help students and teachers in the classroom.

They go on to add:

> Some of the projects we fund will fail. We only accept that, we expect it—because we think an essential role of Philanthropy is to make bets on promising solutions that governments and businesses can't afford to make.

According to McCoy et al. (2009, p. 1645), the foundation has three main social programmes which are:

1. Secondary and post-secondary education
2. A global development programme that focuses on hunger and poverty
3. A global health programme

It has long been argued by social commentators what type of impact does the foundation have. McCoy et al. (2009) have argued that the foundation has had a profound effect in terms of finance assistance and policy changes. However, there has also been criticism as many social policy commentators and scholars who believe that the foundation that there is overemphasis on technology as a solution (Harrington 2012; Elliot 2004; Fieldhouse 1999). As it has been noted in the past before the 1992 United Nations Conference *on Environment and Development* in *Rio* de Janeiro, there has been a different attitude between developed and developing nations on

what technology can achieve. Reed (1996) has noted that developed nations held the view that environment and poverty problems were only a short-term problem which could be solved by the application of technological solutions. However, the developing countries argued that technology was not the only solution; moreover, they argued for more focus on national economy in terms of debt, structural adjustment programmes, and the role of transnational corporations. Interestingly, the developing world has changed its attitude to technological solutions. There seems to be a more cohesive approach whereby developed and developing countries have a two-step approach: (1) a sustainable economy and (2) an impact on technology at a stable rate.

Community Activism and Pre-hospital Care

Access to the emergency management system (EMS) is instigated by dialling 9-1-1, which triggers a two-tier response using an advanced medical dispatch system which identifies the seriousness of the call. This is the first step in managing the patient. The first tier is the emergency medical technician (fire, police, and ambulance services) trained in the basic life support including the use of automated external defibrillators (AEDs). The second level is the paramedics trained in advanced cardiac life support (Smith and Conn 2009; Rea et al. 2010; White et al. 2005). Each level of pre-hospital service is certified or licensed at the individual state level. National recommendations from the Federal Department of Transportation (DOT) and National Highway Traffic Safety Administration (NHTSA) to categorise the rescue services as first responders (fire or police) or trained emergency medical technicians (EMTs) is generally followed by various states with different levels of skills (basic, intermediate, and advanced) prescribed for the EMTs with exact capabilities differing from state to state (Smith and Conn 2009). EMS models in the USA are numerous and varied on account of geography, topography, and resource allocation and could be provided by the government (mostly fire based and police based), privately supported services, or a hybrid one which is partnership between a municipality and private EMS service (see Pozner et al. 2004 for a good discussion of the historical origins of the EMS in the USA and current models of practice and training).

Current academic debates in the USA (and internationally) have included the role of the EMTs and the emphasis on the 'speed of response' in transporting the patient rapidly to the nearest medical facility and keep them alive or taking time at the scene to stabilise the patient before the transport using invasive procedures such as intubation and intravenous fluid therapy (Roudsari et al. 2007; Smith and Conn 2009; Pozner et al. 2004). There is no organisation responsible to provide trauma care in the developing countries as we have discussed in the chapter on India and China. Current evidence regarding the effectiveness of either of the two approaches is inconclusive. In a multi-country comparative study involving high income countries using the dispatch-aided EMS, Roudsari et al. (2007, pp. 994) reported that 'prehospital trauma care systems that dispatch a physician to the scene

may be associated with lower early trauma fatality rates, but not necessarily with significantly better outcomes on other clinical measures'. In another study, Smith and Conn (2009, p. 526) found sufficient evidence for the effectiveness of the pre-hospital interventions beyond the basic life support (BLS) level and in some cases being detrimental to patient outcome.

There are a growing number of empirical studies which have documented a positive correlation between social capital and organisational performance, which in turn would lead to better governance. Leana and Pil (2006) using multivariate statistical techniques found that an aggregated measure of structural, relational, and cognitive social capital positively related to the student test scores in a sample of more than 90 schools in an urban district in the USA. Collins and Smith (2006) similarly found that each of these three dimensions of organisational social capital showed positive correlation between revenue and sales growth of about 130 companies, but these effects were mediated through the capability to transfer knowledge. Tavits (2006), in his analysis of American and German subnational governments, indicated that social capital remains a powerful explanatory variable for the level of government policy activism and 'more civic communities tend to be more effective in pressuring their governments to provide more public goods and services' (2006, p. 223). In their study of fire fatalities in the USA, Andrews and Brewer (2010) tested a model of social capital on the fire service outcomes. The statistical results showed that social capital is associated with a low unintentional fire-death rate, even when controlling for a range of important environmental concerns. Engagement with public affairs and social trust are likely to have the largest positive impact on reductions in the rate of fire deaths (ibid p. 588).

It has been argued that Putnam's (1993, 2000) studies of civic culture in Italy and the USA are crucial benchmarks for empirical analysis of residents' experience of social capital within their localities and communities and Putnam's key arguments that the quality of social, economic, and political life is closely linked to the presence of generalised reciprocity throughout civil society (Andrews 2009, p. 429) is an important argument of this paper. Smith (2002) found some evidence that voting in democratic elections may make citizens more respectful and considerate of each other's rights and also likely to feel an obligation to promote public good (Rice and Feldman 1997). Further research suggests that levels of social disaffection are lower in communities when levels of political engagement are high (Boeckmann and Tyler 2002). Jakobsen (2012) used a randomized field experiment on publicly provided language support for immigrant children, including more than 600 families, and found that government initiatives can improve citizens' coproduction. This positive impact extended to the citizens with the greatest need for the service. The above discussion demonstrates that better economic conditions generate better expectations in the future and increase the voluntary activity participation rate in the communities. This analysis further corroborates the importance of civic engagement for the development of social capital, which is mediated by local factors surrounding associational activities and democratic participation.

Community first responders (CFRs) are volunteer members of community trained to deal with a range of medical emergencies and basic life support including

AEDs. The CFRs are commonly used in the American pre-hospital care system to treat acute emergencies and also meet the performance targets. This is a practice followed internationally (Mosesso et al. 1998; Rea et al. 2010; Wankhade 2011). For example, White et al. (2005) citing evidence from their study, set in the city of Rochester in Minnesota, where police and firefighters were trained in the operation of AED, reported a relatively high survival rate by as a result of employing a non-tiered community-wide approach within the EMS system. Such a collaborative dispatch system using simultaneous dispatch of the police, fire personnel along with the paramedics yielded higher survival rates following ventricular fibrillation arrests (ibid p. 283). Elrick (2003) showed people volunteered for various reasons including (a) having something to offer such as time, knowledge, and skills, (b) acquiring skills, and (c) increasing social networks and giving something back to the community. Timmons and Vernon-Evans (2013), however, highlight the complexity and variable nature of the motives, experiences, and multifaceted nature of the volunteering behaviour exhibited by the CFR groups and further caution about the long term sustainability of the CFR groups which represent good value for money in so far as they are financially self-supporting at present. Rea et al. (2010) in a population-based investigation of public access defibrillation (PAD) confirmed the survival benefits of AEDs but also suggested an important role of subsequent EMS care in most cardiac arrest patients. In another study, Mosesso et al. (1998, p. 200), police use of AEDs in seven suburban communities in the USA decreased time to defibrillation and was an independent predictor of survival to hospital discharge. Few other studies (Bardy et al. 2008; Caffrey et al. 2002; Page et al. 2000) discuss potential motivations for PAD dissemination.

Levels of voluntary participation and civic engagement are impacted by various socioeconomic and geographical factors. Social capital is a key influence on some of these outcomes even in regions depicting social and economic disadvantage (see Putnam 1993). Social capital can provide a collective resource that can be mobilized by individuals to allow the communities to address serious inequalities such as social exclusion (Wallace and Wallace 1997). In his longitudinal study of the American community life, *Bowling Alone,* Putnam (2000) strongly argues that social capital enhances public performance. Putnam (2000, p. 290) argued that "community connectedness is not just about warm fuzzy tale of civic triumph and in measurable and well-documented ways, social capital makes an enormous difference in our lives".

Concluding Remarks

This chapter has discussed and explored the contemporary debates surrounding sociability, social capital, and community development within the context of the USA. It was noted that the rise of voluntarism has had a long association with the civil rights and women's liberation movements in the 1960s. Furthermore, the USA has had, and still has, a number of community initiatives across different states. The

theoretical debates on community development have been explored and the case study examples of Chicago and the Bill and Melinda Gates Foundation applied. The discussion on community activism and pre-hospital care analysed the impact of Putnam's (2000) work on the delivery of the emergency care in the USA. The next chapter investigates some of these issues in the Chinese context.

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Chapter 4
China

The economic and social situation in China makes a fascinating contrast to most of the other countries discussed in this book. Table 4.1 sets out the key economic and social position in China. The country has been well researched in terms of economic rise and urbanisation. Ren (2013, pp. 22–23) has noted:

> China's economic rise has presented an interesting puzzle for social scientists, and scholars have been debating why the country has grown so fast in a relatively short period of time. Two, different, but complementary, perspectives can be observed in the debate on China's rise. The first view China's extraordinary growth as part of the worldwide trend of neoliberalization that began in the late 1970s. It relates China's reform measures to marketization and privatization processes taking in other parts of the world, and sees China's rise as a part, but also a result, of neoliberal economic restructuring globally (Harvey 2005). The second view is more attuned to the Chinese historical-local context, and takes China's socialist legacies and post-socialist institutional arrangements as the foundation of the country's spectacular growth. (Arrighi 2007; Huang 2008)

Voluntary activity in China has been historically embedded and influenced by Confucian ideas of working towards the common good (Wu and Gaubatz 2013). In order to cope with the perennial dangers of flood and famine, for example, China's vast peasant society had to work together to develop irrigation works or 'dig the beds deep and keep the dykes low' (Murray and Cook 2002 p. x) in the struggle to deal with these dangers. However, there was often a top-down dimension to these activities, with local officials or aristocrats leading and controlling large-scale peasant responses, so perhaps these were not quite so 'voluntary' as we would normally understand the term. In many ways, the difficulty of determining the extent to which sociability, the growth of social capital, and community development are bottom-up rather than top-down in Chinese society continues today (Shapiro 2012; Callahan 2010). The Communist Party of China (CCP) now runs the government of China via a one-party state (albeit there are other smaller parties involved that are heavily regulated), and thus the CCP is associated with top-downing. But the CCP is not a small political party sitting astride China's vast population; instead, it contains

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Table 4.1 China summary data. (Source: Britannica World Data 2014)

Country	China
Population, in millions	1357.4 (2013)
Percentage of aged 60 or over	12.3 (2010)
Male life expectancy	72.4 (2009)
Female life expectancy	76.6 (2009)
Top three causes of death per 100,000 population	326.7 malignant neoplasms (cancers) 278.4 cerebrovascular diseases 241.7 heart diseases (2009)
Gross national income per capita	US$ 5740 (2012)
Population per physician	618 (2010)
Population per hospital bed	337 (2010)
Further information	www.stats.gov.cn/english

around 76 million members across the country (Joseph 2010). Further, within the CCP, at its best the party has a strong tradition of serving the mass of the people.

The revolution was brought about in order to free the people from the twin yolk of poverty and subjugation to despotic rulers, including the foreign invaders of the nineteenth century who sought to open up China to world trade (Cook and Murray 2001). For several decades the CCP sought to downplay Confucian ideas due to their association with the country's feudal past, but in the past 20 years or so, Confucianism has been resurrected, as China's leaders have realized that the ethical base of Confucianism can help promote a 'harmonious society' in which people have responsibilities to others (Shirk 2007). It is within this context, therefore, that we examine China in this chapter.

Sociability

In ancient China, sociability was very much based among one's family, kin, or clan, although there was also the concept of *guanxi* that could encompass a wider form of networking beyond one's kith and kin. *Guanxi* encompasses something of the 'old boy's network' of the traditional English public school or university, but is less restricted than that and can cut across family and school links, locational background, and social class in an almost random manner. People with good *guanxi* are well connected within a system of reciprocity that entails obligation to support each other as well as the right to be supported. However, for the most of peasant society, it was the more localized situation of the village kin or clan that defined their social interactions, with a specific trust in each other and a distrust of outsider. Nevertheless, as noted above, the need to engage in large-scale irrigation and flood-control activities meant that there had to be interaction beyond the confines of the single village, even if the element of sociability within this interaction might well be questionable.

In the modern era, probably the most exciting example of sociability at work within China was during the period of the late 1930s–early 1940s during the war with Japan. Japanese forces invaded Shanghai in 1937 and pushed inland from there up to the Yangtze River. Shanghai was the centre of China's industrialization at that time, with lesser centers along the coast or along the Yangtze, centers built up during China's quasi-colonial era in which the Western powers, plus Japan, had forced China to open up its borders to international trade. In response to the crisis of loss of industrial plant to the invaders, a group of radical activists that included foreign expatriates as well as Chinese themselves came together in Shanghai to promote industrial cooperatives in order to provide such key items as guns, blankets, uniforms, and basic goods for the defending armies of China, including nationalists (Guomindang) and Communist forces. The movement was 'Indusco' or 'Gong He' which means 'work together'. This movement attracted funding and support from the leadership of both the main parties in China, led by the New Zealander Rewi Alley and also supported by people from Hong Kong (prior to the Japanese invasion of the colony), the UK, and the USA among others. Jenny Clegg and Ian Cook (Clegg and Cook 2009; Cook and Clegg 2011) provide recent analysis regarding the development of this movement, and show that it only started to flounder once the Guomindang leadership started to exert top-down control from their wartime capital of Chongqing. Nonetheless, Gong He had many successes and provides a sterling example of how people can come together in the face of adversity. The movement was so inspirational that it became the rallying cry for US marines during World War II as the English translation of 'Gong He' into 'Gung Ho'. Today in the West, the phrase is associated with over-the-top macho behavior, but was not so in China at the time, instead it is associated with bravery in the face of adversity, commitment to a common cause, and fellow-feeling.

The International Committee for the Promotion of Chinese Industrial Cooperatives (ICCIC-Gung Ho) was resurrected in China in 1987 and continues today, although funding is periodically problematic, as it often is for such bottom-up activities in other countries. The Canadian Cooperative Movement has been highly supportive of ICCIC-Gung Ho and has assisted with training activities. Although Gung Ho does not have an explicit health remit, it has assisted with rehabilitation after earthquakes in China and therefore promotes health recovery after disaster. It is also becoming more involved in community response to the situation of older people in China, a growing issue in the country (see Cook and Halsall 2011).

An explicitly health-oriented Chinese initiative, which has much to recommend it to poor countries especially, despite being questionable as to its level of voluntarism, was the 'Barefoot Doctors Campaign' of China's Great Leap Forward (GLF) and after. The barefoot doctors were what we would now call paramedics—people trained in basic medical skills, traditional Chinese herbal medicine, and sanitation methods in particular who were sent out into the rural areas to help China's peasantry to improve their health situation. The GLF (see Cook and Murray (2001 for more detail) was the first of Mao Zedong's dramatic and controversial attempts to change China in a short period of time (the other was the later Great Proletarian Cultural Revolution, or Cultural Revolution for short). A few years later, a

speech by Mao that criticized the urban bias of the health ministry led to the barefoot doctors becoming a major part of health policy in China, especially during the cultural revolution. Again, the degree of voluntariness is debatable. One of our Chinese friends, who was himself a barefoot doctor during the Cultural Revolution, is adamant that he was told to become a barefoot doctor, and did not volunteer for this role. Nevertheless, during the GLF itself, there must have been some element of voluntary participation, albeit of the exhorted and patriotic kind. Whatever the truth of the matter, in many societies today, there is still a need for the present day equivalent of barefoot doctors to reach out to the rural poor in order to tackle health problems in rural areas.

Emergency Medical Services in China

In China, the practice of emergency medicine includes the management of patients in the pre-hospital, emergency department, and intensive care settings (Shao et al. 2009). The pre-hospital emergency care system in China has been in development since the 1980s notwithstanding the existence of the traditional Chinese for centuries. The current medical trends combine western technology and traditional medicine (Hsiao 1995). Emergency medical systems have grown by addition and ad hoc adaptation from systems often inherited from international models of emergency healthcare practiced in North America, Europe, and the UK (Hou and FitzGerald 2008; Pei and Xiao 2011).

Owing to its vast population, complex health and social system, rapidly growing population of 1.3 billion and massive variations in economic capabilities, no single model of emergency medicine has emerged in China (Pei and Xiao 2011) . The delivery of the pre-hospital care is planned and coordinated through a hierarchical administrative system from the Ministry of Public Health (MPH) through provincial and city bureaus of public health (Thomas and Clem 1999). There are differing levels of training for the doctors and a formal training of emergency department doctors is currently varied and diversified (see Shao et al. 2009 for a more detailed account of the state of emergency medicine education in China). The current financial status of the health-care system and lack of sufficient number of qualified emergency medicine specialists have further contributed to the current situation (Hou and FitzGerald 2008). A combination of these factors have led to demographic and epidemiological changes in the Chinese population including increased incidents of traffic accidents as well as chronic conditions such as coronary heart diseases (CHDs), stroke, cancer, and diabetes (Pei and Xiao 2011). Pei and Xiao (2011) provide a good summary of the practice of emergency medicine in China, tracing the growth of the emergency medicine systems and models currently in practice. The Chinese Journal of Emergency Medicine is also another resource which represents the development of emergency medicine in China. The journal is supervised by the China Association of Science and Technology and is sponsored by the Chinese Medical Association (CME) and co-sponsored by Zhejiang University.

It is generally agreed that China has invested greatly in technological aspects of the pre-hospital emergency care with the existence of a global positioning system (GPS) technology in large cities such as Beijing and Shanghai at dispatch centres. This allows faster and efficient use of manpower and helps to mobilize resources more quickly. Commentators, however, argue that communications and personnel training remain a major challenge to pre-hospital care in China (Pei and Xiao 2011; Shao et al. 2009; Hou and Fitzgerald 2008).

Social Capital in China

In recent years, there have been a number of studies of social capital in China. For example, in cities, social capital is said by Chen and Lu (2007)to be ‘abundant’ and forms the base for the nurturing of grassroots self-government. There is a focus on different types of social capital, for example, the contrast between ‘bonding’ and ‘bridging’ social capital. The former is based on family and friends, and according to Xia (2011) in her comprehensive survey of 410 villages across China, bonding has a ‘very solid foundation’ in most villages. She found that there were high levels of trust in villagers of the same name (reflecting the kinship ties noted above) but also in other villagers’ too. However, there was a high level of distrust of ‘outsiders’. There were high levels of participation in inclusive networks and cooperative activities with nearly 83 % of villagers working with others ‘sometimes’, ’often’, or ‘very often’ (Xia 2011, p. 148). There was less evidence of the persistence of clan structures, however, with only 114 villages still having clan organizations within them, and only 35 having clan temples. As far as ‘bridging’ social capital was concerned, there was only very moderate formation of this in the villages, which is potentially unfortunate because the changes in China’s rural areas mean that there are greater contrasts, for instance of wealth or economic activity within the villages and therefore the need for bridging social capital is greater. In another study, Atuahene-Gima and Murray (2007) concluded that different dimensions of social capital to be significantly related to the levels of exploratory and exploitative learning to new product development and new technology ventures in China. Examining the effect of entrepreneurs’ social capital on investment decisions of venture capitalist in China, Batjargal and Liu (2004) found that the entrepreneurs’ social capital has significant effects on investment selection decisions in interaction with growth potential and technology products of the venture.

Does Social Capital Enhance Health and Well-Being?

The balance between state intervention including the role of regional agencies and local authorities and that of local communities in contributing to improving health is a matter of growing academic debate (Putnam 1993; Griffiths and Hunter 2007).

While it is generally acknowledged that the state has an important role to play in the delivery of public health, there is a growing recognition about the enormity of the task and how/whether the notion of 'civic-ness' and individual choice will be playing a stronger role in improving their own health (Corrigan 2007). The modern public health challenges of aging, mental illness, and long-term conditions require new approaches including building social capital and social cohesion and not only by specific health interventions (Drinkwater 2007). The big gains in the twenty-first century, are likely to come from professionals mobilising a far larger body of lay knowledge among users. Kawachi and Berkman (2003) in their comprehensive review in *Neighborhoods and Healths* conclude that there is a significant statistical association between neighborhood environments and health.

In terms of health, literature linking social capital to health including well-being is growing, notwithstanding the conceptual ambiguities surrounding research on social capital (Kawachi et al. 2004; Poortinga 2006; Kennelly et al. 2003). Putnam (1993) defines social capital as features of social organization 'that can improve the efficiency of society by facilitating coordinated actions and is widely recognized as a multidimensional concept'. Yip et al. (2007) show the linkages between social capital and levels of health and well-being in rural China. They differentiate 'structural' from 'cognitive' social capital, with the former being measured via organizational membership, while the latter is measured via a composite index of trust, reciprocity, and mutual help. It is the latter which is most closely associated with general health, psychological health, and subjective well-being, but the former demonstrates little relationship with any of these. They suggest that policies are needed to increase social networking and facilitate exchange of social support. They feel that there may have to be a 'redirection' of collective social action from the economic emphasis that has dominated hitherto into social activities.

It is also fair to acknowledge that there is still considerable disagreement about whether social capital is a collective attribute of communities or whether its beneficial properties are associated with individuals and their social relationships not only in China but even within the context of developed economies (Kawachi et al. 2004; Poortinga 2006). Wang et al. (2009, p. 133) using household survey data from 22 villages in China, tested the relationship between social capital and the self-reported health status of the rural population by introducing an overlooked distinction between trust and mistrust. The study results suggested that the individual-level 'trust' and 'mistrust' are both associated with self-reported health in rural China wherein 'trust' was positively associated with both general health and mental health, while 'mistrust' was more powerfully associated with worse mental health. The study also concluded that the effects of individual-level trust and mistrust were dependent on the village context—village-level trust substitutes for individual-level trust, while individual-level mistrust interacts positively with village-level mistrust to affect health. Overall, their study suggested the conceptual difference between trust and mistrust and the differential mechanisms by which trust and mistrust affect health in rural China.

Finally, in this discussion of social capital, we note that Xu et al. (2010, p. 259) suggest (similar to our discussion) that the 'Western definitions of social capital

derived from theories of networking, bonding, and bridging ties may be too culturally individualistic for China, where collectivist society and agrarian kinship networks predate communism'. At the very least, social capital in China must be viewed as a multifaceted and heterogeneous concept (Xia 2011, p. 158) and must be approached cautiously within the unique Chinese context of historical development of social relationships.

Community Development

Community development in China is best approached via an important volume edited by Plummer and Taylor (2004). This work focuses on the processes involved in developing capacity building, particularly in rural areas in response to environmental threats to livelihood. As in other countries, for example, there is a lack of local government capacity to support community participation. Perhaps unlike other countries however, due to the top-down nature of many initiatives, and enforced participation in the commune era, Plummer (2004, p. 10)suggests that there is often an element of resistance or 'passivity' in the community towards new community initiatives. Taylor shows how the authorities have attempted to deal with this by encouraging the setting up of village committees (VCs) and village representative assemblies (VRAs). Since 2005, elections to these have been enshrined in the statute, in the move to 'build socialist villages' which have secret ballots for elections to the VCs, hence resulting in good governance at a local level (Xia 2011).

The objectives of participation are similar to elsewhere and include sustainability, empowerment, accountability, project effectiveness, conflict resolution, and community capacity development (Plummer and Taylor 2004a, p. 39). There is a 'ladder of community participation' (Plummer and Taylor 2004a, p. 42)which at times may only be a masquerade of participation (Plummer and Taylor 2004a, p. 52) designed to placate those—perhaps well-meaning foreigners, local officials, local community leaders—who seek to develop bottom-up initiatives. In all, a number of factors can be identified that affect participation, including village organization, community leadership, culture, values and traditions, household, family and kinship networks, ethnicity, gender, education and literacy levels, economic status and employment, skills and knowledge, and willingness to participate (Plummer and Taylor 2004b, pp. 66–77). The spatial dimension also comes into play, with the specificities of local processes interweaving with levels of external support and availability of pump-priming funding, for example.

Most of the examples cited in Plummer and Taylor's book are not concerned with health issues per se, but the analysis by Li and Remenyi (2004) of the county poverty alleviation planning (CPAP) shows that poverty alleviation has an important health dimension. In particular, if poverty can be reduced, this improves the situation of women, who are at the front line in the struggle against poverty. Should women fall ill, then not only does this have an impact on them personally, but it also affects the level of working days lost more generally as men then struggle to

combine their working time with the their household duties to the family. Illness in rural areas is often associated with poor water quality, and so poverty-reduction initiatives that focus on safe water supply can also have a major positive impact on local health.

Within cities, one of the most vulnerable groups, apart from the aged population, are the *liudong renkou* or floating population who have migrated mainly from rural areas to work in jobs that the indigenous urban population might spurn because of low wages, or being too arduous or even dangerous. Often male, such migrants have no *hukou* registration that would entitle them to urban benefits such as access to housing, education, or health facilities and are at risk of alcoholism, smoking, and sexually transmitted diseases (STDs) due to their harsh existence (Cook et al. 2013). An organization that sprang up in 2003 has sought to address some of these issues. Prompted by the severe acute respiratory syndrome (SARS) crisis and by the sight of migrant children running wild in the streets while their parents were at work, a group of Beijing social workers came together voluntarily to set up a nongovernmental organization (NGO) to work with migrant communities, in order to address their deep needs via support and education. The Beijing Social Work Development Centre for Facilitators (known as Beijing SWDCF or FCCC) is now regarded as a model for such grassroots activity. Ian Cook and his family visited their office in Beijing on 18th October 2013 (thanks to the facilitation of Michael Crook of ICCIC) and found a small group of highly dedicated individuals that included Liu Qian, Li Tao, Li Zhao, Li Mingyu, and student volunteer Wei Wenli from Shenyang Province. There are eight full-time workers in Beijing, four in Nanjing, and six in Zhuhai, supplemented by 200 'major volunteers', and 1000 other helpers each year.

The main objectives of FCCC are to address the needs of migrant workers and their families. This is achieved via publications, seminars, listening to the voices of migrants through such means as self-produced plays, training of social workers and volunteers, and support for the children and, increasingly, the aged parents of migrant workers. 'There is strength in the weak' according to director Li Tao, and the offshoot 'Sunflower Project' (The Sunflower Growing Project for Migrant Workers in the Enterprise Social Work areas) founded in Zhuhai in 2009 seeks to facilitate migrants themselves becoming volunteers or social workers and encourages self-help within the migrant community. Zhuhai in South China is one of the four development zones founded in the early 1980s by the People's Republic of China (PRC) government. A total of 80,000 migrants have been assisted by this programme via the Zhuhai Centre for Social Work Faciliators (Zhuhai CSWF) according to their leaflet (Sunflower Project n. d.). The Beijing office takes the lead to 'provide professional supervision and training supports to "Sunflower Project", assist to make strategic plans, and to popularize the "Sunflower Project"' (ibid, p. 3). The Beijing office has provided services to 150,000 migrant workers as well as provided training for more than 3000 government workers, leaders of social organizations and volunteers, according to this source.

One question Cook asked during this visit was how much support did the PRC government provide? The facilitators responded that there was a small government funding, mainly via donations of equipment, air conditioning units, and the like.

They suggested that there was a tradition in China of giving things rather than money, except for large foundations. This may vary, however, and another Chinese friend has suggested that, today, the middle classes in China are so busy that they prefer to donate cash rather than time because it is easier to do so. Clearly, the FCCC and its offshoots in Nanjing and Zhuhai are worthy of wider support, from whatever direction. Apparently there are other similar organizations in migrant communities but we were told that this one is the longest established. Furthermore, some similar organizations are deemed to be too activist against companies that the government favors, therefore they do not receive any government funding.

Concluding Remarks

The preceding discussion has highlighted the rather contrasting notions of sociability and community development in a society influenced historically by the ideas of Confucius but also grappling with the materialist riches of a rapidly growing economy with increasing migratory population. Such a position is also argued in the case of the pre-hospital care model, wherein a great deal of progress has been made with the technological advances, but limited gains are noticed with regard to communication and training of the personnel. The next chapter highlights some of the similar issues in the context of India.

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Chapter 5
India

When considering India, with regard to the study of sociability and related concepts, the influential and inspirational example of M. K. Gandhi—who became better known as ‘Mahatma’ Gandhi, meaning ‘great soul’ comes to mind. Gandhi spent some of his working life in South Africa and will also therefore be briefly discussed in Chap. 5. However it was in his native India that he led a massive campaign of passive resistance to the British Raj and promoted a range of self-help and community-based initiatives that drew upon historical traditions of village democracy. His legacy continues today, but his assassination in early 1948, by a fellow Hindu, is a reminder that divisions and divisiveness in Indian society can mitigate against cooperation across barriers of caste, religion, and class for the common good. In this chapter we will explore the following themes:

- Sociability versus divisiveness
- Developing social capital
- Community development in India
- Public health and pre-hospital care in India

Sociability Versus Divisiveness

> India has become one of the fastest growing countries in the world after China which accounts for nearly a fifth of the world’s population and a quarter of the world’s poor. (Sahooa and Dash 2009, p. 351)

As the above quotation demonstrates, India has become a key economic superpower. Many economists over the years have compared Indian economic growth comparable to that of China (Barnes 2012; Fan 2011; Sharma 2009; Weisskopf 1975). Table 5.1 sets out the key social and economic indicators for India. Indian society has a vivid and rich depth of culture and tradition that goes back in time through millennia. Indian evolution has led to the growth of ‘a rich history and tradition of

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Table 5.1 India summary data. (Britannica World Data 2014)

Country	India
Population, in millions	1255.2 (2013)
Percentage of aged 60 or over	7.9 (2008)
Male life expectancy	63.9 (2011)
Female life expectancy	67.1 (2011)
Top three causes of death per 100,000 population	420 infectious and parasitic diseases
	268 diseases of the circulatory system
	100 accidents, homicides, and other violence (2002)
Gross national income per capita	US$ 1530 (2012)
Population per physician	1696 (2008)
Population per hospital bed	2449 (2008, Government hospitals only)
Further information	www.mospi.nic.in
	www.rbi.org.in

voluntary actions, community governance as well as of cooperatives formed to promote the social and economic welfare of its members' (Halsall et al. 2013, p. 1120). Cutting against these elements of sociability, however, are the major contrasts between Hindu and Muslim religions and a caste structure which formalizes relations between different caste groups, in particular leading to discrimination against the 'untouchable' caste at the bottom of the caste structure. Further, although the era of colonialism, under the British, brought a system of government control that could at its best ameliorate some of the worst excesses of divisiveness within the subcontinent, it also witnessed the decline of traditional institutions at the grassroots level. It was under Gandhi's exemplary leadership that sociability, via grassroots action, was revitalized. The key concepts of self-help that Gandhi utilized or influenced are shown in Table 5.2. Gandhi believed above all in a simpler form of local economy reliant on local products, and equitable distribution of resources:

> Gandhi viewed the ideal structure of the Indian economy as a society where there is equal distribution and consumption of wealth, where there exists neither rich nor poor, no conflict between capital and labor, and a self sufficient economy, devoid of any competition, exploitation, and violence. This is what Gandhi called 'India of my dreams'. (Koshal and Koshal 1973, p. 191)

The attempted realisation of these dreams included mass campaigns of civil disobedience, but based on non-violence. He also took on the cause of the untouchables, whom he dubbed *Harijan* or 'the children of God'. He sought reconciliation between different religions, including Muslim and Hindu. In later life, Gandhi was so appalled by the violence between Hindus and Muslims as partition of the subcontinent (into Muslim West and East Pakistan and Hindu India) approached in 1947 that he went on a fast to the death in order to stop the killings. 'In September 1947 his fasting stopped the rioting in Calcutta, and in January 1948, he shamed the city of

Table 5.2 Key concepts of Gandhian self-help approach. (Source: Vaswani 2011)

Ahimsa Non-violence
Bhoodan Land redistribution movement led by Vinoba Bhave in the 1970s, influenced by Gandhian ideals
Khadi Movement that encouraged spinning and wearing of native cloth rather than wearing the products of British cotton factories
Panchayat raj Village government, traditional form of local-led government, encouraged by Gandhi
Sarvodaya 'Welfare of all' movement in modern era, led by Jai Prakash Narain, influenced by Gandhian ideals, based at village level, 'free of external control and with fairer distribution of the fruits of the villagers' labours' (Cook 1990, p. 13)
Satyagraha Non-violent resistance to authority
Swadeshi Self-help movement based on cooperation and village industries
Swaraj 'Self-rule', initially the drive for independence from British colonialism

Delhi into a communal truce' (Encyclopaedia Britannica 1985, p. 653). Soon after, sadly, he was killed by a young Hindu fanatic, but his legacy has lived on, not just in India where modern-day movements of land redistribution and *satyagraha* are based on Gandhian ideals, but also via his influence on cooperative endeavour and mass non-violent protest across the globe.

Developing Social Capital

One of the paradoxes of cooperative action in India is that

The Indian co-operative movement was initiated by the government and it was thanks to government support that it became the world's largest and most diverse co-operative movement. (Vaswani 2011, p. 266)

Government support has been good in terms of quantity, helping the movement to grow to the extent that there are now 545 million individual cooperative organisations containing 236 million members and assets of 3,400,555 million Rupees (ibid. p. 269). The first acts were passed in the era of the Raj, and then since Independence, key committees have periodically been established to progress cooperative activity, as Table 5.3 summarises.

In general, there has been much quantitative progress, but Vaswani argues that the performance of such cooperatives 'in qualitative terms has not been up to the desired level', in many Indian states the cooperative sector 'is weak and inactive' and 'The sickness in cooperatives is fairly widespread and growing' (ibid.). Nabar (2009) suggests that although the benefits of cooperatives are difficult to prove, they are especially useful in remote rural areas and have a role to play in environmental sustainability, for example. But, just as the Gung-Ho initiatives in China during World War II (see China chapter) eventually foundered due to excessive government intervention from the Guomindang, so too in India have many cooperatives

Table 5.3 Key committees and cooperative legislation in India. (Source: Vaswani 2011)

Date	Committee or act with outcome
1904	Cooperative Credit Societies Act: focused on farmers' indebtedness and poverty
1912	Cooperative Societies Act: enabled formation of non-credit societies and federal cooperative organisations
1942	Multi-unit Cooperative Societies Act: delegated power of central registrar of cooperatives to state registrars
1951–1954	All-India Rural Credit Survey Committee: led to state partnership with cooperatives in terms of share capital and management
1955	The Committee on Cooperative Law: strengthened government control over cooperatives
2005	High-Powered Committee on Cooperatives: led to the report in 2009 that suggested to update legislation for the twenty-first century

fallen victim to bureaucratization and interference at the political level, with too many chairs being taken by Congress Party members, up to 74 %, for example, for chairs of sugar cooperatives during 1952–1972. Concerns over cooperative performance grew to the extent that a high-powered committee on cooperatives was set up by the Indian government in 2005, with a key term of reference being to ensure that legislation was produced to maximize the 'democratic, autonomous and professional functioning of cooperatives' (ibid. p. 270). The committee report was presented in 2009 and recommended that the problems were rooted in the need to ensure better governance, and that this could only be guaranteed via amendments to the Indian Constitution. Karthikeyan (2009) supports this analysis, suggesting that cooperatives need to be freed from the 'meddling of external forces' in order to cope effectively in the competitive business environment of today. Previous committees and other experts have argued, however, that such constitutional amendment is unnecessary and would add to the problem of regimentation that faces Indian cooperatives.

Whether via constitutional amendment, legislation by central or state government, or via campaigns to change mindsets, it seems clear that the progress will require, for example:

- Cooperative autonomy (that) needs to accommodate the human rights of individual members, and incorporate mechanisms to prevent breaches of accountability and mismanagement, to protect the interests of the members and the society.
- An active and engaged membership is thus seen as essential for cooperative stability and success (ibid. p. 276).
- Cooperatives urgently need a complete paradigm shift from 'government to governance'. At the same time, we need to convince cooperative practitioners and policymakers that effective regulation is necessary to address the systemic threats (ibid. p. 277).
- Consolidation at sectoral level and adopting a stronger business model seems to be a priority in meeting market challenges (ibid. p. 280).

In future, members of cooperatives in India will have to be able to see clearly 'what's in it for them', not just for those engaged in day-to-day cooperative management. This need not be economic benefits per se but via services, for example, to the membership, 'adding value' to their membership of these organisations across the country.

In terms of what is achievable in cooperative activity, Nabar (2009) cites the example of the Warana Group of Cooperatives, based on the River Warana in West Maharashtra. This group has 20,000 members, 10 billion Rupee sales and a total of 725 co-operatives including a hospital. The Warana group became well known internationally as one of the first cooperatives to be 'wired', with 70 villages being linked up via mobile phones so that members could check sugarcane prices, for example, and find the best market for their produce. There are also community department stores run by the group with an income of 310 million Rupees and 40,000 items for sale.

Community Development in India

Just as cooperatives form an important branch of the growth of social capital in India, so too can we see the importance of the third sector or non-profit sector more generally. Halsall et al. (2013, p. 1118) note that 'India has been using participatory tools to enable communities to become the primary architects of their own development'. This sector is necessary due to the failures of both state-led and market-led models of development, and it is now realised that 'active involvement of the voluntary sector is needed in the process of nation building' (Halsall et al. 2013, p. 1119). As these authors note:

'Participatory community-based governance tools help to

- Build consensus on public issues using conflict mediation techniques
- Create action plans based on community consensus about the highest priority needs and ways to address them
- Assist local institutions to mobilize their own resources to focus on these priority needs
- Form partnerships with government, non-governmental organisation (NGO), and private sector agencies
- Instil community ownership and pride in the projects they implement'

Using participatory tools creates an environment where all members of the community—men, women, youth, elderly, poor, and well-to-do can come together to openly discuss the future of their community (Halsall et al. 2013, pp. 1119–1120). We can see the similarities to conditions in China too, as our China chapter notes, but in India, the segmentation of caste and class can mitigate against broad-based voluntary organisations. Instead, it is more likely that homogeneous social groups will bond together more tightly, in part to cope with their disempowerment (Halsall et al. 2013, p. 1121). The links of such groups to government mean that

they can participate more effectively in the development trajectory and develop social capital.

The scale of such activity is seen by the fact that two million such voluntary organisations are registered under the Societies/Trusts Acts in India. In terms of public health, these include *mahila mandals* (women's organisations), old age homes, and hospitals, but although registered, not all will be currently operational. Also, district rural development agencies and district health societies have recently been registered as societies. Various key agencies such as ministries have been supporting an estimated 10,000 different voluntary organisations and community governance in the country. In 1994, it was estimated that 60 % of these organisations were concentrated in the four states of West Bengal, Tamil Nadu, Maharashtra, and Uttar Pradesh, but it is difficult to obtain accurate data to estimate the scale of resources taken by such voluntary organisations.

What is known, however, is that there are successful examples in specific states, and these include, inter alia, women's self-help groups in Andhra Pradesh supported by funding from government as well as the Society for Elimination of Rural Poverty (SERP), 'a registered autonomous body, [which] is playing a key role in this process by providing facilitation support to groups and by sensitizing line departments of the government, banks, and insurance companies towards the needs of the poor' (Halsall et al. 2013, p. 1122). There is a similarity to the self-help groups for rural development in Tamil Nadu. Here, 'the members of the group agree to save regularly and convert their savings into a common fund known as the group corpus. This fund is used by the group through a common management strategy' (Halsall et al. 2013, p. 1122). In Kerala, The State Poverty Eradication Mission—Kudumbashree—was launched by the state government of Kerala in 1998 with the active support of the government of India and the National Bank for Agriculture and Rural Development. The main objective was to eradicate absolute poverty in 10 years under the leadership of local self-governments.

These examples are rural based but the Jawaharlal Nehru National Urban Renewal Mission (JNNURM), 'which will invest US$ 12 billion in leading Indian cities by 2012, emphasizes the development of urban water and sanitation service together with governance reform centring on a formal role for citizen participation in investment decisions and the monitoring of service delivery' (ibid. p. 1123). Such examples and others illustrate the potential for growth of a healthy civil society based in the grassroots. But, as Halsall et al. (2013, p. 1125) conclude:

> The challenge for India is to formulate policies and the framework of rules that will allow and facilitate collective community action that is instrumental in generating and managing local resources, and create conditions to support participatory decision-making and organisational capacity, especially among the underprivileged masses.

In his work, Dixit (2009, p. 546) has identified strengths and weaknesses of India having good economic governance, as he notes, 'Probably the most important is the well-educated and well-interconnected community of people from government, business and academia, who are able to act as guardians of the system.' In his analysis of economic governance in India, Dixit has come up with a number of strengths

and weaknesses of economic governance. Firstly, he mentions two strengths: (1) 'There has been a steady progression of reforms. Even when the party in government changed, there was no wholesale reversal of reform; (2) The freedom of media that exist in India is extremely important; and one overall weakness (1) Frequent elections are a problem. They are exactly the kinds of institutions that promote short term thinking' (Dixit 2009, p. 546–547).

It has been well documented that the key to the success of community development in India is the level of input at a local level. Daftary (2010, p. 1692), who has undertaken research on community development strategies in India, has argued that:

> Democratic decentralisation or the devolution of power and resources from higher levels of government to lower level elected bodies is considered to promote good governance by bringing government closer to communities.

In her work, she discovered that the success of community development mainly relied upon power relationships between community leaders, elected representatives, and residents. As Daftary (2010, p. 1706) notes, 'the community and its elected leaders mutually constitute each other, representing democracy's dialectics of legitimised negotiation of power.' Overall at the centre of the success of community development at local level in India is governance and as Bardhan (2009, p. 315) writes:

Democracy has brought about a kind of social revolution in India. It has spread out to the remote reaches of this far-flung country in ever-widening circles of political awareness and self-assertion among socially hitherto subordinate groups. These groups have increased faith in the efficacy of the political system, and they vigorously participate in larger numbers in the electoral process.

Public Health and Pre-Hospital Care in India

As stated earlier in this chapter, India, like China, has increasingly attracted much global attention in the recent years because of its rapid economic growth. Both countries also face similar external forces that challenge their health care systems; since major income growth has created new consumer expectations and demands for higher-quality services (Yip and Mahal 2008). As with China, the public health agenda is potentially huge, catering to more than 1.2 billion population and covering extensive tracts of public policy and human activity with a complex nature of tasks and range of issues to be tackled. Orme et al. (2007) mapped some of the key global public health challenges, which include an aging population, child health and mental health issues, accidental death, transport and regional imbalances, and poverty—all of which require constant juggling of government priorities. Commentators (Brugha and Zwi 1998; Bhatt 1996) further point out the growing influence of private healthcare providers who often provide inadequate care, but often get away with this due to lack of capacity of the state to enforce regulatory controls.

In 2005, the increasing incidences of road traffic deaths, injuries, and disabilities, coupled with poor pre-hospital care is reported to have resulted in the death of more than 110,000 persons, 2.5 million hospitalisations, and economic losses to the tune of 3 % of India's gross domestic product (GDP; Gururaj 2008; Joshipura et al. 2003, 2004; Joshipura 2008; Garg 2012) with those injured in India having up to a sixfold higher mortality rate (Fitzgerald et al. 2006). Furthermore, see (O'Reilly et al. 2012) for a review of the state of the trauma system in India. The World Health Organisation (WHO) has projected that by 2020 road accidents will be a major killer in India. India ranks 132nd among 179 nations according to the Human Development Index (2008) in contrast to being the fifth biggest global economy. This strange disparity is mainly due to low investment in health and education, which allows the perpetuation of family-level poverty and unsatisfactory living standards, which are often considered the parameters for assessing the human development of any nation (John and Muliyil 2009).

Garg (2012, pp. 49–50) provides a moving account of *Rambhor*, a 50-year-old vegetable vendor who was hit by a speeding vehicle and died in the early hours of November, 2010 in the national capital city of New Delhi. This was a direct consequence of not receiving emergency treatment for his injuries. Three big tertiary level hospitals allowed *Rambhor* to die for want of treatment. In the first hospital, he was refused treatment on the pretext of non-availability of an intensive care bed at that time. The second hospital, a trauma center, refused treatment as the ultrasound machine was not in a working condition. The third hospital refused admission to *Rambhor* because the medico-legal papers were not complete. He was transferred from one hospital to another but denied treatment on one or another pretext. He died in an ambulance without receiving any treatment. In this case, all three hospitals flouted the orders of the Supreme Court of India. According to the apex court rulings, every state is bound to have a central bed bureau, under the health secretary, which maintains all records of bed availability in every speciality, such as the intensive care units across the state. This documented experience of Rambhor, provides a telling account of the state of pre-hospital care in India.

Emergency medicine and pre-hospital care in India is still a nascent speciality without a proper identity. It is mostly practiced by inadequately trained clinicians in poorly equipped emergency departments, a consequence of the burgeoning population, lack of standardisation of medical education, and variations in pre-hospital medical systems (David et al. 2007; Garg 2012; Fitzgerald et al. 2006; Gururaj 2008). Lack of effective and timely provision of pre-hospital trauma care is a major cause of death and disability with a few victims receiving treatment at the scene and a fewer still receiving safe transport to the hospital in an ambulance (Sasser et al. 2006, p. 507). The police, fire brigade, charities, and private ambulances provide some pre-hospital care to the injured with some ambulances owned by private hospitals operating a free-for-service basis with only an oxygen cylinder in the name as any form of medical life support (Murlidhar and Roy 2004). Unlike the UK's 999 service or the 911 service in the USA, there are still no countrywide telephone numbers in India to access an ambulance or emergency health care services, meaning that patients are routinely transported to hospital casualty wards in personal or commercial vehicles.

The Medical Council of India (MCI), the governing regulatory body does not recognise emergency management as a distinct speciality. As a result, the young medical graduates do not consider pre-hospital care as their career plan and are therefore likely to choose other conventional medical specialities. Though a nation-wide network of transport vehicles and first aid stations along the national highways is currently functional to expedite the transfer of victims from the crash site, the system cannot reduce morbidity unless backed by the concurrent development of emergency departments backed by trained ambulance personnel (David et al. 2007). Roy et al. (2010) reported from their study in Mumbai, one of the India's most populous cities that the injured victim is usually rescued by a good Samaritan passer-by (43.5 %) and also helped by the police (89.7 %). The study added that with no one waiting for the emergency medical service (EMS) ambulance to arrive, a taxi cab is the most popular substitute for the ambulance (39.3 %). The study also reported a trauma patient in India is usually a young man in his late-twenties, from a lower socioeconomic class who mostly finds himself in a government hospital, as private hospitals are reluctant to provide trauma care to the seriously injured. The study continued that the injured who do receive pre-hospital care receive inadequate and inappropriate care due to the high cost of consumables in resuscitation, and in part due to the providers' lack of training in emergency care (ibid. p. 145). In another study based in Chennai (fourth largest city in India), Ramanujam and Aschkenasy (2007) reported increasing mortality from trauma with one third of the annual hospitalisations was from trauma and acute coronary syndromes. The study also concluded that half of the trauma victims had no formal pre-hospital interventions and the standard of care in the emergency departments varied considerably with less than half of them carrying defibrillators and only a third of them carrying intubation equipment (Ramanujam and Aschkenasy 2007, p. 491). The authors also suggested necessary changes for establishment of emergency medical services model to meet the evolving health care needs.

Economic constraints appear to be likely institutional factors for poor pre-hospital health outcomes (Bennett and Bion 1999). It has been further argued (Murlidhar and Roy 2004, p. 390; Mock et al. 1993, 1998) that trauma mortality is inversely proportional to a country's per capita gross national product (GNP). It is, however, worth noting that in many states of India, there are new private providers claiming to provide professional emergency services. Notable among them are *Lifejet Ambulance* (http://www.lifejetambulance.com) providing emergency transport services in Mumbai. The biggest private operator, *GVK EMRI* handles medical, police, and fire emergencies through the '1-0-8 emergency service' access number. This is a free service delivered through state-of -the-art emergency call response centres and provides service in more than 18 states/union territories in India (http://www.emri.in). A recent review (Rao 2013) summarised the key issues in addressing a national ambulance code along with specifications for various types of ambulances.

The involvement of the private providers in delivering the pre-hospital care is a good example of the public-private initiatives (PPI) but does not address the core issues highlighted in this section (Garg 2012, Fitzgerald et al. 2006). The problems of an absence of a national EMS remains a major hindrance in tackling the growing number of current and future trauma related injuries and deaths.

Concluding Remarks

This chapter has highlighted the contrast between an emerging economic superpower with a burgeoning urban middle class but with a society (especially in rural areas) ridden with caste, religious, and class differences. This contrast is further evidenced in the growing number of cooperatives and voluntary organisations, one of the highest in the world, to deal with social injustice and prejudices covering poor, women, and the underprivileged. The pre-hospital care model further accentuates this class disparity and highlights the contrasting role played by the state to intervene effectively in some aspects of community and social development (such as support given to cooperatives) and apathy to improve the state of emergency care. The next chapter explores these issues in the context of South Africa.

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Chapter 6
South Africa

Arguably, South Africa was, until relatively recently, home to the most unsociable society on earth, dominated by a racist apartheid system that actively discriminated against non-White people and used corruption and extreme violence to suppress Black people in particular. But even then, when apartheid was at its height, sociability could still be found, but usually within ethnic confines limited by colour. However, following his release from prison in the early 1990s, the late Nelson Mandela proved to be an exemplary figure who was able to forgive across racial boundaries and became on a par with the likes of Mahatma Gandhi in his inspiration and example to others. This is particularly appropriate given that Gandhi was radicalised during his own sojourn in South Africa in the early twentieth century, and he sought to uphold the rights of the non-White races at that time. See Table 6.1 which summaries the key social and economic statistics of South Africa.

Apart from the horrors of apartheid, South Africa has also suffered the scourge of HIV/AIDS that has contributed to the high death rate and lowered life expectancy of recent decades (Whiteside 2014). Meeting this threat has similarly provided inspirational behaviour, in this case of thousands of carers and community workers across the country. We shall examine the themes of this book in terms of:

- The community response to HIV/AIDS
- Developing social capital in adverse circumstances
- Community development issues
- Community and the emergency services

The Community Response to HIV/AIDS

As Cook and Halsall (2011, p. 68) note:

The scale of infection by HIV is massive. The Government Office data for 2010 show that, for example, the HIV prevalence rate is 10.5 % of the total population,

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Table 6.1 South Africa summary data. (Britannica World Data 2014)

Country	South Africa
Population, in millions	53.1 (2013)
Percentage of aged 60 or over	8.0 (2011)
Male life expectancy	54.9 (2011)
Female life expectancy	59.1 (2011)
Top three causes of death per 100,000 population	289.4 infectious and parasitic diseases 204.6 circulatory diseases 152.2 respiratory diseases (2009)
Gross national income per capita	US$7,610 (2012)
Population per physician	133 (2007)
Population per hospital bed	30 (2007)
Further information	www.statssa.gov.za www.resbank.co.za

with 5.24 million estimated to be HIV positive, although some unofficial estimates go as high as 7 million. Among adults aged 15–49, the rate is estimated officially to be 17%. New HIV infections were recognised to be 410,000 in 2010, with 40,000 of these in children. Government statisticians estimate that 1.6 million people aged 15 or above, plus 183,000 children, would need antiretroviral therapy (ART).

In the face of such figures an unprecedented community response has sought to ameliorate the huge impact of this disease, a response that has occurred at all scales, from the international community down to the local community and the individual family members. At the international scale, for example, Cook and Halsall (2011, p. 71) cite the following initiatives:

1. The President's Emergency Program for AIDS Relief (PEPFAR) from the USA
2. The UK international finance facility
3. The French 'solidarity' levy on airline tickets
4. The Japanese 'Health and Development Initiative'
5. The work of the Bill and Melinda Gates Foundation, mentioned in our US chapter

These were not necessarily aimed exclusively at South Africa, but South Africa became a big recipient of international funds, such that, for example, official development assistance (ODA) rose from US$90.8 million in 2002 to US$595.7 million in 2009, with 96% of the latter aimed at millennium development goal (MDG) 6 that includes reduction of HIV/AIDS as well as reduction of malaria and other communicable diseases (Cook and Halsall 2011). Nevertheless, as Chan (2011) notes, financial support in itself is not enough; effective functioning of health systems is essential in order to ensure that funds reach those, usually the poor, who are the most in need. As she puts it, 'if you miss the poor, you miss the point'.

To ensure that the point is not missed, the local community response has become crucial, given that the national health system has become under such pressure due

to the scale of the HIV/AIDS threat. In a recent review of community-based HIV care across the whole of sub-Saharan Africa, where around 22 million of those 33 million people with HIV live, Mwai et al. (2013) find five out of 21 studies that were conducted specifically in South Africa, with one of the latter having two articles to make six in all. And so, Grimwood and colleagues have analysed patient advocates in two related pieces (Grimwood et al. 2012 and Igumbor et al. 2011). In the 2102 paper, they conducted a cohort study of 3,563 children over 36 months, of whom 49 % were female. The roles of the patient advocates were to give adherence and psychosocial support for the children's caregivers, conduct home visits, HIV education, and health promotion. The findings showed that as a result of these interventions, there was an improved patient retention, roughly 5 % better than for those without patient advocates. With the Igumbor et al. (2011) study, results were similarly positive. They examined the role of patient advocates retrospectively, examining the patient records of 540 children over 40 months. Of this group, 64 % were female. The roles of the patient advocates included ART adherence support, adherence counselling, and assisting disclosures of HIV status (the stigma of HIV is so great that individuals and families may seek to keep HIV infection secret from others in the community and thus endanger their own and others' lives). The retrospective analysis found that with patient advocates there was better viral suppression at 6 months of treatment, better retention of patients in care, and a higher proportion of patients with patient advocates (89 %) attained a treatment pickup rate of 95 % or more. Further, there was a higher disclosure rate among patients with, than without, patient advocates, at 58 % with compared to only 42 % without.

Other studies referred to by Mwai and coauthors include several on community health workers (CHWs), whose roles include counselling, follow-up, HIV education, and health promotion. Schneider and colleagues (2008) for example found in their study of 260 CHWs conducted over 21 months that there was an increased ART uptake if CHWs were involved. Similarly, Wouters and coworkers (2009) found that CHW support improved disclosure to family members, increased motivation to adhere to ART and improved the quality of care, while another study by Uys (2002) of community care givers (CCGs) who were involved not only in home-based hygiene and wound care but also bereavement, partner, and succession counselling helped markedly to enhance the dignity of, and quality of, care for people living with HIV.

In all, as such examples show, the role of these community based non-health professionals has become very important in the fight against HIV/AIDS. For example, ensuring adherence to ART is essential to ensure 'Positive changes in life expectancy, demographic composition and fertility' (Mwai et.al. 2013, p. 1), and lay workers and others based in the community play a vital role in monitoring and encouraging ART. The shortage of highly qualified health workers across sub-Saharan Africa meant that in 2008 the World Health Organization (WHO) recognised their role and 'endorsed task shifting to allow lower cadres of health workers to assume greater responsibility in HIV care delivery' (Mwai et al. 2013, p. 2). Far from being a step backwards in health support, the counselling provided and the tackling of stigmatisation have been a positive step forward, so much so that one study has suggested

that intervention of such community-based workers is ‘comparable or better than that provided by health care workers’ (Mwai et al. 2013, p. 8). They can enhance the ‘sense of belonging and companionship to those who would otherwise have felt isolated’ (Mwai et al. 2013, p. 10) and provide support in an emotional sense, not just in terms of taking medicines regularly, important though this undoubtedly is.

The need for this emotional, psychosocial involvement is highlighted by Marais et al. (2014) who study the mental health aspect for children who are orphaned or vulnerable (OVCs). They refer firstly to Schneider et al. (2008) who estimate that there are 60,000 community based care workers across the country. Marais and colleagues studied five community based organisations (CBOs) involved with OVCs. Three of these were government run, one was a non-governmental organisation (NGO), and one was a faith-based organisation. These CBOs provide a range of care and support services, aiming to strengthen and support community and family capacity to offer increased psychosocial support to those in need. They found, however, that those funded via the South Africa government were more likely to support government policy, which places the main emphasis not so much on emotional support but on socioeconomic problems. Thus, they seek to ensure improved ‘access to grants, food and clothing’ (Schneider et al. (2008, p. 156). They argue that while this is important, the vulnerable mental state of these OVCs is such that they need increased attention being paid to their mental health needs, and that more needs to be done to ensure this.

This reference to socioeconomic aspects is a reminder that South Africa is a poor country. In a richer country, volunteers are often able to work without remuneration because they or their families have the resources to ensure that volunteering can be unpaid. In South Africa as in other poorer countries, however, remuneration may be a key element in ensuring that volunteers can contribute to the community initiatives that are needed. Some years ago, for example, Kironde and Klausen (2002), in a study of lay volunteers involved with tuberculosis (TB) treatment, found that remuneration was the most important factor to ensure that they volunteered. Similarly, the Marais et al. (2014) study noted that in their sample CBOs many of the staff had previously been unemployed and that the 500 Rand remuneration per month had attracted them to work in these CBOs. As South Africa begins the key task of integrating CHWs into the wider public health system, it will be increasingly necessary, as Mwai et al. (2013, p. 12) argue, that the CHW’s contribution ‘is formally recognised and remunerated’. This echoes with what Cook and Halsall (2011, pp. 72–73) discovered in their analysis of older people in South Africa who are in families struggling to cope with loss of their sons and daughters to HIV/AIDS. Many grandmothers in rural areas in particular have become the crucial caregiver and finance provider via their basic state pension. They cite Schatz and Ogunmefun (2007, p. 1392) who discuss how one grandmother who with her husband supported 12 family members including four AIDS orphans among her seven grandchildren. People like her saw the pension not as money just for their own use ‘but rather as a subsidy for the household as a whole, or at least for themselves and their grandchildren’. But as Cook and Halsall conclude:

Despite the pension, however, this is life just above subsistence level, with no leftovers and no extras; welfare would need to be additional in order to lift the household beyond this level. (2011, p. 73)

Developing Social Capital in Adverse Circumstances of Inequality

Inequality is a feature of many societies, but in South Africa it is compounded by the legacy of apartheid. Cook and Halsall (2011, p. 70), for example, showed the contrasting longevity rates by gender for the four main population groups in the country, namely Black Africans, Coloureds, Indian/Asians, and Whites. Thus, 22 % of White women were aged 60 or over, contrasting with only 6.8 % of female Blacks, with 12.5 % for Indian/Asian women and 8.5 % for coloured women. Likewise, for men, the percentage was only 5.1 % for Blacks, then 6.6 % Coloured men, 10.2 % Indian/Asian men, and then the highest proportion was 18.6 % for White men. These figures are a surrogate for poverty, but Statistics South Africa has produced an in-depth analysis in 2014, based on sample households in 2005–2006, 2008–2009, and 2010–2011 (of approximately 24,000 in 2005–2006 then nearly 31.5 thousand households in 2008–2009 and 2010–2011). The data show the increase of poverty levels in 2009 as the global recession hit the country, compared to 2006, and then some decline to 2011. For example, South Africa lost an estimated 1 million jobs in 2009, and has only clawed back 350,000 of these to 2011. The study uses different measures to analyse the results, including a food poverty line and different poverty lines, and also analyses the poverty gap and, via use of the Gini coefficient, inequalities in different groups and locations.

Some of the key findings include that in 2011, there were 10.2 million South Africans living below the food poverty line and 23 million below a poverty line. It would take huge resources to pull people out of these categories, estimated by the Statistics South Africa as 12 billion Rand to pull people out of food poverty, and 73.7 billion Rand to pull them out of poverty. Inequality is slightly reduced in 2011 compared to previous but, at 0.65 for expenditure data and 0.69 for income data, remains ‘among the highest in the world’ (p. 13). The richest 20 % have 61 % of total consumption, while the poorest 20 % have only 4.5 % of consumption. Even if the lowest measure of poverty was used, it would take 31.7 billion Rand to pull this group out of poverty. But despite such negatives, and despite the ongoing problems, the report notes success in providing social assistance grants to the worst off in the population, with child support grants, a key element in poverty reduction, increasing from only 150,000 in 2000 to around 10 million in 2011, while welfare grants increased from 3 million in 2000 to around 15 million in 2011.

There has been some success, therefore, in reducing poverty, or at least reducing levels from what they might otherwise have become. But tremendous poverty gaps remain, by ethnicity, by gender, and by location. Thus, poverty by ethnic group was 54 % for Black Africans, compared to 27.6 % for Coloureds, then down to 3.4 %

for Indians/Asians, and only 0.8 % for Whites (p. 27). Similarly, the poverty gap for these groups is 23.6 %, 9.6 %, 1.0 %, and 0.3 %, respectively (p. 28), while the Gini coefficient has similar alignments. There are also other contrasts that cut across these ethnic variables, with children and youth (aged 18–24) having high levels of poverty, as do women, and people living in rural areas, where six out of ten people are poor, and the poverty gap is high. The data also illustrate such marked inequalities when analysed at the household level, and so, for example, female-headed households had an 18.2 % poverty gap in 2011 compared to 9.9 % for male-headed households, and despite male-headed households being greater in number, female-headed households are 52.6 % of all poor households. For Black-headed households, the gap is even greater, at 40.3 % and thus 93.9 % of all poor households are headed by a Black African. The data are also given for average household expenditure and is nearly 56,000 Rand for Black-headed households, nearly 98,000 for Coloured-headed ones, then nearly 199,000 for Indian/Asian and 315,000 Rand for White-headed households. Poor households spend 34.7 % of their income on basic bread and cereals compared to 21.1 % of income for non-poor households. These inequalities mean that for a rural, Black, female-headed household with children or youth, the likelihood of being poor is high indeed, and it can be seen that it is difficult to develop social capital in such adverse circumstances.

The role of social capital in promoting health is now widely debated with an assumption that understanding and in fact measuring social capital will bring positive results notwithstanding the lack of a universally accepted way to measure social capital (Ramlagan et al. 2013; Harpham et al. 2002; Putnam 1995; Kawachi et al. 1997; Sampson et al. 1997). Several factors seem to contribute towards escalating the risk to HIV/AIDS including extreme social and economic inequality, high rates of labour migration, entrenched gender inequality (Pronyk et al. 2008a, b; Fenton 2004; Gilbert and Walker 2002). Social capital has been discussed as a conceptual framework to link individual health outcomes such as HIV to the risk environment (Szreter and Woolcock 2004). It is further argued that better understanding of the relationship between social capital and HIV risk can influence and inform prevention strategies (Poundstone et al. 2004). Reduction in antenatal HIV prevalence from 30 % to under 10 % has been reported in Uganda by Green (2003) as a result of effective social mobilisation through peer-to-peer network (Pronyk et al. 2008b, p. 200). In contrast, Campbell (2003) noted the absence of community cohesion and transformation of social and sexual norms to complement an intervention programme in South Africa. Pronyk et al. (2008b, p. 2007) also reported that social capital has the potential to influence the vulnerability to HIV. Their study (ibid. p. 207) further suggested that ‘strong community relations, characterized by a sense of mutual support, reciprocity, and collective mobilization around common concerns, are linked to lower levels of HIV risk among men and to a lesser extent among women’. Another empirical study (Pronyk et al. 2008a, p. 1566) concluded that intervention combining group-based microfinance with gender and HIV training has the potential to ‘catalyze shifts in multiple dimensions of social capital among participating households relative to a matched comparison group over a two year period’.

Community Development Issues

Community development in South Africa is somewhat interesting. The common purpose of community development in South Africa is to provide social development that offers a stable and prosperous outlook (Eweje 2006). Historically, the debates on community development have mainly focused on the political upheaval of South Africa. This political upheaval has been duel focused on 'apartheid', and as Gidron et al. (2002, p. 39) notes, 'Since the beginning of the twentieth century, South Africa governments—in league with organized mining, industrial capital, and increasingly white labor—had been committed to providing cheap, unskilled black labor for white-run businesses.' Before examining South Africa's community development programme it is necessary to examine the background context of one the most powerful institutions in southern Africa. In 1980, the southern African states created the 'Southern African Development Community' (SADC). This inter-government organisation, which has its headquarters in Gaborne, Botswana, today has 15 member states. Back in 1980, there were nine southern African states where the aim of the organisation is, according to Ramsamy (2005 p. 283), 'to reduce their economic dependence on South Africa and achieve collective self-reliance'. On the SADC website today (2014) the principle objectives

…are to achieve economic development, peace and security, and growth, alleviate poverty, enhance the standard and quality of life of the peoples of Southern Africa, and support the socially disadvantaged through Regional Integration.

History has informed us the release of *Nelson Mandela from Prison in 1990 brought a new era in South African democracy. Nelson Mandela, who died on 5th December 2013, had a clear vision on community development in South Africa and to that of other developing countries. As the former President Mandela famously said,* 'Education is the most powerful weapon which you can use to change the world' (UN 2014). Today South Africa is a multiparty democratic state that has a constitution which is a sovereign nation with a strong belief in human rights. At the centre of the success of community development is the importance of clear community participation. As Buccus et al. (2008, p. 300) state:

> "The requirement that national and provincial legislatures consult is reflected in Section 59(1) of the 2006 Constitution which states that 'The National Assembly must…facilitate public involvement in the legislative and other processes of the Assembly and its committees'. Section 118 makes similar requirements for the provinces. Notably, the Constitution makes it clear that decision-making power resides with parliament alone, reflecting the reality that public participation is limited to informing the deliberations of parliament."

One of the key driving forces of community development in South Africa, at a local context, is the concept of local economic development (LED). Nel (2001) has stated that LED occurs when the local population and agencies seize the initiative and engage in actions which unify communities and thus make improvements in their local area. In this sense, local economic development has precise economic development objectives and is motivated by geographical locality. Lawrence (2013, p. 526) has noted that local economic development has played key facilitation, co-

ordination, implementation, and connecting roles between private-public and community sector interests in the context of territorial development. The idea of LED is perceived as a strategy that democratically manages local needs, resources, and aspirations (Abrahams 2003). Moreover, Abrahams (2003, p. 185) has noted that LED is acknowledged as achieving 'sustainable development' and that

LED has increasingly become an important component of their core function and local governments are faced with the challenge of developing sustainable settlements that will meet the basic needs of local communities and, simultaneously, improve their quality of life and contribute to the growth of the local economy.

Research carried out by Binns and Nel (1999, p. 405) has demonstrated that LED in South Africa is not wholly dependent on 'locational variables', but it is the means of 'community initiated' and 'owned development' which operates as the 'catalyst' to other case study areas. Hence, as they noted the success of LEDs relies on four key components: (1) community vision, (2) reconciliation, (3) strong leadership, and (4) cooperation in planning for a brighter future. However, Binns and Nel (1999) have also argued that LED may not always be locally driven; this is due to a lack of funding. They use Philani a community development project which is a rural service in Balfour to justify their argument.

In the light of the inequalities described in the last section, community development can become a controversial topic. An example of this is the activities of *Abahlali baseMjondoho,* the movement of the shack dwellers that began in a shanty town district in Durban in 2005 and has since spread to other cities. The movement has been led by S'bu Zikode who has led his shack dwellers in confrontation with the municipal authorities, via roadblocks especially, in order to prevent bulldozing of their dwellings and large-scale eviction. Their website http://abahlali.org/ gives details of their aims and objectives. They see themselves as a 'Third Force' in South African politics, between the African National Congress (ANC) government and the democratic party opposition. They welcome help from outside but want outsiders to come and live with them in their conditions in order to 'feel the mud', struggle against the rats that are everywhere and be with them while they bury their children who die of AIDS among other diseases. In their objectives, health care is included, as is 'support for people living with and orphaned by AIDS and so one'. They are against voting in elections and see themselves as basing their ideas on the living reality that they face. The success of democracy and community development can be summarised as Benatar (2006, p. 93) notes:

South Africa's transition from apartheid to fledgling democracy is a remarkable example of how negotiation, compromise and cooperation can lead to peaceful progress, bypassing the civil war that could have resulted from centuries of oppression and many decades of brutal apartheid policies. Peaceful transition through a 'negotiated revolution' exemplifies a paradigm shift that has been widely recognised and admired.

Community and the Emergency Services

Notwithstanding the global acknowledgment of injury as a major public health problem in the twenty-first century, limited attention has been accorded in South Africa (Murray and Lopez 2006; Berger and Mohan 1996). The health impact of injuries in Africa measured in terms of deaths, road-traffic-collisions (Odero 1996) morbidity, and disability though immense (see Forjuoh et al. 1998 for a detailed discussion about injury control in Africa), but remain understudied. It has been estimated that 59,000 people lost their lives in road-traffic collisions in 1990 and that figure is likely to rise to 144,000 by 2020, an increase of 144% as compared to decreasing trend in the developed countries since the 1960s (Koptis and Cropper 2005). A more detailed discussion is contained in Lagarde (2007) and Hofman et al. (2005).

Trauma is the second biggest cause of death in South Africa after cardiovascular diseases with more than 30% patients (compared to about 12% in North America and about 8% admissions in the UK) brought to the emergency departments bear injuries through a combination of factors such as interpersonal violence, road traffic collisions, and alcohol and drug abuse (Stein et al. 2002). Emergency care is viewed as a basic human right enshrined in the constitution of South Africa but there is ambiguity about the exact meaning of this offer whether it includes the right to basic emergency centre (EC) care or a more definitive intensive care treatment (Wallis et al. 2008).

Emergency medicine is often seen in its infancy outside North America and Europe and South Africa is no exception. Following a transition to democracy in 1994 and its legacy of apartheid, the country faces unique challenges regarding its health care system. Widespread morbidity and mortality from diseases prevail in areas were Black and mixed race people were segregated and are still concentrated, resulting in scare resources and understaffed hospitals. This is in sharp contrast to the metropolitan areas formerly for Whites only which boast of world class medical systems and state-of-the-art facilities and medical specialities (Clarke 1998, p. 367). For further information, please see Clarke (1998) for a compelling comparative case study account of differences in facilities and treatment in urban versus rural areas. One is at Johannesburg General Hospital with an air ambulance service in Johannesburg, the financial capital of South Africa, which had ample financial investments under the apartheid system. And that of the Umtata General Hospital in Easter Cape Province in South Africa comprising of three formerly segregated Black homelands along with their neighbours. Increasing urbanisation, migration, and westernisation are further leading to rising morbidity and one of the highest mortality rates from trauma and accidents in the world (African National Congress 1994). It is only since 2003 that emergency medicine has been recognised as a speciality by the medical establishment in South Africa. This resulted in varying patterns of staffing in the accident and emergency units across the country. Clarke (1998, p. 371) concludes:

Equalizing access to emergency services for all citizens is especially challenging given the disparity in infrastructure, educational opportunities, and resources between regions, and even within the same province.

South Africa has the most developed system of emergency care and the national healthcare plan is to ensure that basic life support is available to all residents within 20 min and the differing nature and quality of care suffered from racial inequalities is being addressed (Goosen et al. 2003).

There is a national toll-free emergency number (10177). However, a burgeoning number of privately funded emergency call systems have converged on metropolitan control centres resulting in funding of rapid response but this has come at the cost of poor penetration (Goosen et al. 2003). For instance, *ER24 EMS* is a private emergency medical service in South Africa that provides pre-hospital emergency care nationally, including emergency care transportation by road and air both at public and private levels nationally (Emergency Medical Care 2014). Rehabilitation following injury is inadequate, especially in the public sector with a quarter of beds blocked at any stage by patients awaiting transfer to rehabilitation facilities. However, the exact opposite situation to that of the private sector (ibid. p. 707). Hardcastle (2011, pp. 160–161) articulates the *11P's* as being the requirements for developing a cost efficient and patient-centred Afrocentric trauma systems relevant to South Africa and are outlined below:

1. *Political will requiring more than a tacit acceptance, but adequate level of funding and personnel*
2. *Public pressure on the government to improve care and establish care systems*
3. *Participation from multiple sectors involving all stakeholders, government departments, citizens, and volunteers*
4. *Professional compliance ensuring evidence-based practice and adherence to professional standards*
5. *Provisional restructuring to combat the regional inequalities and urban-rural divide*
6. *Private sector participation to complement public offer*
7. *Professional society accreditations to determine public policy and quality of care*
8. *Proper data management to benchmark performance and ensure quality of care*
9. *Purpose-driven governance* to revise practice and improve outcomes
10. *Posttrauma rehabilitation* and support services to be given equal priority
11. *Financial sound model* of practise to be developed

A high rate of exposure to traumatic stressors is potentially an integral part of the job of an emergency care practitioner resulting into serious mental health and behavioural problems, posttraumatic stress disorder (PTSD), anxiety and depression. In a study of emergency paramedics in Western Cape province, Ward et al. (2006) reported higher rates of critical incident exposure than found in studies in the developed world, associated with symptoms of PTSD, and with aggression between coworkers with younger ambulance staff more vulnerable to attack. Mahomed et al.

(2007) in their study to review the infection control policies in the pre-hospital environment, argued for a need of a national communicable disease and infection control policy and training regime specific to the need of emergency medical service. Gottschalk et al. (2006, p. 152) further highlighted the use of differing call triage system arguing the need for a robust triage instrument for use in the South African medical arena and the need for development of new care protocols (MacFarlane and Benn (2003). Availability of the emergency care is also an added challenge. A majority of primary health care clinics are open only during office hours and also do not focus on trauma training for the healthcare nurses.

The state of the emergency care in South Africa has developed rapidly in the last 20 years. Since 2003, emergency medicine is now a recognised speciality with the concurrent establishment of the College of Emergency Medicine (CEM (SA)) and is currently enjoying governmental attention as part of the preparation towards the Fédération Internationale de Football Association (FIFA) 2010 Soccer World Cup (Lee et al. 2008). The college offers a reciprocal fellowship in immediate medical care of the Royal College of Surgeons in Edinburgh, Scotland along with other university training programmes available in South Africa. Pre-hospital care has graduated from isolated fire departments providing basic medical assistance to a complex, sophisticated system of emergency response covering the whole of South Africa to varying degrees. Emergency care practitioners are now registered with the Health Professions Council of South Africa (HPCSA) with response times varying from 15 min in urban areas to 40 min or longer in some rural areas.

Emergency medicine, as mentioned earlier in the section, is a new speciality with a curriculum based largely on consensus and adapting international curricula and is not evidence-based (Cohen and Wallis 2011). There is, however, inequitable distribution of services with many rural areas poorly resourced along with the challenges of patient overload, under-investment in the public sector, and lack of equity in distribution of resources (MacFarlane et al. 2005; Brysiewicz 2001; Perrott 2003).

Concluding Remarks

In this chapter, we have explored key debates concerning sociability, social capital, and community development within the context of South Africa. A major theme within South Africa has been the legacy of apartheid, which has led to huge inequalities of health provision between different ethnic groups. This has been compounded by the dreadful impact of HIV/AIDS upon the Black community especially. However, in response to this threat, the community response has been unprecedented, and we referred to a number of studies that have shown the positive impact of community intervention, not least upon the emotional and psychological wellbeing of HIV/AIDS patients. Secondly, we have shown the sometimes controversial nature of community development in South Africa, with the excluded people in the shanty towns of Durban and other cities developing their own solutions to the poverty with which they are faced, via *Abahlali baseMdonjoho*. Thirdly, the chapter explored issues around the emergency services, which have historically been very unequal

across ethnic groups. As we illustrated, there is a need for a new Afro-centric approach to trauma in order to reduce such inequalities. The next chapter explores similar issues within the context of another poor country, Bangladesh.

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Chapter 7
Bangladesh

In 1971, Bangladesh came into being as a state. This was when the independence movement of the Awami League, led by Sheik Mujibur (Mujib) Rahman, was backed by Indian military forces against the invading forces of West Pakistan. These combined forces sought to ensure that the country remained East Pakistan, as it had been since the partition of the Indian subcontinent in 1947. The surrender of the West Pakistan forces led to the establishment of the 'Land of Bengalis', Bangladesh, under Mujib. Born out of violence and upheaval, the new country has had a chequered history since its birth, with assassinations of its leaders, including the founder Mujib, and alternating periods of military rule and democracy, as shown, for example, in the country profile timeline provided by the British Broadcasting Corporation (BBC 2014, www.bbb.com/news/world-south-asia-12651483). In recent years, control of this large democracy of around 150 million people has oscillated between parties led by the daughter of Sheik Mujib, Sheik Hasina Wazed (Wajed), and the daughter of assassinated former leader General Zia ul-Rahman, Begum Khaleda Zia, respectively. At the time of writing, Wajed is prime minister and it is Khaleda Zia who has been committed for trial on corruption charges, as of March 2014.

This political variability and potential vulnerability of Bangladesh is mirrored by the variability of weather conditions and the potential vulnerability caused by global climate change, especially the 'global wetting' that is a major consequence of this climatic change (Dummer et al. 2011). These authors cite Anam (2008, p. 8) who suggests that

> In the next 50 years, 17 % of Bangladesh's landmass is sure to go underwater, causing more than 30 million people to become homeless. Those who live further inland will be only slightly better off: the cyclones and floods that are already a feature of the weather will occur more frequently and with greater ferocity.

Khan (2009, p. 19) focuses more on the country's economic and demographic prospects and in similarly gloomy vein states that despite the many years of domestic and international efforts to improve these prospects, 'Bangladesh remains poor, scarce of resources, overpopulated and ill-governed'. However, since that was written, there are some positive signs of improved economic prospects, especially with

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Table 7.1 Bangladesh summary data. (Britannica World Data 2014)

Country	Bangladesh
Population, in millions	154.7 (2013)
Percentage of aged 60 or over	7.1 (2010)
Male life expectancy	67.6 (2010)
Female life expectancy	71.3 (2010)
Top three causes of death per 100,000 population	97.2 old age 90.6 diseases of the respiratory system 76.2 high blood pressure, heart disease, and stroke (2006)
Gross national income per capita	US $ 840 (2012)
Population per physician	2783 (2009)
Population per hospital bed	1869 (2009)
Further information	www.bbs.gov.bd www.bangladesh.bank.org

the booming textile trade in 2011, for example, which more than offset the loss of remittances from Bangladeshi expatriates in the Middle East due to the impact of the 'Arab Spring' upheavals that year (Sparks 2012), and there is evidence of further improvement with an annual gross domestic product (GDP) increase of 6.6% in 2012 (Mathieson 2013) which continues with a reasonable level of economic expansion in recent years. But this expansion is double-edged, however, as the collapse of a garments factory in May 2013 led to 1100 deaths and extensive, heated protests against low wages and terrible working conditions. Table 7.1 presents an overview of Bangladesh economic and social indicators.

This factory disaster illustrated not only the theme of multinationals' low wages (or at least of insufficient inspections by multinationals to ensure that local wages were not set at low subsistence levels and that working conditions did not involve exploitation of vulnerable people, especially young women), but it also showed the enormous bravery of those who sought to rescue those trapped in the dangerous wreckage. Often working with their bare hands, at least until the authorities eventually organised large-scale machinery to assist with this task, people showed their sociability and fellow-feeling in this rescue process. Below, we shall explore sociability in less dramatic situations, the essential processes necessary in order to support the vulnerable in Bangladeshi society. The themes will be:

- International and local response to health and aging issues
- Community development in a developing country
- Developing social capital: the Grameen Bank situation
- Community response and the emergency services

International and Local Response to Health and Aging Issues

As with the impact of HIV/AIDS in South Africa, which as we have shown in this book requires intervention at all levels from the local community to international level, so too the combination of poverty, health problems, and recent aging in Bangladesh requires a similar contribution at different scales. Khan (2009) refers to the contribution of several charitable organisations in the aging area, including the work of Help Age International (HAI) and the Sir William Beveridge Foundation at the international level, and the old people's home set up by K.A.Z. Mukul, a local industrialist and philanthropist. Rajan et al. (2002) show that the latter home is aimed to cater for 500 senior citizens and is set in 22 acres, 50 km from Dhaka. The home is designed to be self-sufficient via 'pisci-culture, poultry raising and other community ventures' (Rajan et al. 2002, p. 50). Sir William Beveridge wrote the report that helped establish the welfare state in Britain, and the Foundation set up in his name is seeking in Bangladesh to respond to the great pressures on older people, in part due to the climate change noted above:

> In Bangladesh, the problem of caring for the elderly is acute not least because of climatic catastrophes that have hit the country. Flooding in the south combined with the rise of the sea table, has forced many families to move north to higher ground and to seek work in Dhaka … The population of Dhaka is currently around 30 million and rising and the services are unable to cope with demand. (Sir William Beveridge Foundation 2014)

This population figure is far higher than the official figure, which was nearly 13 million in 2008, and indicates the recent pressures of urbanisation in the country. The foundation suggests that this has meant that families cannot cope with their aging relatives and that respect for older people has diminished. A team of 'Beveridge Carers' has been trained under guidelines issued by the UK Care Quality Commission to visit people's homes in order to provide basic care. Their website shows that this has made a tremendous difference to those that they visit, enabling them to regain their respect and sense of wellbeing.

In similar vein, HAI (2014) give examples of positive outcomes from their work, including a 72-year-old male and his 60-year-old wife who used a grant from HAI to start producing baskets for local farmers. The income provided even helped them to visit the local health centre, which otherwise they would not have been able to do. HAI has been involved with their affiliates and partners in Bangladesh since 1991, which include the Bangladeshi Women's Health Coalition (BWHC) and the Dhaka Ahsania Mission (DAM). In the last year, this charity has been involved in providing assistance and help in the following areas:

- Livelihood and social security: provided 1215 poor older households with US $ 184,000 to develop income generation such as via the basket-making business noted above
- Emergency response and disaster risk reduction: gave 2500 older people in the south of Bangladesh food, basic items, and emergency medical care
- Rights: encouraged 50,000 to march in 'Age Demands Action' across 64 districts

Plans for the next 12 months of activities include work to help develop a national policy on aging, help capacity-building of 525 older people's associations, provide better social care for 2500 older people and contribute further to raising awareness of problems faced by older people.

Another international contributor is based on the Muslim concept of *Ummah* or community. The Ummah Welfare Trust (UWT) is UK based but has an international reach including Bangladesh. Their website (Ummah Welfare Trust 2014) sums up the food production problems of the country:

> Food production barely meets the minimum nutritional needs of a rapidly expanding and mostly destitute nation that is regularly subject to tropical storms and flooding during the rainy season … Despite the considerable international assistance over the years, Bangladesh has been unable to eliminate extreme poverty and hunger prevalent in the rural areas.

In order to help deal with these concerns, the UWT, as with HAI noted above, has been involved in income generation schemes 'to engender self-sufficiency' and has also engaged in supporting orphans and building wells in the rural areas.

Recent studies (El Arifeen et al. 2013; Puett et al. 2013) have examined community-based approaches to wider health concerns in Bangladesh. The first of these, outlined in the *Lancet* gives the result of research into innovations via local communities in the shape of community clinics that deliver health care services and shows that these have led to advances in reducing fertility levels (thus helping to tackle the issue of high birth rates) and also reducing rates of mortality in mothers, infants, and children thus helping to bring down death rates in these groups. The second study, in *Health Policy and Planning,* examined the cost effectiveness of community-based approaches to severe acute malnutrition (SAM) by community health workers (CHWs) in the south of the country. The study showed that there was a marked difference between this community-based approach compared to in-patient treatment in hospital, with children recovering from SAM in the community doing so at one-sixth of the cost of inpatient treatment per household. The authors concluded that, provided that CHWs are given sufficient training and supervision, this model of treatment can be rolled out in other areas in order to tackle SAM in Bangladesh.

In this book, we have demonstrated how effective community action can be. Underlying many of the examples discussed is the spirit of voluntarism from the third sector rather than the public or private sectors of society. But these sectors, too, can respond in a community-oriented fashion if the will is there. Another recent study conducted in Bangladesh by Sharmin et al. (2014) evaluates what they refer to as a widely publicised corporate community involvement (CCI) initiative, namely the Lifebuoy Friendship Hospital (LFH) which is a floating hospital facility supported by Unilever Bangladesh Limited (UBL) in partnership with a local non-governmental organisation (NGO) called Friendship. The facility is in a poor riverine area in the north of the country. These two organisations claimed that this project was a successful example of their corporate social responsibility (CSR), an area that many businesses are seeking to develop. However, the research of these authors brings these claims into question. Interviews and focus groups with local

community members found that there was a divergence between the rhetoric and the reality. For example, it costs money to hire a boat to reach the hospital and local people cannot necessarily afford to do this in an emergency situation (although a 'water ambulance' has now been provided by LFH). Further, local people felt that they were not involved sufficiently in deciding the priorities of the hospital facility. The authors (p. 49) 'conclude that although the initiative has clearly brought in vital healthcare services to some of the most vulnerable and desperately poor communities, the level of actual engagement of the local people has been marginal'. UBL was content to provide the financial resources for the project, but there were concerns expressed that should they choose to withdraw their funding at any stage (for example, should the product Lifebuoy soap be discontinued), then the project would be jeopardised. The authors feel that UBL has achieved its aims and that

> the corporate role in terms of practical efforts in the field has been mostly superficial and limited. There are two reasons for this. First, UBL feels complacent about this which was demonstrated from the interviewees' quotes provided earlier. It has achieved synergy of one of its premier brands Lifebuoy by getting involved in this project. It has also provided access to one of the remotest areas of Bangladesh. As a commercial organisation it is unwilling to commit further as it has served its purpose already. Second, stakeholder engagement and community ownership of this initiative remains questionable and this further undermines the sustainability of this initiative. (Sharmin et al. 2014, p. 49)

Community Development in a Developing Country

> Bangladesh is one of the countries with improving human development indicators, a huge donor presence in the development sector and continuous political bickering. It continues to struggle with the issues of persisting poverty, increased conflict in civil society and a political milieu concerning varied political actors. Despite three decades of developmental activism and continuous international donor support to alleviate poverty, Bangladesh remains a country with a substantial majority living on less than a dollar a day. (Rashid 2012, p. 215)

The above summarised citation explains the current economic, social, and political situation in Bangladesh. Since the introduction of community development in Bangladesh, there has been a great emphasis on public participation. Public participation acts as a linchpin between government, NGOs, and the community. Discussion and debate in academic literature have focussed on community involvement at a local level (Chowdhury et al. 2013; Datta 2005; Bernhart and Kamal 1994; Fuqua 1986; Haque 1986). Moreover, since the late 1990s, the discourse on community development has also focused on the concepts of 'civil society' and 'good governance'. As Parnini (2006, p. 189) has noted, the ideas behind civil society and good governance 'are concerned primarily with the increasingly high profile community of local and national government office with a development portfolio, as well as non-governmental organisations (NGOs) which have become involved in the life of the country'. The emergence of the concept of the civic society, in the context of Bangladesh, has been influenced by the dialogue surrounding democracy.

Over recent times, the country has experienced political upheaval, and Osman (2010, p. 315) provides a frank appraisal—'In recent times, Bangladesh politics has become highly confrontational, which generates unhealthy competition (often violent) between the winning and the losing party, instead of constructive engagements, causing severe damage to state institutions.' Hence, the concept of civic society in Bangladesh is somewhat popular because it is seen as a 'contemporary orthodoxy of liberal thinking' and what is known as 'démocratisation discourse' (Davis and McGregor 2000, p. 48). Social scientists (see Schurmann and Mahmud 2009; Lewis 2004) have discussed at length the understanding of civic society in a democratic state and the term

> Civil society is seen as an associational arena between the family and the state, usually not including the organisations and institutions of the state, or the market. Its value is seen in its role in reinforcing societal pluralism and securing individual rights; leading to the furthering, underpinning and balancing of liberal democracy. (Davis and McGregor 2000 p. 48)

Therefore, the success of civic society is the integration of organisations that have a strong relationship with the local community. One of the positive themes from the promotion of a civic society in Bangladesh is that it is a good example of 'governance to cope with the forces of globalisation' (Parnini 2006, p. 190). As it has been demonstrated throughout this book, participation with members of the public, government, NGOs, and other organisations are crucial because it achieves the development's objectives. According to Ahmed (1999), one of the underlying barriers to community development being a success in Bangladesh is governance. Ahmed (1999, p. 295) has argued that the country has two governance problems, which are:

1. '…neither the government nor the international development community (IDC) is wholly responsible for the state of misgovemance in Bangladesh. Rather, the misgovemance of the country is a product of historically constructed structures which the government keeps reproducing.'
2. '…the present historical conjuncture—politically, economically as well as culturally—good governance in Bangladesh can neither be thought of nor practised without taking the IDC into consideration.'

Research carried out by Buckland has (1998, p. 237) 'suggested that NGOs in Bangladesh have opted for the minimalist notion of participation, seeking beneficiary input and assistance in implementing projects that are largely designed, funded, and managed externally'. Similarly work undertaken by Bhuiyan (2011) has critically explored the community strategies of Bangladesh and India. Bhuiyan's (2011) findings argued that both countries have lessons to learn when it comes to promoting civic society, within the context of social capital. He feels that NGOs, development practitioners, donor agencies, and policy planners need to place a contemporary emphasis on social capital to accomplish 'sustainable community development'. As Bhuiyan (2011, p. 542) notes:

> …the microfinance programme of Bangladesh also proves that peer pressure, the bank's rules and regulations and economic necessity together with social values, culture, mutual support and understanding made the credit recipients more reliable and trustworthy to each other. These contextual lessons have an immense value for policy makers, development practitioners, academics, NGOs, civil society and donors in using social capital as a catalyst to promote sustainable community development.

Developing Social Capital: The Grameen Bank Situation

As this latter example indicates, community involvement can be contestable and controversial. This is also seen with reference to the Grameen Bank initiative in Bangladesh. This bank was set up over 30 years ago as a micro-finance facility designed to provide small loans, to women in particular. Today, 8.3 million women are the main shareholders (Al-Mahmood 2012). The founder, Professor Muhammad Yunus, won the Nobel Prize in 2006 due to his leadership of this facility, which has been lauded around the globe.

Much has been written about Grameen Bank's exceptional success in achieving the debt recovery rate in the range of about 98 %, its model for rural credit for the poor has been replicated in many parts of the world. In determining its success, the Bank's policy of replacing traditional financial collateral with social collateral and by making a group of five borrowers responsible for the repayment of each other's debt has often being been singled out (Jain 1996; Yaron 1992a, b). Jain (1996, p. 80) provides a more comprehensive explanation that the success of the Grameen Bank is due to fostering a 'combination of strategic credit policies and organisation design-induced credit conducive culture among employees and clients'. Similarly Lawrence (2001) using Grameen Bank as a pointer suggests that members in the rural communities, mainly women, have the opportunity to gradually change their social situation by building the trust and networks that will form their social capital. Lawrence (2001, p. 11) further provides a fascinating account of the meeting norms in the Bank centre where the male GB worker addresses each woman by her first name rather than, as is common practice in rural Bangladesh, by a possessive term denoting her relationship to her family's male members. The Grameen Bank's norm of personal address has provided each woman with regular personal acknowledgement that she now has an individual identity outside her family and opportunity to begin to see herself as a member of an additional community; that of a Grameen Bank member and business woman. To quote:

> This untraditional form of address, in combination with regular interaction in a common space, enables members to expand their opinions of themselves from 'only' daughters, wives or mothers to individuals with identities apart from traditional strictures. Emboldened with the awareness of identity beyond kinship ties, each member began to build a collective identity with an extrafamilial group beyond her para (neighborhood). (Lawrence 2001, p. 16)

While the success of Grameen Bank and microfinance in Bangladesh and elsewhere is well documented mostly for bringing economic benefits, little attention is paid to the social capital building aspects of microfinance and organisations such as the Grameen Bank. Dowla (2006, p. 110) argues that the bank's trust in poor borrowers and the reciprocal trust of the borrowers in the Grameen Bank were instrumental in changing credit relation norms in rural Bangladesh while simultaneously helping to create the norm of credit discipline (Yunus 1999). The network implications of the Bank, especially for women, have also been highlighted (Todd 1996). The Grameen model, now used widely around the world, has further policy implications. Dowla (2006, p. 119) concludes that since social capital is a public good—non-excludable

and non-rivalrous—the market will under-provide such good. Thus, microfinance corrects another type of market failure—under provision of a public good, in addition to correcting the failure of the credit market.

Social capital is often generated by the expectation of the rural poor who are victimised by government and market failures. Cooperation based on mutual trust and norms of reciprocity contributes to the creation of other kinds of social capital, especially economic and human capital that are mutually reinforcing (Mondal 2000). This recognition has inspired innovative approaches to development, such as the now popular microfinance model and implications for feminist objectives of social transformation (Rankin 2002). The role of NGOs in developing innovative development models has been discussed in the literature, but their focus on income-generation at the expense of longer-term structural changes (Buckland 1998). Poverty, combined with disability issues, however, impact on access to social networks and formal services and is often a facet of the social exclusion and stigma which can be a morally and socially devastating ordeal (Foley and Chowdhury 2007). Developing citizen involvement and building trust to tackle corruption in Bangladesh has been argued as a key requirement for smooth functioning of the public institutions in the country including those in health and education sectors (Knox 2009a, b).

The World Bank (Grootaert and Van Bastelaer 2002, p. 421) identifies social capital as crucial for poverty reduction and a critical asset for creating opportunities that enhance wellbeing and for achieving greater security and reduced vulnerability. Notwithstanding the popularity of the concept, the definition and measurement of social capital, particularly in the context of public health, is still evolving (Kawachi et al. 2004; Shortt 2004). With particular reference to aging, Cannuscio et al., (2003) argue that access to social capital enables older people to maintain independent and fulfilling lives. In a population-based study, Nilsson et al., (2006) provided empirical evidence that social capital (both at individual and community levels) was directly associated with the 'quality of life' (QoL) of elderly people in rural Bangladesh. The study also reported correlation between QoL and advanced age and low economic status.

In recent years, however, in echoes of what has happened in the UK with respect to the Co-operative Bank, there has been emerging concerns about governance of the bank, and the Bangladeshi government has intervened in order to make the bank behave more like a normal commercial bank (BBC 2012). Yunus, who had now reached the mandatory retirement age of 70 for bank directors, was forced by the government to resign in 2011, and despite an appeal through the courts, this action was upheld. As Al-Mahmood (2012) explains:

At the heart of the dispute are conflicting interpretations of the bank's ordinances. A government review committee concluded last year that since Grameen was created under a special law, it was a statutory public authority—in other words, a government bank.

Despite this controversy, Muhammad Yunus continues to have many supporters in Bangladesh and beyond, not least because 80 million people in the country make use of the Grameen Bank (Black 2012). Black, who founded *Wavelength* and *Friends of Grameen Bank,* eulogises Yunus in this piece, noting that although he has made mistakes, and has a definition of social business with which not everyone

would agree, nevertheless his achievements are tremendous and inspirational for many, not least for the poor of Bangladesh who have access to funds in a way that was not possible before the development of this bank.

Community Response and the Emergency Health Care

Emergency medicine in Bangladesh has been described in a recent article as ‘an evolving concept’ (Miah et al. 2012), a no-man’s land with serious concerns expressed, regarding the inadequacy of emergency services throughout the country. Findings from a recent cross sectional study conducted at Dhaka Medical College and Hospital (DMCH) revealed that nearly 45 % of patients admitted to the hospital in the emergency ward were road traffic accidents with lack of adequate training to staff in dealing with the emergencies (Ferdouse et al. 2014). With a population of nearly 160 million and high rates of accidental deaths, recognition of emergency medicine, as a distinct speciality, along with a well-developed emergency medicine system (EMS) is still lacking in Bangladesh, including the situation as compounded by the prohibitive cost of private transport.

In Bangladesh, there is no specific department to manage and coordinate emergency health care. Most of the hospitals have their own ambulance services to transport the patients to their hospitals, but in many cases they are not functional. Recently private operators have started to provide free ambulance service to patients but they are concentrated in major urban centres such as Dhaka. One of the largest private ambulance providers, Anjuman Mufidul Islam (http://amibd.org/service_det.php?cid=33&sid=13) operates some ambulances in the capital. There are no national emergency access numbers in Bangladesh, and hospitals, both in public and private sectors, use their own ambulances; however, they lack emergency kits and trained paramedics to deal with any life-threatening calls.

The lack of emergency care was evidenced in 2013 when a garments factory in Dhaka collapsed with more than 1000 casualties and reported injuries to about 2500 people (BBC Asia 2013). It took more than a fortnight to deal with the situation. Similarly in 2007, the cyclone claimed more than 4000 lives; this figure reflected on the level of efficiency and response by the emergency services (Haque et al. 2012). Issues around medical decision-making and the actions necessary to prevent needless death due to time-critical health issues are still prevalent in the country (Razzak and Kellermann 2002). The model of having trained paramedics to deal with patients urgently therefore effecting a safe transfer to a hospital is virtually non-existent, with the exception of a few centres in the whole country (Miah et al. 2012).

Safe emergency care to women has been identified as a major issue in Bangladesh. Given the high maternal mortality rates in the country, access to emergency obstetric services is necessary (Nahar and Costello 1998). Poorer women face greater challenge in receiving emergency treatment as relatives and friends might not be in a position to raise the necessary cash (Pitchforth et al. 2006). An effective

emergency obstetric care (EmOC) intervention in reducing maternal mortality has been recommended (Paxton et al. 2005).

Concluding Remarks

In this chapter, we have explored the contemporary debates concerning sociability, social capital, and community development within the context of Bangladesh. One of the themes with Bangladesh has been the political stability of the country. This chapter firstly outlined the international and local response to health and aging issues. As it was discovered, the country places great emphasis on community-based approaches. Secondly, the chapter moved on to discuss the country's approach to community development. In this section, it was found that the concept of the 'civic society' plays a crucial role in community development. Thirdly, the chapter evaluated the contribution of social capital with reference to the Grameen Bank initiative. The Grameen Bank has acted as a catalyst for economic benefits for many people in Bangladeshi society. Finally, the last section explored the community response to health in Bangladesh. The emergency service was used as a case study. As this section outlined, there is no distinct department to govern and coordinate emergency health care. The next chapter explores similar issues within the context of Japan.

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Chapter 8
Japan

As noted in the introduction, Japan is one of the wealthiest countries in our sample; it is also demographically one with the oldest inhabitants, a country where 'super aging' is found. The combination of wealth, notwithstanding the fact that some Japanese are poor, plus high levels of aging, produces a fascinating mix of issues (Poston and Bouveir 2010). Table 8.1 gives an overview of the key social and economic indicators of Japan.

To this can be added Japan's location on the Pacific Ring of Fire, which means that the country's vulnerability to earthquake and volcanic activity is greater than many other countries. Further, Japan's historical legacy is one in which China influenced the country greatly via the written script, for example, with the observation of the tea ceremony and other daily ceremonies and, importantly for the present text, the ideas and rituals of Confucianism. As MacPherson (2011, p. 204) notes:

> National movements in other countries stress their own co-operative traditions, many of them, as in the case of Japan and Korea, pointing to the ritualised collaboration of their rural ancestors during periods of planting and harvesting.

This 'ritualised collaboration' reflected ancient practices and increasingly from the seventh century the Confucian virtues from China of self and family obligation towards the wider society, towards the greater good. On the positive side, this could enhance social cohesion and stability, but on the negative, there was a hierarchical gendered structure to Confucian ideas in which the male was dominant at all levels from the head of the family to the emperor, the figurehead of society. Upon marriage, the wife moved to her husband's home and was the lowest of the low until such time as she bore children and matured to become a vital asset to her new family. This patrilocal dimension meant that women were regularly considered subordinate in traditional East Asian society, including Japanese society. On the other hand, however, there was an element of reciprocity to this gendered hierarchical system of social organisation, with those higher up the hierarchy having obligations to those further down the social ladder, with responsibilities as well as rights over their social inferiors. Such ideas were interwoven with those of Buddhism and the ancient Japanese religion of Shintoism to ensure a rich tapestry of religious and quasi-religious ideas on which traditional Japanese society was based

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Table 8.1 Japan summary data. (Britannica World Data 2014)

Country	Japan
Population, in millions	127.6 (2013)
Percentage of aged 60 or over	32.2 (2012)
Male life expectancy	79.9 (2012)
Female life expectancy	86.4 (2012)
Top three causes of death per 100,000 population	279.5 malignant neoplasms (cancers) 160.9 heart disease 97.6 pneumonia (2011)
Gross national income per capita	US$ 47,870 (2012)
Population per physician	434 (2011)
Population per hospital bed	75 (2011)
Further information	www.stat.go.jp/english/index.htm www.boj.or.jp/en

(Collcutt et al. 1988). Historically, sociability was an integral feature of Japanese society, albeit one that was heavily bounded by rituals and constraints from Confucian and other ancient traditions. Below, we shall consider the extent to which such ideas are still found in modern Japanese society.

Sociability was a clear feature of response to the disastrous earthquake and tsunami of 2011 and the impact on the Fukushima Daiichi Nuclear Power Plant when people mobilised to help each other in response to these terrible events. Some of the response came from unexpected avenues with altruistically motivated offers of help. For instance, Cook and Halsall (2011, p. 45) end their chapter on Japan by reference to Buerk's article (2011) on the British Broadcasting Corporation (BBC) news service that details the plans of a retired engineer, aged 72, for him and his former colleagues to enter the Fukushima Plant in order to help control the radiation risk (also subject of a recent Hollywood blockbuster). They volunteered to avoid the risk to younger workers, with their reasoning being that 'radiation-induced cancers would take 20–30 years to develop' whereas he and his retired colleagues only had 13–15 years to live, and would therefore be able to continue their lives after they entered the plant. Another marked response to the disaster came from Japan's military partner, the USA, which assisted as Schoppa (2012, p. 419) summarises:

> At the peak of the relief efforts, some 20,000 U.S. personnel, 20 ships, and 140 aircraft were in the disaster area as part of Operation Tomodachi ('Friend'). The media coverage of the disaster recovery, showing U.S. troops assisting Tohoku residents, helped Japan see the benefits offered by the military alliance.

This operation, in effect, built up social capital by the USA in Japan; social capital that would prove important in the following year when tensions over the US base in Okinawa and a rape charge against two US military personnel were in part defused by the goodwill that had been built up via this disaster response (Schoppa 2013, p. 443). We shall examine such issues in terms of:

- The oldest old and community alternatives to care
- Community development in a highly urbanised society
- The development of social capital in an advanced capitalist society
- The emergency services and community participation

The Oldest Old and Community Alternatives to Care

The rise, globally, of countries aging populations is exemplified by Japan, which, by 2005, became the world's oldest society (Cook and Halsall 2011, p. 37). Life expectancy in 1947 was only 54 years for women and 50 for men, but by 2006 this had reached just under 86 for women and 79 for men (Ogawa et al. 2009, p. 134). The latter source shows that the rate of aging became three times that of Sweden or Norway, for example, while nearly 60% of those aged 65 years or more are forecast to be aged 75 or over in 2025 (compared to just under 41% in 2000). The 'baby boomers' of 1947–1949 are now at retirement age, adding nearly seven million people to that retirement cohort. There are worries concerning the social and economic implications of this process of super aging, with those who see older people as dependent being gloomier concerning future prospects, whereas those who view the aged as an asset (and who command financial assets that can contribute to the wider economy) being more sanguine about the future. For example, Ogawa et al. (2009) note that while the economic participation rate in 2006 of older men was less than 10% in Europe and 18% in the USA, it was 29% in Japan; therefore, retirement can be and is being mitigated in Japan by part-time employment especially. Some regard the asset control exercised by older people who are long-term savers as being the 'second demographic dividend' (the first was the baby boomers' contribution to economic growth when they were in the employment bracket); however, Cook and Halsall (2011) cite Kihara (2009, p. 142) who is worried about the potential for 'Asset Market Meltdown' because 'population aging has a substantial and negative impact on the saving rate'. Certainly, interest rates, as in many other countries at the time of writing, have remained low in Japan for some years, but one advantage of the globalisation processes is that investment can be made in expanding economies, such as those of Brazil, China, or India, where interest rates can still provide a higher return.

Whatever these, and other arguments concerning the impact of an aging society, it is clear that governments are now required to put in place long-term plans for older people (Cargill and Sakamoto 2008). With Confucian ideas, it was expected that it was the elder son's responsibility to look after his parents, with his wife doing most of the caring. In 1948, Japan was one of the first countries to enshrine this idea in law (Singapore and China for instance have since followed suit), with family members being obligated to support their aging parents. Ogawa et al. (2009, pp. 139–40) report that in 1995 there were 112 legal cases in Japan regarding families seeking to avoid such obligations to parents who were 65 or older. Many parents would live with sons in the patrilocal residence, but as industrialisation and urbanisation took

off in the 1950s and 1960s, there was a rapid change to such familial arrangements. By 2001, only 22 % of older people lived in multi-generational households in Japan (compared to 37 % in 1981 and 32 % in 1991), although this was still much higher than in the USA for instance where the corresponding percentage was 2 %, or Sweden where the percentage approached zero. There was also a changing perception among middle-aged women, those who would be the traditional caregivers, of the norms and expectations to look after older people, and this expectation is diminishing with modern urban life (ibid.).

In response to such concerns and societal change, the Japanese government introduced the Long-Term Care Insurance Scheme in 2000. Further changes were made to the scheme via the Long-Term Care Insurance Act of 2005, implemented in 2006. Tsutsui (2014) and Matsushige et al. (2012) analyse these changes and further amendments subsequently, which sought to increase the amount of mutual help or mutual aid in communities, in order to combine community care with integrated care as a community-based integrated care system. For example, the concept of mutual aid was presented by a research committee of the Ministry of Health, Labor, and Welfare in 2009. As developed by this group, the idea was to ensure that care for older people was provided by people known to the receiver of care, including family members, friends, neighbours, and colleagues, in their home. One particular concern in Japan is that most people, around 80 %, die in hospital or a similar institution rather than their own home (Matsushige et al. 2012, p. 544), therefore a model has been developed that encourages patients to leave hospital via a staged system that considers pre-discharge, the decision to return home, stabilization after the return, and then for seriously ill patients, the final stage is end of life care.

In order to study this model, Matsushige et al. developed a qualitative research study, based on grounded theory, of care in Onomichi, a location known for good rates of stabilization and bottom-up medical practitioners who engaged well with local people. They interviewed 15 caregivers, four patients and two health care professionals. Of this number of 21 respondents, 17 were female, and they note that, even with changes to the traditional practice, 'in Japan, about 72 % of the family caregivers who live with the care recipient are female'. Among their findings, they found that home visits were made by a range of service providers, including a dental hygienist, dermatologist, urologist, and the family physician. Even if patients were seriously, perhaps terminally, ill, they became more active

> regardless of the progression of their disease. This appeared to stabilize the mental state of both the patients and family caregivers, and in turn, allowed for a positive attitude towards home care. (Matsushige et al. 2012, p. 545)

The process also ensured that patients had higher quality time at the end of their lives. Those professionals who were involved in this activity were found to put in extra hours outside of their paid working time. They also provided support and information beyond their own specialism in a process of mutual aid to their patients. By such means, there was collaboration across the formal and informal provision of care in an integrated approach.

Tsutsui (2014) examines the 2012 revisions to such practice. She shows that the changes were designed to improve the service provided:

> One goal of the revision of 2012 was to clarify the responsibilities of municipalities and to promote the cooperation between the medical and social care field through the establishment of mandatory multi-disciplinary conferences in order to make the delivery of services more efficient and effective. (Tsutsui 2014, p. 8)

Both these articles suggest that the community-based integrated care approach in Japan owes much to the traditional cultural norms discussed above. Tsutsui (2014), for instance, suggests that 'the contribution from families [is based on] the strong Eastern Asian belief that family should take care of each other' (Tsutsui 2014, p. 8). Similarly, Matsushige et al. (2012, p. 547–548) note that

> The opportunities of mobilizing mutual aid may also be connected to the Japanese culture, including a tradition of eastern patriarchal gender arrangements. Thus, the Japanese case of integrated home care cannot easily be transferred to other healthcare systems and countries but underlines the context dependency of new health policies.

Hopefully, the examples in this book refute this argument. We have seen sterling work in related areas across the countries we have examined, even in those without traditional Confucian or related approaches. However, it is not a given that in Japan older people will wish to be involved in a system of community-based support, as Yoshihiko (2013) illustrates. This study examines the constraints that prevent such involvement. These include 'living solo' and being a non-driver. In order to help overcome such constraints as these, the author calls for local authorities to ensure that their city becomes 'age-friendly' via such means as arranging regular visits to those aged people who live alone, give young people incentives (e.g. tax breaks) to live with their aged parents or relatives, increasing the number of community buses to ensure that those dependent on public transport can access appropriate health services, and increase community taxis by deregulating the industry so that local people can provide a community taxi service. Matsushige et al. (2012) add to this list by noting that government funds may also be required, but there is a caveat that this may create a 'dilemma' for mutual aid if government funds are involved, in that mutual support could be potentially undermined if dependency on government expenditure is increased at the expense of mutual aid.

Community Development in a Highly Urbanised Society

> Studies of Japan and the Japanese have tended to deal in large proportion with phenomena and problems of the nation as a whole rather than with its component parts. In contrast, community studies focus upon some of the smallest social units of a nation. Community studies have been attempted as an approach to understanding Japan and the Japanese only recently and [taken up] by relatively few foreign scholars. (Beardsely 1954, p. 37)

The above quote is taken from Richard K. Beardsley's work in 1954, who at the time was associate professor of anthropology and research associate at the Museum of Anthropology at the University of Michigan. As the above citation notes, debates

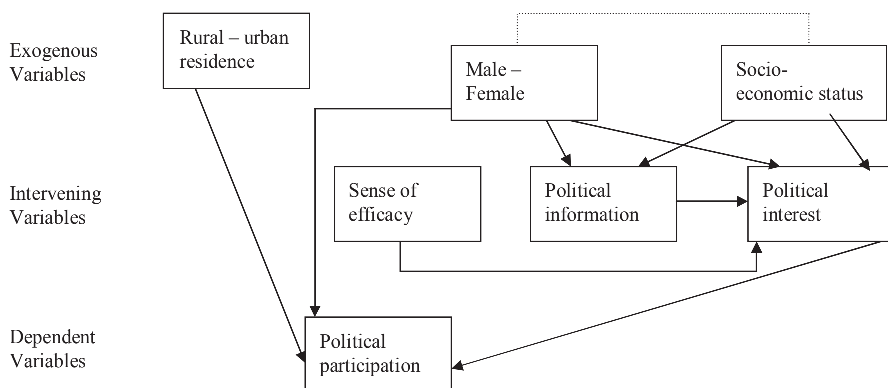

Fig. 8.1 The ‘seven-variable causal model’ of political participation in Japan. (Watanuki 1977)

on communities have tended to focus at a national scale. Academic research in the 1970s focused on the political participation activity of community development in urban and rural areas of Japan. Watanuki’s (1977, pp. 65–66) research discovered three propositions when examining political participation at a local level, they are: (1) ‘Political participation is higher in rural areas than in urban areas.’ The reason for this is the issue of ‘social pressures’ or ‘social norms’. (2) ‘Urban residents are generally better educated and have higher level occupation than rural residents.’ Consequently, the low interest of political participation is due to ‘the disintegration of a sense of community in the cities…’. This is caused by the failure of urban residents joining associations, and ‘the spread of a sense of futility’. Finally, (3) ‘The mode of political participation in Japan is, thus, characterised by a higher degree of mobilization in rural areas … and a high degree of alienation in urban areas.’ This analysis on political participation by Joji Watanuki leads the scholar to develop a ‘seven-variable causal model’. As Fig. 8.1 demonstrates, there is a complexity of different variables which interact with political participation.

According to the Population Reference Bureau (1975, p. 396), by the mid 1970s satellite cities in Japan continued to develop swiftly but ‘the largest cities of Tokyo and Osaka have stopped growing, and Nagoya and Kyoto have shown declining rates of increase’. It is worth noting here that at the 1975 census a great majority of Japanese tended to live in cities than in the countryside (Ward 1978) and by this time

> Massive changes in social organisations had also taken place. The rigid system of class stratification had been abolished; free, public, and universal education had become the norm; social and economic mobility and opportunities had been greatly enhanced and expanded; equality before the law had been established; and the national standards of living, well-being…. (Ward 1978, p. 2)

Past and present political parties in Japan have a strong association with their local community. MacDougall (1980, p. 66) discovered that political organisations that have a strong political base at a local level ‘provide positive incentives for communities’. Politicians locally have diverted to having strong relationship with

their local community due to the influence of the emergence of citizens' movements. Many social commentators and scholars have provided discourse on the contribution of citizens' movements. For example, McKean (1980, p. 228) has argued that there has been a

> …parallel development of citizens' movements and progressive local governments, and they have argued that these movements serve as a vehicle for the expansion of new combinations of progressive forces at the local level….

The 1980s experienced a new emphasis on the growth of cities in Japan (Buckley 1990). With the process of globalisation and the advancement of information technology, cities, such as Tokyo, emerged as a major global financial centre. As Miyao (1991, p. 131) notes:

> As soon as the 1980s arrived, however, advantages of the agglomeration of large cities began to be revaluated with respect to expanding financial and service industries in major metropolitan centers. The rapid development of information technology and the globalization of business and financial activities have played a crucially important role in revitalizing large cities and making them interrelated with each other beyond national borders.

Today, the focus on community development is surrounding environmental disasters, participatory community-based decision-making and social isolation (Satoshi 2014; Okada et al. 2013; Stevens 1997). Research carried out by Okada et al. (2013, p. 46) examined the effective of participatory community-based decision-making in Japanese society and argued that 'We believe that community-based decision making in Japan is an important model for decision processes everywhere….' Hence, in their research Okada et al. (2013, p. 51) have emphasised that the country has great expertise in 'community management and participatory methods to support group decision and negotiation' that other countries across the world can learn from and implement themselves if environmental disasters occur.

The Development of Social Capital in an Advanced Capitalist Society

Japan, with its unusual combination of similarities and differences with Western societies, has become a part of scholarly agenda and public discourse (Freitag 2003) being the only non-Western country that has developed into a completely modern and industrial society (Eisentadt 1996).

Inoguchi (2000) argued that the Japanese society is often one with a high premium on social capital identifying two key strands of arguments—the one advanced by Putnam (1993) that social capital enables democracy to work. Putnam argued that the historically acquired and accumulated social capital (so true in case of Japanese society) in terms of the propensity of individuals to engage with others in community and associational life facilitates the task of democratically working out the resolution of conflicts of interest and collectively producing good public policy. The other strand advanced by Fukuyama (1995), suggests that social capital allows

the creation of prosperity through a high level of social capital, which enables business firms to take risks and stretch networks fully in the creation of wealth on a large scale for a prolonged period of time. Trust is thus seen as the main component of social capital, which in turn is a necessary condition of social integration and economic efficiency (Newton 2001) and community governance (Bowles and Gintis 2002).

There has also been an increasing recognition of social determinants of health, and systematic reviews using cross-sectional data have found that social capital may be a useful factor in the prevention of mental health (De Silva 2006; De Silva et al. 2005; Fujiwara and Kawachi 2008; Kondo et al. 2009). In a multi-level analysis in Japan, Hamano et al. (2010) found that high levels of cognitive social capital measured by trust and high levels of structural social capital measured by participation in associations were associated with better mental health after adjusting for age, sex, household income, and educational attainment. Similarly Yamaoka (2008), in his cross sectional study investigating social capital and health and well-being in East Asian countries including Japan, found evidence that dimensions of social capital are positively associated with self-reported somatic symptoms and overall well-being.

Ichida et al. (2009, p. 498) from their multilevel analysis of older people in 25 communities in Japan found evidence to suggest that people who lived in the conditions of high-income inequality tend to exhibit low trust and that social capital mediates the relation between income inequality and health.

Similarly, Fujisawa et al. (2009, p. 500) in their study reported that the two aggregated indicators of community social capital (kindness and greeting), along with the social cohesion index, showed a statistically significant association with general health, which showed the existence of a contextual effect of social capital on health outcomes, although individual differences in social capital perceptions in Japan were considered. In another study investigating income inequality, social capital, and self-rated health in Japan, Aida et al. (2011, p. 1567) concluded that

> Among older Japanese, community-level structural social capital (volunteering) attenuated the association between income inequality and poor self-rated health, whereas social capital had no effect on the association between income inequality and poor dental status.

The above discussion clearly indicates the linkage between social capital, income inequalities and health inequalities in Japan and future research will help to determine how social capital mediates these relationships.

The Emergency Services and Community Participation

Japan is at the crossroads in the development of the emergency medical services currently operating a ‘scoop and run’ model (picking up a patient from the scene of injury and transporting them to the emergency departments) but having a strong desire towards expansion of the scope of the paramedic practice to include more complex protocols (Miyamichi et al. 2012; Lewin et al. 2005; O’Malley and

O'Malley 2006; Kobayashi 2005; Tanigawa and Tanaka 2006; Mashiko 2005). During the 1960s, the rise of Japan as an economic power was represented by an increase in car ownership which resulted into remarkable increase in fatal traffic accidents and the term 'traffic wars' became notorious in Japan (Tanaka et al. 2003). The impetus for increased emergency services was also provided by the successful bid to host the 1964 Olympic Games and the fire defence agency made the transfer of emergency patients a duty of the fire brigades. However, some areas of Japan operate cars with medical staff, medically staffed helicopters and lifesaving emergency centres (Tanaka et al. 2003, p. 700).

The development of pre-hospital care has some temporal and philosophical parallels to that in North America when the Meji Empress founded the Japanese Red Cross during the Reformation and the Japanese physicians developed field treatments for the sick and wounded during the wars and natural calamities in the nineteenth and twentieth centuries (Olive 1994). Japan is considered to be the most industrialised country outside the USA and a technologically advanced country with 130 million residents. However, the pre-hospital care scope of practise is severely limited compared with that in the United States and other countries in the western hemisphere (Lewin et al. 2005; O'Malley and O'Malley 2006). The national emergency medical service (EMS) system is comprised of the highly trained emergency life support technicians (ELTS) whose complete protocols 'appear on six faces of a small, folded card containing the essence of their scoop-and-run-defibrillate pre-hospital philosophy' and the emergency care in Hokkaido, Kyushu, or giant Tokyo regions and, which are different in geography, transport distance and epidemiology, are all bound by the same protocols (Lewin et al. 2005, p. 237). Until as recently as 2006, paramedics were not allowed to administer medicines and resuscitate drugs or intubate the patients, severely impacting the overall quality of the care to the patients (Tanigwa and Tanaka 2006).

The Nihon telecommunication network (NTT) operates the toll free 24-h 1-1-9 telephone emergency service (similar to the 9-9-9 service in the UK and the 9-1-1 facility in the USA) which is directly connected to the dispatch centre located in the regional fire defence headquarters. The period of time for an ambulance to arrive at the scene of emergency is approximately 6.4 min (Tanigwa and Tanaka 2006). On receipt of the emergency call the nearest available ambulance is sent to the scene of emergency and the ambulance also provides transport to the hospital. As in the UK, there is no charge to the patient for the care/or the transport and all expenses are covered by the local government via the tax revenue.

Currently, there are no Western-style trauma centres accepting and treating only the injured patients (Tanaka et al. 2003) and all emergencies, including trauma cases go through three hierarchically organised categories of the medical facilities:

1. Primary emergency care facilities having no hospital beds and aiming to treat patients with mild conditions such as colds and sprains
2. Secondary emergency hospitals treating patients who need hospitalisation and intended for patients with moderately severe conditions manageable by a single clinical department

3. Tertiary emergency hospitals, identical to the emergency departments of university hospitals, equipped with intensive and coronary-care units for most severe emergencies

It is also important to note that hospitals can refuse to take a patient on account of *Taraimawashi* or 'rotating around' which is derived from the custom that a hospital is allowed to refuse intake of emergency patients, a practise which has been significantly reduced but still prevails where medical practise is inadequate or due to a high admissions rate (Lewin and Hori 2006).

Natural and man-made disasters have also played an important role in accelerating the advancement of the emergency care systems in Japan. Reference has already been made to the 1964 Olympic Games in Tokyo. In 1995, the Hanshin-Awaji (Kobe) earthquake hit Japan (Tanaka 1996) followed by the infamous 'Sarin' gas attack in the Tokyo subway by the Aum cult in March 1995 (Okumura et al. 1996). Then in 2002, there was the sudden tragic cardiac death of Prince Takamadonomiya at the Canadian embassy in Tokyo resulting in a huge public outcry in a call to expand the scope of paramedic practise in the Japanese EMS from a simple basic life support (Lewin et al. 2005, p. 238). These incidents have helped the Japanese authorities to understand the importance of expanding the protocols of the paramedics, improving disaster preparedness and decontamination procedures.

Citizens' involvement (Putnam 1995, 2000) and public education are fundamental to the development of an effective EMS system and are an evolving phenomenon in Japan. Training courses for residents are offered by the fire defence headquarters, the Japanese Red Cross, and other volunteer groups. Licensed drivers are required to undergo cardiopulmonary resuscitation (CPR) training courses (Tanigwa and Tanaka 2006; Callaham and Madsen 1998). There has also been a significant development of increasing public involvement in the defibrillation programme with the law being amended in 2004 allowing lay persons to use Accident & Emergency Department (AED). In 2005, at the world expo in Aichi, four patients were resuscitated by community volunteers (Nakagawa et al. 2006). This is in conformity of international practise of using volunteers in the community to assist ambulance services in dealing with emergencies.

Despite recent improvement in pre-hospital care, outcomes for pre-hospital patients, especially with cardiac arrest, remain poor in Japan (Shimauchi et al. 1998). Notwithstanding the change of guidelines in 2006 for pre-hospital CPR, current evidence on survival rates is mixed and a recent study (Yanagawa and Sakamoto 2010) analysing the pre-hospital care for cardiac arrest cases in an urban setting in Japan did not find conclusive evidence of improving recovery of such patents. The Japanese EMS system is also facing pressure from increasing 119 emergency call activity with more than 5.03 million ambulance dispatches (one every 6.3 s) reported in 2004 with an average of 13, 750 persons transported daily by ambulance with the majority of emergency calls for minor injuries and illness (Tanigwa and Tanaka 2006). The use of the emergency telephone consultation service, introduced in several countries including the UK (e.g. NHS Direct), to educate public on the use of ambulances and prevent misuse of the emergency 119 facility in Japan has been a new innovation. The centre started its operations in Tokyo in 2007 and has been found to have contributed to the appropriate use of ambulances and a reduction

in costs in Tokyo (Morimura et al. 2011). Development of information systems and clinical decision support systems for emergency departments is also being encouraged to maximise optimal use of resources (Inokuchi et al. 2013).

The big debate currently is arriving at a consensus to expand the scope of the paramedic practice and clinical training to be comparable to that of western hemisphere countries including the USA (Mashiko 2005). This can be both expensive (in social, economic, and professional terms) and also controversial since current international evidence about pre-hospital interventions at the scene of emergency is rather mixed (Lewin et al. 2005; Lewin and Hori 2006; Callaham 2003). A recent study (Matsumoto et al. 2006) investigating the effectiveness of the doctor-helicopter system in the Japanese EMS showed improved probability of survival for life-threatening emergencies but failed to compare data with traditional ambulance survival rates since the Japanese EMS does not have the regular doctor manned ambulances (Shatney et al. 2002) and the current practice of rarely using helicopters to transport critically ill patients (O'Malley et al. 2001).

Japanese resilience, the EMS response, and the emergency preparedness and disaster management plan have been once again tested when on 11 March 2011 an earthquake of the magnitude 9.0 occurred in the international waters of the western Pacific inducing a huge tsunami. These natural disasters hit the northeastern part of Japan and has caused heavy casualties and enormous property losses (Norio et al. 2011) The Fukushima Daiichi nuclear power facility, in the Futaba district of the Fukushima prefecture in Japan, was severely damaged by the earthquake and ensuing tsunami leading to the ongoing environment leak of radioactivity (Srinivasan and Rethinaraj 2013; Dauer et al. 2013). The disaster also prompted the Japanese Association for Acute Medicine (JAAM) to launch an emergency task force and sending the physicians to the local response headquarters. A recent study (Morimura et al. 2013, p. 997) praised the efforts of the Japanese EMS response to the incident and concluded:

> In an environment where the collaboration between organisations in the framework of a vertically bound government and multiple agencies and institutions was certainly not seamless, the participation of the JAAM as the medical academic organisation in the local system presented the opportunity to laterally integrate the physicians affiliated with the respective organisations from the perspective of specialisation.

Concluding Remarks

This chapter has examined the existing discussions with regard to sociability, social capital, and community development within the context of Japan. It was noted that the country has provided one of the most fascinating representations of social and economic indicators. Hence, the first section explored the contemporary debates on the policies that have been put in place to provide sustainable medical and social care for older people. The measures that have been put in place have focused on community-based integrated approach. We also provided a critique on the development of social capital in a progressive capitalist society such as Japan including a need for future research agenda on the linkages of social capital, income

inequalities, and health inequalities within Japan. We concluded with an overview of the emergency services and community participation in the sector. Having discussed at length the social and economic situation in Japan, the next case to be explored is that of the Netherlands.

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Chapter 9
The Netherlands

The Netherlands (also commonly referred to as Holland or, along with Belgium and Luxembourg, as the Low Countries because much of their territory is below sea level) is one of the most prosperous countries in the world and according to a quality of life survey in 2011 also the happiest. Arguably, this happiness is a reflection of liberal views on such topics as soft drugs, sexuality, and gay marriage, for example, and Amsterdam especially is seen as a very liberal (for some too permissive) city. Some might associate the Netherlands with Protestantism, due to the historical legacy of William of Orange, but in fact Roman Catholicism is the largest religion, particularly in the south of the country, although nowadays the Dutch Christian churches are facing similar problems to those in other western countries with declining attendances and fewer coming forward to the priesthood or ministry. This is in part due to the legacy of Dutch colonialism, and in part due to modern economic prosperity. There is a substantial immigrant population—from the Moluccas or Indonesia (the 'Dutch East Indies') for instance—and migrants from Turkey, Morocco, Brazil, and elsewhere, while non-Christian religions include Islam and the Sikh religion. But many inhabitants refer to themselves as 'humanists', sometimes in combination with such religions, and reflect the ideas of such great Dutch humanists as Erasmus, who influenced Thomas More's vision of Utopia in the sixteenth century.

In the contemporary era, Dutch liberalism is associated with 1960s and 1970s squatter, hippie, counter-culture, Provo and Kabouter movements, influenced by social anarchists such as Kropotkin, and a novel feature was the ideas of sexual liberation from the 1930s onwards, that gave Dutch anarchism 'a new cultural and ethical dimension' (Altena 2012, p. 402). Sociability was an important feature of life in the Netherlands with high levels of social cohesion and mutual trust in society. Given the changes working through Dutch society, however, such as increased levels of material prosperity and sometimes negative response to immigration and immigrants, there has been a recent 'widespread feeling' that social cohesion is eroding, and there is a perception that the country is moving from being a high trust society to being a low one (Schmeets and te Riele 2014, p. 791). However, these

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Table 9.1 Netherlands summary data. (Britannica World Data 2014)

Country	The Netherlands
Population, in millions	16.8 (2013)
Percentage of aged 60 or over	22.2 (2011)
Male life expectancy	79.2 (2012)
Female life expectancy	82.8 (2012)
Top three causes of death per 100,000 population	254.3 malignant neoplasms (cancers) 236.8 diseases of the circulatory system 78.1 diseases of the respiratory system (2010)
Gross national income per capita	US$48,250 (2012)
Population per physician	349 (2008)
Population per hospital bed	215 (2009)
Further information	http://www.cbs.nl http://www.dub.nl/en/home/

latter authors have conducted large-scale surveys that show no empirical evidence for such a decline in trust, although they note that there are large gaps between different groups in Dutch society, such as between those with high and low levels of education, natives, ethnic minorities, and various religious groups. But they suggest that such gaps are not widening, and have been stable for 'participation' since 1997 and for 'trust' since 2002. See Table 9.1 which shows the overall economic and social indicators of the Netherlands. We shall consider such issues in terms of:

- Social capital, health, and wellbeing at the neighbourhood level
- Interventions to increase sociability and social capital
- Community development in the Netherlands: case study of Bijlmermeer
- Community and the emergency services

Social Capital, Health, and Wellbeing at the Neighbourhood Level

In the field of community participation in health, the Alma Ata Declaration of 1978 was an important stimulus to local level engagement in health issues (Fienieg et al. 2012). In the Netherlands, community health centres actually preceded that declaration with government support from the 1960s. Batenburg and Eyck (2011) have analysed the growth and decline of these centres in the country, identifying four periods of different outcomes. Firstly, from 1967–1984, there was high growth due to government subsidies. The latter came under pressure in the more difficult economic times of the 1980s, and so in the period of 1985–2000, there was a period of decline as government subsidies were reduced. There was then a short revival from 2001–2006 as funds were once again prioritised for these centres before a

current period of decline. This began from 2007 and continues today, although there was another brief upsurge in 2009. Today is a period of consolidation and merger of community health centres, rather than being one of founding of new establishments, and the total number who attend such centres is around 1 million. Despite the reductions since the heyday of 1967–1984, the Netherlands still rank highly on 'accessibility and quality of care' (ibid. p. 245). These authors are concerned, nonetheless, about the market-led, fragmented nature of primary health care and so they conclude that it is an 'open question if community health centres will become the main organisational form to cope with these risks in the near future' (ibid. p. 245).

This conclusion is perturbing because such community health centres are an important part of the growth of social capital in their localities. Certainly there is a wide range of Dutch studies that show the importance of social capital in a number of topic areas. For example, Cramm et al. (2013) conclude in their analysis of the wellbeing of older adults that neighbourhood social services, social capital, and social cohesion 'may act as a buffer against the adverse effects of being single and poor'. Similarly, Mohnen et al. (2013) firstly from a literature review of 32 studies show that 'people who live in neighbourhoods with more social capital are healthier' (p. 33). They analyse this phenomenon for adults with young children and for the elderly, two groups who are likely to spend more time day-to-day within their neighbourhood. They find that it takes 6 years or more for a neighbourhood effect to become evident, and also that this effect seems to tail off after 22 years. With regard to the elderly, it is inconclusive as to the intensity of exposure, but for adults with young children their self-rated health levels were strongly affected; therefore, they advocate (p. 39) that 'interventions focusing on the health of people with young children may want to stimulate the creation of social capital'.

Kunst et al. (2013) find similar positive effects in their analysis of social capital and links with suicide rates with areas of higher social capital having lower rates of suicide and vice versa. Suicide rates could be 8% higher in areas of low social capital, and for unmarried men aged 0–50, rates were higher still. Likewise, a study of crime rates in 140 Dutch municipalities found that social capital could account for a significant 10% of variation in these—a 'substantial magnitude' according to the authors (Akcomak and ter Weel 2012, p. 324). Indeed, after controlling for a number of variables, the

> exogenous component of social capital is significantly and negatively correlated with current crime rates. (Akcomak and ter Weel 2012, p. 323)

Their analysis showed that areas of low social capital provide anonymity for potential criminals and a feeling that they can therefore get away with criminal activity. In contrast, in areas of high social capital, offenders could be more readily identified by the community, while the role of volunteers meant that there was 'strength of intermediate social structures, such as charities and clubs' that would help deflect youth especially from crime. Given the role of youth in such activities, there was also the need for intervention to tackle related concerns, such as high levels of school dropout and youth unemployment.

Interventions to Increase Sociability and Social Capital

Two of the studies cited above refer to potential interventions in order to increase social capital and thus stimulate positive social outcomes. Interventions that have already been attempted in the Netherlands have been analysed at different scales, from the level of the municipality down to the level of the residential care home. Thus, Steenbackers et al. (2012), for example, conducted an action research study of the Dutch health in all policies (HiAP) where the regional public health service in South Limburg supported and encouraged municipalities to engage in health promotion. These authors found that for campaigns against obesity, six out of the nine coached municipalities showed positive outcomes for such campaigns, although these positive outcomes fell away after a 30-month period. Steenbackers et.al. concluded that future engagement was needed to more fully involve municipal management, some of which had been sceptical towards these campaigns, and there was an onus on the public health service to demonstrate expertise in these matters. In all, the success of HiAP posed a challenge to both the municipalities themselves and to the regional public health service.

At the intermediate level of the community, we can point to the work of Jonkman et al. (2005) in the field of communities that care (CtC) programmes and that of Verhagen (2013) in community based intervention with ethnic minorities. Firstly, the CtC programme was piloted in the USA and the UK in order to tackle problem behaviour of young people in large cities. Jonkman et al. analysed pilot interventions in Amsterdam-Noord, Arnhem, Rotterdam, and Zwolle. In Amsterdam-Noord from 2001–2003, the outcomes were positive, and the project was set to continue. Alcohol consumption was reduced, as was truancy, school dropout levels, and ‘community disorganisation’ (p. 112). There was also ‘some improvement’ in family management problems. In Arnhem, in contrast, there were less-marked improvements, and because there were also other programmes in place, any success could not necessarily be attributed to the CtC programme per se. But a major problem was the low level of support provided by the city authorities, which, combined with low finance, has meant that the CtC programme was ended there. This was unlike Rotterdam where CtC has gone so well that not only would it continue, but it would also be rolled out to other city neighbourhoods. Then in Zwolle, a previous programme of intervention was adjusted to fit the CtC one, and there was no real change to report except that ‘lack of neighbourhood organisation’ was actually worse. But despite that, the CtC programme was ‘positively judged’ (p. 112) and would be continued and broadened in that city.

Jonkman and colleagues concluded that for a CtC programme to succeed the following features would have to be maximised:

- Quality of planning and decision taking
- Collaboration among service providers
- Coordination in input in progressing of previous interventions
- Focus of preventive interventions on risk and protective factors
- Use of demonstrated effective and promising approach
- Involvement of young people and other citizens from previous interventions (p. 113)

And, to end this example on a positive note, these authors pointed out that the pilots had gone well enough for the CtC programme to be also applied in the cities of Leeuwarden and Almere.

Verhagen (2013) studied the role of ethnic community health workers who were selected and trained from their own community in order to carry intervention programmes for older people into the ethnic community, in this case of Turks, Moroccans, and Moluccans the community health workers were part-time and operated in four stages. Firstly, they made home visits to older people, and then they build up problem-focused working groups of 8–12 older people in each. They then cooperated with these groups in order to search for solutions and improvement programmes. Finally, the solutions were then implemented by the local providers of health care from outside the ethnic community. Training and mentoring were important in this process, and the selected ethnic community health workers were deemed to have an 'empathetic attitude' to elderly people and were known in the community as a 'trusted and respected community member' (ibid. p. 3). The project involved translation of research instruments from other countries and the results are expected in spring 2014.

The above interventions are at the neighbourhood/community or municipal scale. But Baur et al. (2013) show that such positive intervention can also be found in a residential care home, using the *partner* approach. Residential care homes are associated with passivity and loss of autonomy and independence for the residents, but this approach is designed to combat these negativities in order to encourage feelings of social belonging, empowerment, and develop structural practices between residents, volunteers, and staff. The project is designed to aid the transition 'to a living community' (Baur et al. 2013, p. 358) via:

1. Agenda-setting by residents in groups of 8–10 people who meet regularly with a facilitator in order to tease out topics of interest.
2. Homogeneous groups of residents who meet 8–10 times.
3. Heterogeneous groups of residents, staff, and volunteers in a 50/50 split who also meet frequently.
4. Formulating ideas and plans is then done. These involve negotiations as to what is/is not feasible or practical.
5. Action in practice—during stage 3—to agree collaborative action.

Research evaluation was carried out by the project team via semi-structured interviews, focus groups, participant observation, and so on. One interesting issue that was noted was that those who became active did not want to force social interaction upon those who wanted to be left alone. Among the action group, the authors 'observed the development of a sense of belonging among the members' (Baur et al. 2013, p. 362). Another interesting point was that at the time the Dutch media (like many in other countries) were reporting abuse of people in such care homes. There was a call for an anti-bullying charter to be applied to children and older people, but the action group wished to protest this because they opposed stereotypes of abuse as they were 'not children' (Baur et al. 2013, p. 363). As a result, one of the key authors, residents, and care home management collaborated to write two letters to Dutch newspapers to present such views to a wider Dutch society. Actions within

the home itself involved the development of 'gallery parties' after finding out what people like to do, and also a 'buddy' project to help people get to know each other better. The care home manager had been supportive from the start but even those staff who were sceptical began to see the need to involve residents and to find out their views before taking action.

Baur et al. (2013) concluded that

> The outcomes of our study challenge a discourse in which older people who live in residential care homes are seen as passive, dependent recipients of care…[there is a need for] partnerships…[plus] inclusion of multiple perspectives and voices in what really matters for people. (p. 366)

Such positive outcomes, in a time of austerity, will require volunteers as well as paid staff. Fienieg et al. (2012) examine the motives of volunteers who participate in health promotion activities. They utilised qualitative research to interview 24 volunteers and found that they were motivated by 'purposeful action', 'personal development', 'exemplary status', and 'service and reciprocity', with nine participants being motivated by one of these, the rest with various combinations. Thus, seven were motivated solely or primarily by purposeful action defined as the 'desire to produce tangible results in the advancement of a specific group of people and/or issue' (Fienieg et al. 2012, p. 420). Eight were concerned solely/mainly with personal development to 'advance oneself mentally, socially, and/or occupationally' (ibid.), five solely/primarily with service and reciprocity 'to have or maintain valued relationships and to do one's bit' (ibid.), and the smallest number, four, solely/primarily with exemplary status 'to be recognized as an example to others' (ibid.). Driven by this range of motivation, volunteers could be highly committed, with some of those driven by purposeful action being so involved that 'the project's health goal had actually become their personal mission' (p. 424). Further, those driven by purposeful action or exemplary status were more likely to take leadership roles in these health promotion activities.

Community Development in the Netherlands: Case Study of Bijlmermeer

Community development in the Netherlands is well established. Back in the 1920s, neighbourhoods in urban and rural areas had a range of social and cultural activities and support for people who were unemployed. According to Vois (2005), the first community development agency was set up in 1926 in the northern province of Drente. The motivation for establishing this agency was the fact that many residents, who lived in the area experienced poverty, were unemployed and lived in poor housing. Peper (1973) in Vois (2005, p. 405) noted that the

> Central Association for the community development in Drenthe (Centrale Vereeniging voor de opbouw van Drenthe) had as a major goal the promotion of the cultural, economic and sanitary reconstruction of Drente. One of the principles adopted was the involvement of

> the people themselves: participation alongside the contribution of professionals, effectively community development workers 'avant la lettre'. The association's activities showed a wide range of services, for example, a settlement centres, social work, care for deprived children and a health centres for babies.

The 1930s saw the concept of 'Randstad' being introduced. The Ranstad is a typical example of a conurbation and consists of the four largest Dutch cities (Amsterdam, Rotterdam, The Hague, and Utrecht). According to Herrschel and Newman (2002, p. 86) the 'Netherlands spatial planning has emphasised a polycentric structure, with the Ranstad being the most important agglomeration….' The concept behind the Randstad was the first attempt to draft a social and spatial profile of the Netherlands thus making clear distinctions. Peter Hall, a British town planning academic, has stressed that the Randstad has had a profound influence on urban development and thus the reestablishment of community development in the Netherlands. As Hall (1992, p. 198) states:

> Urban Development in the western Netherlands has taken the form of a horseshoe-shaped ring of cities, each performing specialized functions (government in the Hague, commerce in Rotterdam, shopping and culture in Amsterdam), with a central 'green heart' which it is planning policy to preserve.

After the Second World War, the Netherlands went through a period of reconstruction. One particular area for change was social policy. A fundamental rethink was given to using community development as a tool to bring stability within the country. The motivations for this were primarily linked to geographical demographics. Vos (2005, p. 406) has noted that

> During the period 1945–1960, community development was seen as an instrument to combat the disrupting consequences of industrialization and modernization. The cultural elites, vertically differentiated along religious and ideological lines (Roman Catholic, protestant, social democratic, liberal), feared the creation of an anonymous society leading to moral decay and the rise of antisocial elements.…

By the early 1960s, the Netherland's government interpreted community development in a more precise way. The main focus on community development came from the Ministry of Social Work and centred 'on the design of the social environment of the individual and family—to make the social environment liveable' (Vos 2005, p. 407). Hence, the government felt that community development should involve local people 'promoting the quality of life' and like previously 'Participation' was again the key word (Vos 2005, p. 407). This vision had a fundamental affect on the Ministry of Social Work because in 1965, the department was renamed as the Ministry of Culture, Recreation and Social Work. This new ministry had three policy domains: (1) social assistance, (2) social services, and (3) community development. The new ministry perceived community development as the

> …policy domain [which] implied community development in old and new urban neighbourhoods as well as in rural villages. This department was concerned also with the integration of deprived groups like caravan dwellers, the Moluccan people and migrants. Last but not least it continued its pre-1976 policy in relation to the former development areas in which it had played a prominent role in developing policies with regard to urban renewal, small villages and minorities…. (Vos 2005, p. 408)

There has been much debate in recent years on the success of high-rise living in European cities. Since the 1980s, high-rise estates have received negative attention in the media, in terms of developing social inequality. One case study, Bijlmermeer in Amsterdam, has generated increasing academic discussion (Halsall 2013; Wassenburg 2011; Gilderbloom et al. 2009; Smets and den UYL 2008; Helleman and Wassenberg 2004). Past research has demonstrated that Bijlmermeer was perceived to be a good idea at the time but turned into a problematic, large-scale housing project, which demanded urban regeneration. The existence of Bijlmermeer came out of the shortage of post-war housing. As Shakur and Halsall (2007) have pointed out:

> From the outset the Bijlmermeer development was seen to be a desirable place to live in the 1960s. This was indicative of the mood of post war Amsterdam in that it reflected a move away from the traditional style of living to the modern. This modern approach gave people who lived in the Bijlmermeer access to open green spaces, transport links and more importantly attempted to meet the needs of the community. (Shakur and Halsall 2007, p. 2)

For this piece of research, a number of qualitative semi-structured interviews were undertaken. This work is based on a 5-year longitudinal study of the development of Bijlmermeer. The findings from the research suggest that residents who lived in Bijlmermeer were sceptical on the regeneration plan that has taken place but there have been improvements in the area. This work has followed on from previous work undertaken by Leeming and Shakur (2005). Both authors argued that within a relative short space of time it became clear that housing regeneration scheme experienced problems in particular maintenance as a both community leisure site. Hence, as Leeming and Shakur (2005) argue rather than Bijlmermeer becoming a satellite model town, the area came to be a place where multiple social and economic disadvantages groups felt cut off. In the interviews that were conducted for this research, residents who live in Bijlmermeer indicated that today they like to live in the area but were sceptical on the amount of regeneration work that has been undertaken. As three residents pointed out in interviews in 2013:

> 'It is nice living there. Different styles of culture. People talk to each other. Life is good.
>
> Bijlmermeer is a good place to live. It is one big family.
>
> It is still the same. I'm disappointed that the buildings are broken. They have moved people away. You had more communication when we lived in flats.'

The above qualitative quotes demonstrate that the area has improved significantly and that residents, on the whole, enjoy living there. However, the residents were sceptical on the regeneration changes that have taken place. This scepticism is due to the lack of sense of community and this is similar to the findings in 2007 by Shakur and Halsall when they discovered that some residents felt that there was 'no sense of community' among the ethnic minority groups.

Community and the Emergency Services

As a result of a public debate in the late 1980s and 1990s about the nature of emergency care in the Netherlands, there has been renewed interest by politicians, stakeholders, and the general public about the quality of care to trauma patients, lack of standardisation in delivery systems for trauma care and in pre-hospital settings and the role of the ambulance service in the country (Duis and van der Werken 2003; Roorda et al. 1996). The issues surrounding crowding of emergency wards, increasing cost of pre-hospital care and restructuring of out-of-care along with the introduction of a training programme for emergency physicians in 2000 further influenced this debate (Thijssen et al. 2012; Klaassens 2011). As a consequence, rules have been sharpened with recommendations for improvements made in various reports (Connected with Care 1997). It is thus reported that

> The regionalization of ambulance care, the introduction of mobile medical teams, the availability of trauma helicopters, the categorization of hospitals, the designation of trauma centres, the given responsibility of these centres in the regionalization of trauma care will and already have resulted in an important quality improvement, not only of the individual organisations but for all of the entire chain of trauma care. It has become a major step forward in the philosophy: get the individual trauma patient at the right time at the right hospital. (Duis and van der Werken 2003, p. 722)

Pre-hospital Care

Emergency care in the Netherlands is sometimes referred to as the ‘chain of acute care’ involving the emergency departments (ED), general practitioners (GPs), the ambulance service, and the mental health service although coordination between the four constituents and the various providers can be limited (Thijssen et al. 2012; Brotcorne et al. 2003, p. 7). The GP cooperatives deal with a larger number of out-of-care emergencies with trained nurses operating the telephone triage supervised by family physicians (Grol et al. 2006). Very few ‘self-referrals’ volunteer to go to the emergency departments on their own but the concerns of the overcrowding of the emergency departments, compared to the referrals of patents to out-of-hours facilities, show an international pattern including that of in the UK (van Charante et al. 2007). The underlying motive of the ‘self-referred’ patient to the emergency departments is a growing research area (Kooiman et al. 1989). The ambulance service, as with many other countries discussed in the book, is the first point of contact between the patients and the health care system. Paramedics play a crucial role in dealing with various emergencies without much advance notice of the trauma since information at the time of dispatch is often limited (van Vopelius-Feldt and Benger 2013). The Netherlands, compared to the UK, is a small country but has a high density of population and models for optimal ambulance location with random delays and travel times have been tested (Ingolfsson et al. 2008).

Historically, the key determinants of health care use in the Netherlands are old age, disability, heart diseases, and mental illness with large share of the budgets being spent on ‘care rather than cure’ (Meerding et al. 1998). The ambulance service provides the pre-hospital care in the Netherlands. Nearly 80 % of paramedics are qualified intensive–care nurses with a specialist medical training in dealing with trauma patients following strict protocols. All active nurses are registered according to the Individual Health Care Professions Act. The Netherlands is divided into 26 regions, each with a central control room or *centrale post ambulance* (CPA) that can be contacted by dialling the European emergency access number *112*. The CPA coordinates the activities of the various services and dispatches ambulances, depending on the type and emergency of the alarm call. The key response target for the ambulance service is to reach the scene of emergency within 15 min of the call being made in more than 90 % of the cases (Holmes 2010).

Trauma centres are also equipped with a hospital service, with the crew consisting of a medical specialist and a paramedic. They stabilise the patient before transportation to the appropriate hospital and specialised trauma centres, making pre-hospital interventions (van der Velden et al. 2008; Ringburg et al. 2005). The clinical interventions by the staff are quite advanced and reported to be safe (Bosch et al. 2013) involving comparative international practices (van der Wulp et al. 2008). Efficient time management and adequate acute treatment of patient in the ‘golden hour’, i.e. immediately after the trauma, is considered crucial in the initial care of the trauma victims (van der Velden 2008).

Historically, the emergency departments have not been a major facility in Dutch hospitals, and most departments remain antiquated and under-resourced. This is partially as a result of a dearth of emergency medicine and basic sciences in Dutch undergraduate courses. In contrast, major trauma and non-trauma resuscitation are usually well managed at least in the bigger hospitals. Unfortunately, emergency physicians are frequently marginalized as senior doctors from several disciplines will typically attend every patient in resuscitation rooms (Holmes 2010). It is fair to say that newly credentialed Dutch emergency physicians require considerable further experience and training to equip them to practise to a comparable level as their colleagues internationally.

The new Ambulance Care Act (2012) has further underlined the progress made in evolving the delivery of crucial pre-hospital care services in the Netherlands. The financing of ambulance care services and access to them are regulated in the Ambulance Transportation bill (wet Ambulance vervoer (wAv) of 1971) which defines and sets the quality demands expected by the government of the service. Ambulance care is delivered through 25 separate regions (Regional Ambulance Services (rAvs)) within this structure the ambulance services and their ambulance care dispatch centres (meldkamer Ambulancezorgs or mkAs) work closely together. Each Regional Ambulance Service (rAv) can be publicly or privately organised, or a joint venture of both as health care is also financed differently in the Netherlands (Gras 2011). Every Dutch citizen must be insured for ambulance care services, alongside all other health care needs, by the premiums they are required by law to pay for their health insurance (Henegan 2011).

The Netherlands also provides a 'daylight only up-time' (07:00–19:00) physician-staffed helicopter emergency medical system (HEMS) called the helicopter mobile medical team (HMMT) with the main goal of the HMMT being getting a physician to a life-threatening emergency rather than transporting the patients by air (2–25 %) to improve survival and reduce morbidity (Ringburg et al. 2005). The air medical team is situated in four of the ten designated trauma centres around the country. But calls for a 24-h service are gaining grounds along with the improvements in dispatch rates and dispatch criteria adherence currently reported around 14 % to be low (Petrie et al. 2006; Duis and Werken 2003).

While the health care system including the emergency care in the Netherlands is highly applauded, a few concerns have been debated recently. These include the current policy focus to concentrate specialised trauma centres and GP cooperatives and lack of adequate funding of trauma-related research (Duis and Werken 2003, p. 726). Similarly, Thijssen et al. (2012) raised concerns on the quality of care in the Dutch emergency departments and the need for national emergency medicine guidelines giving emergency physicians the clinical autonomy. Holmes (2010, pp. 78–81) undertaking a comparative study with that of the Australian emergency management system summarised the following challenges in the current Dutch pre-hospital care:

- There is a patchy and variable implementation of the emergency medicine curriculum across the country with the triage differing between institutions. Apart from trauma, urgency of disease is seldom appreciated or addressed.
- Historically, emergency medicine has lacked a defined role, and hospital administrators are ignorant of the benefits that accrue from a mature emergency medicine system. Thus, at the institutional level, there is little corporate vision for its development and little motivation to resource emergency departments (ED).
- Emergency medicine is neglected in Dutch undergraduate courses, although increasing numbers of medical students now spend elective terms in ED.
- There is fragmentation of emergency care with many hospitals having separate 'emergency units' for different problem-based categories, most frequently Eerste Hart Hulp ('Heart First Aid'), Eerste Hersen Hulp ('Brain First Aid') and Paediatrics (ibid. p. 80).

Despite the significant challenges, there has been rapid growth in emergency medicine throughout the Netherlands, with increasing numbers of women joining the training; this is largely as a result of the enormous drive and belief of the founding specialists and the extraordinary enthusiasm and dedication of the young trainees who have embraced a career in emergency medicine, even at a time when there was no clear goal of speciality status to be achieved (Holmes 2010).

Concluding Remarks

We have argued in this chapter about the deep rooted liberalism in the Dutch society which celebrated high levels of social cohesion and mutual trust. Notwithstanding the immigration issues and material causes, the Netherlands remains a strong case of community development as the Verhagen (2013) case demonstrates. The case of Bijlmermeer brought in fore some the tensions challenging the traditional neo-liberal values in the country. We ended with a positive story about the growing number of women joining the emergency services, a traditionally male-dominated profession. The next chapter concludes this volume.

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Chapter 10
Conclusion: Looking to the Future: What Next?

Introduction and Background

The research for this book has taken the authors on a revealing, analytical journey, examining community engagement in eight countries, paying particular reference to their application to public health. This concluding chapter seeks first to draw together the common threads of each case study, then the weaknesses and strengths of community intervention, and future research directions. Public health is a large and dynamic field of study, and we recognise that within the scope of this book; it has not been feasible to cover all the emerging themes and concepts of public health, particularly those related to ethics and law. However, the book's three key themes have been explored in the context of the eight case studies discussed in this book, namely:

- Sociability
- Social capital
- Community development

Within these three broad themes, we have also examined the four subthemes of:

- Aging
- Governance and institutions
- Emergency services and public health provision
- Community activism and involvement

The chosen themes and subthemes emerged from their contemporary relevance. We argued in our introduction that democracy is best served with a combination of community spirit and sociability attributes (Cook and Norcup 2011). Self-help is another commendable feature of social life while social responsibility and caring for others depend more upon communitarian values. Our second theme on social capital is something which has become increasingly very popular. Social scientists from a variety of disciplines have adopted the concept of social capital to aid analysis of a variety of issues. The issues around 'generalised reciprocity' and 'social trust' (Putnam 1993; Gambetta 1988; Misztal 1996) have been explored in each of the

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eight countries' case studies with a specific focus on any of the four subthemes. For instance, in Chap. 7 on Bangladesh, we have discussed how social capital improves the prospects for development (Grootaert and van Blastelaer 2002) and analysed its impact through the *Grameen Bank* (Dowla 2006). In the chapter on Japan, we explored the two aggregated indicators of community social capital (kindness and greeting) and its association with general health (Fujisawa et al. 2009). On the issue of community engagement, we have explored the theme in many different ways. For example, in Chap. 8 on Japan, we explored the significance of the role of identifying citizen involvement and public education as fundamental to the development of an effective pre-hospital care system and how it is an evolving phenomenon in Japan. Chapter 6 on South Africa explored a very detailed community response to tackling the HIV/AIDS virus in South Africa. The three themes on sociability, social capital, and community development converge in our discussion and analysis of the health and wellbeing of increasing number of older people in different chapters (Cook and Halsall 2011; Rowland 2009).

Summary of Key Findings from Each Case Study

Chapter 2	United Kingdom
Chapter 3	United States
Chapter 4	China
Chapter 5	India
Chapter 6	South Africa
Chapter 7	Bangladesh
Chapter 8	Japan
Chapter 9	The Netherlands

The first country that was examined was the UK. This was one of the obvious countries to select as the UK currently has many social and economic challenges (O'Hara 2014; Dorling 2013). As it was discovered in our introductory chapter, aging in the UK is becoming a more significant social and economic problem that has caused central government to take action, within a social policy context. One area that has experienced added pressure is the National Health Service. By using documentary data sources from the British Broadcasting Corporation (BBC) website, we briefly touched upon the Stafford Hospital scandal where there were concerns over poor care and high mortality rates amongst patients (Francis 2013). We also provided a detailed discussion on the type of diseases that are experienced by older people, in particular: cancer, Alzheimer's disease, and dementia. In addition to this disability, other health issues were discussed. We showed that the Macmillan Cancer Support, Alzheimer's Society and Mind, which are nationally recognised in the UK, play a crucial role both in facilitating support to the people who suffer

from these conditions and in providing funding for scientific research. A theoretical discussion was given to show the complex relationships between community development, governance and institutions. The work of Anthony Giddens (1987) was closely referred to. In the UK, institutions play a fundamental role in crystallising the success of community development (Hoggett 1997). As it was noted in this chapter, there are a number of institutions that are involved in community development, namely central and local government and the third sector. The election of a New Labour Government in May 1997 saw a greater emphasis placed on community development in the UK and a more active role in different institutions (Powell 2013). However, one of the contemporary debates in the UK society today is the worrying consequence of failing institutions. Over the last decade, we have seen a number of cases where public institutions have failed the public. In the chapter, we have made reference to Jimmy Saville, Cyril Smith, Asian Grooming and the case of *Daniel Pelka*. The final part of this chapter discussed the significant changes in the National Health Service within the context of emergency services. The UK coalition implemented the Health and Social Care Act (2012) which created a new emphasis *on* accountability and commitment of the service user in the National Health Service.

Chapter 3 examined the USA and discussed the country's complex relationships between sociability, social capital, and community development. It is interesting to note in this chapter that many of the contemporary scholars that have written on the subject of social science, a subject which this book focuses on are American-based academics, such as: Susan Saegert, Robert D. Putnam, and James Defillppis. British academics, such as David Harvey and Doreen Massey have also been covered in this chapter. Both Doreen Massey and David Harvey's research has provided a critical analysis of social and economic consequence and how this relates to globalisation and community development (Massey 1984; Harvey 1989). Firstly, this chapter provided a discourse on the advancement of sociability and voluntarism, and as it was noted, the USA has a long history associated with this and in particular the liberation movements of the 1960s. Secondly, the chapter moved on to provide a critique of volunteering at a local level. The authors found that the internet has had an impact on the way community organisations operate. Thirdly, a theoretical assessment of community development in the context of the USA was provided. In this section, we highlighted the criticality of the concept of community development and the institutional framework of the Community Commission Development in Chicago. Moving on from this we examined the crucial work that the Bill and Melinda Gates Foundation does in communities across the world. We showed that the foundation has provided financial assistance and has created changes in social policy. Lastly, the chapter presented an overview of the challenges faced by the emergency medical services, and as it was discovered, the key focus for debate recently has been the 'speed of response'.

Chapter 4 on China highlighted various issues against the backdrop of the country's sudden economic rise in a relatively short period of time. It analysed the growing influence of Confucianism in the last two decades owing to the realisation by the ruling elites that the ethical base of Confucianism can help promote a 'harmonious

society' in which people have responsibilities to others (Shirk 2007) as a historically embedded influence of Confucian ideas of working towards the common good (Wu and Gaubatz 2013). The chapter also highlighted that sociability was very much based among one's family kin or clan although there was the attended concept of *guanxi* that could encompass a wider form of networking beyond one's kith and kin. The chapter illustrated how a combination of factors including complex health and social system, rapidly growing population of 1.3 billion, and massive variations in economic capabilities has resulted in absence of integrated model of emergency care in China (Pei and Xiao 2011). We further argued that the social capital in China must be viewed as a multifaceted and heterogeneous concept (Xia 2011, p. 158) and must be approached cautiously within the unique Chinese context of historical development of social relationships. The chapter concluded with the analysis of the recent trends in community development, accompanied by a lack of local government support for community participation.

Chapter 5 on India as with China began with a contrasting perception of a growing economic superpower and its burgeoning middle class, but also a growing social and class and caste division. The social disparity is further highlighted in the 132nd rank out of 179 nations in the Human Development Index (2008) in contrast to being the fifth biggest global economy. The contribution of Gandhi and his legacy in dealing with these barriers and challenges provided an interesting case study. The chapter analysed the role of 'cooperatives' as an important form of social capital in India. In particular, the role of government in the development of the Indian cooperative movement as the world's largest and most diverse cooperative movement (Vaswani 2011) was also discussed. Similarly the contribution of more than 2 million voluntary organisations registered under the societies and trusts acts in India and their role towards community development and engagement was further investigated (Halsall et al. 2013). The state of the country's pre-hospital care was scrutinised and the emergency medicine state in India was seen as a nascent speciality without a proper identity (Fitzgerald et al. 2006; Gururaj 2008). The heart wrenching case of *Rambhor* was discussed (Garg 2012) to highlight inadequately trained clinicians in poorly equipped emergency departments as a consequence of the burgeoning population and a lack of standardisation of medical education and variations in pre-hospital medical systems (David et al. 2007). The emergence and involvement of the private providers in delivering the pre-hospital care was seen as a good example, but more involvement is necessary in order to improve this aspect of care.

Chapter 6 of this book examined South Africa. It was discovered that one of key themes in South Africa is the legacy of apartheid which has led to many inequalities in terms of public health and quality of life. This situation has been compounded by the uneven impact of HIV/AIDS that has disproportionately hit the Black community especially. But in the face of this scourge, we found that the community response has been unprecedented. Community intervention has come via 'community advocates' for example, who have assisted local communities to respond to the psychological and emotional pressures of this major health threat. Studies by Grimwood et al. (2012) and Igumbor et al. (2011), for example, demonstrate the

positive impact of such community intervention. The international community, too, has had an important role to play in helping South Africa to deal with HIV/AIDS. In terms of community development within South Africa, and notwithstanding the progress that has been made in recent years, many shanty town dwellers in cities like Durban and elsewhere still feel excluded from the fruits of socioeconomic progress and have responded by developing their own communities via *Abahlali baseMjondoho* that seeks to tackle the high poverty levels and unequal health outcomes that are still found in such localities (Abahlali 2014, http://abahali.org/). The final part of this chapter explored the unevenness of emergency health care in the country, and outlined the work of Hardcastle (2011) who has called for an Afro-centric approach to trauma based on a set of clear principles of intervention. Community involvement will also be necessary in this important area.

Chapter 7 of this book examined the country of Bangladesh. As it was discovered one of the common themes of Bangladesh is the political instability of the country. Over recent times many scholars have provided a critical commentary on the political divide within the country (Chowdhury 2009; Khan and Thorpe 1986). Islam (2013, p. 155) has argued that Bangladeshi politics today are substantially more polarised than ever before thus causing divide and there is a mentality of 'winner-takes-all power game [which] can be used to describe the political polarity in Bangladesh'. The chapter started off by outlining the international and local response to health and aging issues. Within the social policy context, it was discovered that the country places great importance on community-based approaches. Then the chapter moved on to evaluate the contribution that community development has had on Bangladesh. As it was established the common thread through community development is the emphasis of a 'Civic Society'. The reason why the concept of the civic society is so prominent in Bangladesh is that the concept is seen as a champion of democracy and as Carothers (1999, p. 24) notes, 'Bangladesh is rich in civil society, with thousands of NGOs, advocacy groups, and social service organisations operating at the national and local levels.' From constructing analysis on community development, the chapter then critically explored the theoretical perspective of social capital and used the Grameen Bank as a benchmark of a successful local initiative. The final part of the chapter explored the community response to health in Bangladesh. We showed that the emergency health care in the country has no clear department, and thus in recent times the delivery of a safe emergency service to women has been identified as a key concern.

The case study of Japan was discussed in Chap. 8. As it was noted in the introduction of this book, and in the introduction of Chap. 8, Japan's social and economic demographics have provided an intriguing insight to the country. One of the significant features is the country's sustained economic growth, which has been achieved by expanding public investment tailored with a great emphasis on industry, such as, car making, shipbuilding and steel, textile and electronics (Therborn 2008). The first part of this chapter provided a current representation on aging and the policies that have been implemented to offer a sustainable medical and social care system. The community-based integrated approach has been put in place and the motivation for this is drawn from traditional cultural norms. As noted by Fukuyama (2001,

p. 12) 'Japanese cultural characteristics' are an inherent aspect of functioning public institutions. Then, the second section provided an historical analytical discussion on community development. As it was noted in this section, community development is effective in both urban and rural areas. In cities, such as Tokyo, there has been rapid economic transformation (Sassen 1991). The most successful part of community development in Japan is the expertise in 'community management' and 'participatory methods', and thus countries across the world can learn from this in terms of effectively dealing with environmental disasters. Moving on from this, a critically conceptual framework of social capital was provided by Japan. It has been noted by several scholars that social capital in Japan is in self-transition due to historical political changes (Newton 2001; Inoguchi 2000; Woolcock 1998). As we have demonstrated, further research is needed with regard to the relationships of social capital, income inequalities and health inequalities in the context of Japan. Lastly, the emergency services and community participation in Japan was scrutinised and it was found that the emergency medical services are currently at a crossroads in terms of paramedic practices.

Chapter 9 on the Netherlands began with a discussion on the evolution of the contemporary Dutch, influenced by social anarchists (such as Kropotkin) with the novel feature of the ideas of sexual liberation giving Dutch anarchism 'a new cultural and ethical dimension' (Altena 2012, p. 402). The chapter argued the current state of consolidation for the social capital in the health and wellbeing at the neighbourhood level in the backdrop of global climate of austerity. Two mini cases were discussed. The first pertained to the work of Jonkman et al. (2005) in the field of communities that care (CtC) programmes which led to the reduced rates of alcohol consumption, as that of truancy, school dropout levels and community disorganisation. The second example was that of Verhagen (2013) who studied the role of ethnic community health workers, selected and trained from their own community, in order to carry intervention programmes for older people in the Turkish, Moroccans and Moluccan communities. We discussed the *Bijlmermeer* site case as an example of poor community development and how, due to various reasons leading to scepticism, residents felt there was 'no sense of community' among the ethnic minority groups (Shakur and Halsall 2007). The chapter also reviewed the state of the emergency medical service (EMS) in the Netherlands and argued that due to historical reasons, emergency departments have not been a major facility in Dutch hospitals, and most departments remain antiquated and under-resourced. We also noted the extraordinary enthusiasm and dedication of the young trainees who have embraced a career in emergency medicine despite an absence of a clear goal of speciality status to the EMS (Holmes 2010).

Weaknesses and Strengths of Community Intervention

The above examples, plus others that the authors have found on their intellectual journey through these countries, illustrate the positive aspect of community intervention in the area of public health. We are certain that such intervention will be

increasingly important as the state seeks to reduce expenditure and curtails its activity in the broad welfare support system where such a system already exists, or does not develop it markedly where it does not exist. Private capital could perhaps fill the gap provided by a lack of state intervention, but the major issue with private capital is that it seeks profit for investors and shareholders, and in the area of public health, there can be tensions between the making of profit and the wellbeing of patients, particularly poor patients who may not be able to afford access to basic medical care, as we have shown in the examples cited in this book. The 'Third Way' that communities provide can go a long way to meeting the needs of those who might otherwise be excluded from public health provision. However, the authors do recognise that community-based alternatives are not always the be-all and end-all, and that there can be weaknesses in community provision. For example, we can identify potential weaknesses as including:

- Legitimacy and leadership: Community leaders are often self-selecting. They have leadership qualities such as charisma, eloquence, drive and certainty. At best, they can lead their community to great futures; at worst, they are unelected and self-centred, too parochial, unskilled and set in their ways to be able to interact meaningfully with local authorities or local state, or engage effectively with wider agendas.
- Professionalism: This is a paradoxical issue. In order to address some of the weaknesses noted as part of the previous issue, community groups often seek to overcome their low skills and knowledge base via hiring of professionals who can offer higher-order skills that communities may lack. But the danger of this approach is that 'our professionals' speak to 'your professionals' in a process that may move further from the wishes of the community itself, leading to remoteness or alienation from the community that the professionals represent.
- Funding and sustainability: Community groups come and go. They are difficult to sustain as the leadership group moves away from the area or dies, or as funding for basic activities cannot be sustained. Government may see community as a cheap option, but at the very least, community volunteers need funding for travel and expenses, and basic training. Communities need premises, communication systems and facilities, all of which must be paid for, preferably on a long-term rather than on a short-term basis.
- Size and remoteness: Some of our examples, such as the Macmillan Cancer Support or Alzheimer's Society mentioned in the UK chapter or the Grameen Bank of Bangladesh are now large organisations. Once a voluntary organisation grows to such a scale, we wonder if there comes a point beyond which the organisation merely replicates a non-voluntary one due to the potential remoteness of the board that runs the organisation from the 'coalface' of community engagement at the grassroots. Since beginning this book, for example, the scandal of the UK Cooperative Bank has hit the headlines due to the huge scale of its losses, and in a massive blow to the UP cooperative movement the then chair of the bank, Paul Flowers, has been disgraced due to his involvement in drug-taking and payment of rent boys (Boffey and Treanor 2013). This relates back to the question of legitimacy raised above.

Nevertheless, scandals hit state and private sector organisations too, and the voluntary sector does not have an exemption from the involvement of bad apples. Despite the ‘humiliation’ to which Boffey and Treanor refer, the current authors believe that the advantages of community involvement outweigh the disadvantages. For instance, we can summarise the key advantages as including:

- Voluntarism: Throughout the pages of this book are examples of people giving freely of their spare time, often for little if any financial reward. These are the ‘do-gooders’ a phrase that in the UK at least can have surprisingly negative connotations, being identified by some as those who see themselves as better than the majority, perhaps as being ‘holier than thou’. But such people are often the bedrock of community support for the vulnerable in society. The hours that volunteers put in can assist with those who have such diseases as cancer, dementia or HIV/AIDS and help patients to grapple with such terrible illnesses, reaching out to those in their communities who might otherwise be overlooked by the state or private capital.
- Soft support: Community intervention is often at the soft rather than hard end of public health provision. The hard end is the world where the biomedical model dominates, where expensive hardware is used to try to treat difficult diseases. The soft end is where community volunteers help people to tackle the emotional and psychological costs of disease, as we have shown in the Netherlands or South Africa, for example, where community advocates or community workers help people to declare their illness to the wider community and thus to remove the stigma of a disease such as dementia or HIV/AIDS and help these people to achieve a better quality of life than might otherwise be the case.
- Identity: Via a process of community engagement, identity becomes an important element. Identity may be as a patient with a specific illness, membership of a particular ethnic group, or as a community volunteer. Identification with a community, whether a local community grounded in a locality or a ‘community without propinquity’ as Webber (1964) once put it, is an important element in social and psychological wellbeing and assists the process of social interaction that aids recovery from ill health or coping with trauma.
- Cost effectiveness: Although, as noted above, there is a danger that the powers that be may view community intervention as a cut-price alternative, it is nonetheless the case that employment of community volunteers is highly cost-effective compared to the alternative support systems that the state or private capital can provide. It is a fine line between being cost-effective and being cheap, but the authors believe that community alternatives are highly useful additions to the arsenal of public health interventions across different societies.

Future Research Directions

We suggest that future research might involve, for instance:

- Further evaluation of the costs and benefits of community intervention via further case study analysis.
- Funding and sustainability concerns must be addressed in order to find better means of providing support for medium and long-term sustainability of community groups.
- Additional cross-country and cross-sectoral comparisons should be developed to provide more lessons on the best way forward.
- More in-depth in-country studies are sought in order to increase the spatial and socioeconomic coverage of different countries with different situations.
- A greater range of themes and subthemes such as the role of the internet in facilitation of community intervention, ethical and legal concerns could be examined.
- We hope to address some of these topics via collaborative research involving colleagues and community groups across the globe.

In all, 'calling up the community' is not without problems, but it is nevertheless a sound and viable alternative to state and private capital provision in public health. We conclude this book by dedicating it to the many who give of their time selflessly in 'little societies' across the globe, to the betterment of those with whom they engage in community intervention.

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