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Rural eHealth facilitators strategic development concept:

How to approach and plan the engagement of Rural eHealth Facilitators

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REACT
Rural eHealth Facilitators
Funded by the European Union

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Foreword

"Rural eHealth facilitators" (REACT) is an Erasmus+ project implemented in four European countries from 2022-2025. The REACT project has tested the involvement of eHealth facilitators in strengthening the digital inclusion of vulnerable groups across four different welfare state contexts.

Drawing on the lessons learned from the project, this report presents a strategic development concept along with recommendations, aimed at other players and stakeholders engaged in digital inclusion for digitally vulnerable populations.

We would like to express our sincere thanks to the actors in voluntary and public organizations who contributed to the project by participating in workshops, by running pilot projects and by contributing to data collection throughout the project period.

Barbara Fersch
Esbjerg, December 2025

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1. INTRODUCTION

The EU-funded Erasmus+ project "Rural eHealth Facilitators" (REACT) was established to address challenges related to the digital transformation of society by developing digital readiness, resilience and capacity. This was more specifically tested through the "Rural eHealth facilitators" concept developed to provide tools to help vulnerable, older citizens in rural areas by building digital capacities to become included in eHealth offerings.

The Erasmus+ project has resulted in four reports and a PowerPoint master with tools to apply (all openly available here: https://www.sdu.dk/en/clf/react). The first publication was a needs analysis (Vilaça et al., 2024), followed by both a final recommendations report (Thuesen et al., 2025) and an implementation and evaluation report (Bavnbæk et al., 2025). This strategic development concept report complements the other deliverables by offering insights into how other actors can approach and plan the engagement of rural eHealth Facilitators. The report therefore provides guidelines and recommendations on how to approach and plan local collaboration with rural eHealth facilitators, aiming to mitigate the risk of digital exclusion in rural areas (Fersch et al., 2025).

Understanding specific national and local contexts is a necessary precondition to enable local organizations and professionals to implement the REACT concept in an effective and sustainable way. Therefore, this project was based on a bottom-up approach reinforced by local collaborations. Indeed, three regional or local health and social care providers were involved in each participating country. This provided a transnational overview into the diverging welfare mixes. The knowledge provided in the report also builds on the results of the former European needs analysis (Vilaça et al., 2024). Together, this gives insights into:

- the specifics of the local organization and culture of health and social care providers in different countries
- how to identify the right professionals as trainers
- how to gather knowledge on training and skills needs
- and how to understand the social and cultural aspects of voluntary engagement in the respective places.

This will help to create the local conditions to engage both citizens (as volunteers) and professionals in co-production processes.

Beyond the four partner countries, the ambition is to develop a general set of practices and recommendations to ensure that the concept can be used widely all over Europe. Thus, the strategic development concept contributes to the overall objective of the REACT project by contributing to making the rural eHealth facilitators concept translatable to diverse contexts and, in this way, also potentially sustainable beyond the REACT partner contexts.

2. TRANSNATIONAL OVERVIEW – DIFFERENCES IN THE WELFARE MIX

The research literature on the principles and the ways in which health and welfare services are provided in different countries has introduced the welfare triangle in Figure 1 (Evers & Laville, 2004 ; Pestoff, 1992) Within the "welfare pluralism" of welfare states, particular mixes exist of which kind of organizations are providing which kind of services and how they are financed (taxes, public or private insurances, market fees, etc.).

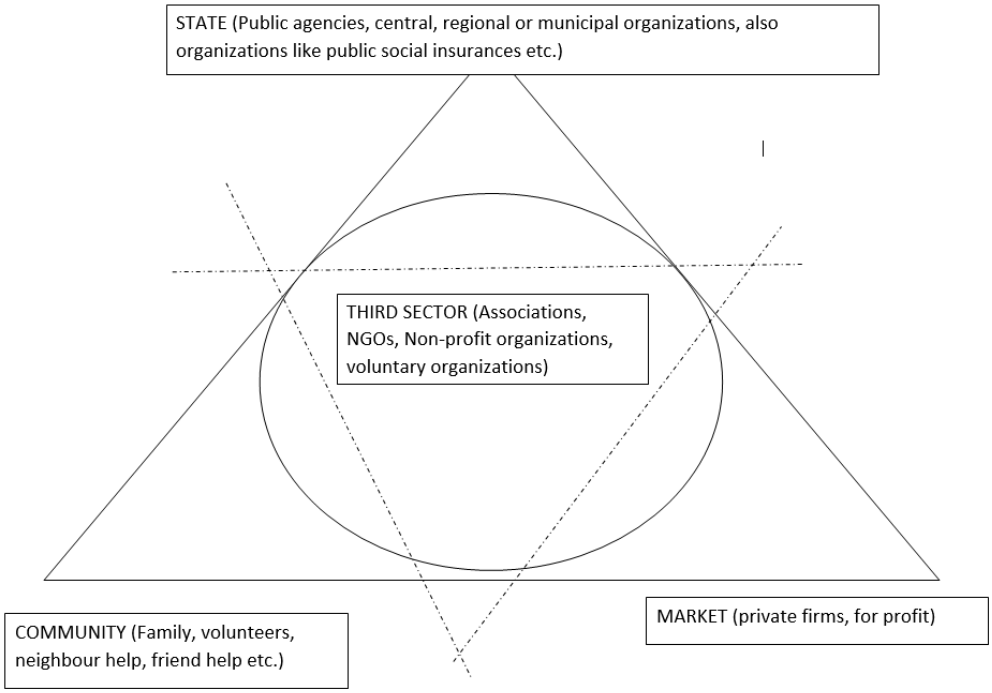

Figure 1: The welfare triangle (Pestoff, 1994 and Evers & Laville 2004)

Analytically, Evers & Svetlik (1993) distinguish between four main actors involved in service provision in European welfare states (here referring to health and social care services in a very broad sense). These are, namely, (1) family members, (2) non-profit organisations, (3) for-profit organisations and (4) public sector organisations. Leibetseder et al. (2017) provide a more detailed overview in Table 1 of actors and modes in the provision of care services.

Table 1: Care provision modes (Leibetseder et al., 2017, p. 137)

Modes of provision	Provider	Resources mobilised	User	Care Worker
Informal Care	Family; immediate community	Reciprocity, love, responsibility	Member of family or community	Unpaid (female) family member; friend
Voluntary and charity work	Non-profit (I) Community, charity and voluntary organisations	Fundraising, voluntary work, public subsidies	Targeted user	Unpaid volunteer
Non-profit care service organisation	Non-profit (II) welfare organisations	Fundraising; membership or user fees, public subsidies (*social insurance*)	Member, targeted user, customer	Paid or semi-paid worker, unpaid volunteer
For-profit commercial providers	For -profit (I) Companies, for profit service organisations	Service charges, public subsidies, social insurance	Customer	Paid (professionalised) worker
Privately hired caregivers	For-profit (II) Self-employed caregiver	Service charges; (public subsidies); social insurance	Employer, customer	Paid (professionalised or informal) worker
Public providers	Central/ regional / local authorities	Taxation; service fees; social insurance	Citizen, resident, user (more or less targeted)	Paid professionalised worker; sometimes volunteer (additional)

These providers exist in various empirical "mixes" in all countries. In an optimistic understanding, all the diverse providers have different strengths and weaknesses and could, in the right mix, complement each other very well. Less optimistic interpretations point to the blurring of boundaries between providers and that hybrid modes might endanger quality, universality and political accountability (Evers, 2005).

In recent decades, several reforms have changed the modes and composition of the welfare mixes that can be found empirically. A notable development has been taking place that can be described as shifting away from the public provision of several forms of care and welfare services (in places and areas where they had become public in the second half of the 20th century). Leibetseder et al. (2017) call this "welfare re-mixes" and describe

the following three main directions of development (1) marketisation, (2) familialisation and (3) communitarisation, which are further explained in Table 2.

Table 2: Key shifts in welfare re-mixes (Leibetseder et al., 2017)

Direction of change	Forms of Change	Mechanisms (examples)
Marketisation	Active marketisation Passive marketisation Informal marketisation De-marketisation	Choice/tender models/ cash-for-care Austerity/cuts Immigrant care work Insourcing
Familialisation	Active re-familialisation Passive re-familialisation De-familialisation	Cash for care/moral incentives State withdrawal Expansion in service provision
Communitarisation	Active communitarisation Passive communitarisation Formal communitarisation Informal communitarisation De-communitarisation	Partnership/network models Increased competition, austerity Bottom-up initiatives

All in all, the welfare mix and re-mix perspective gives an insight into what governance reforms described in the public sector and governance literature as New Public Management and New Public Governance (Torfing & Triantafillou, 2013) mean for the division of labour, tasks and responsibilities between the sectors and the provision of health and welfare services. With the re-mix lens, we can describe the REACT project as some kind of communitarisation, i.e. the stronger involvement of voluntary involvement in such service provision, albeit "through the backdoor", i.e. and also providing a solution to another reform direction, namely digitalisation.

To implement the "Rural eHealth facilitators" (REACT) project it is therefore relevant to in a first step think through which particular welfare mix the communitarisation project is aimed to be implemented into, to find out who the most relevant and promising voluntary partners could be accordingly.

In the case of the REACT pilot countries and cases, we can find the picture presented in Table 3.

Table 3: Actor-mix in the REACT pilot projects

Country	Case	Provider	Voluntary organization/ volunteers
Denmark	Nordfyn municipality	Municipal health and elder care organization (public provider)	Dan Age (voluntary and interest organization for older people)
	Haderslev municipality	Local general practitioner clinic (for-profit commercial provider)	Dan Age (voluntary and interest organization for older people)
	Aabenraa municipality	Municipal citizen service (public provider)	Blue Cross (Christian voluntary organization focused on help and voluntary social work for marginalised citizens)
France	Université of Aix-Marseille	Dentists and nurses	Health service students (interdisciplinary training that engages health students in preventive actions for vulnerable populations).
	University of Lorraine	Teacher-researchers, hospital practitioners, or teachers in health training departments and institutes (the Maieutic Department of the Faculty of Medicine, Nursing Care Training Institute, and Institute of Physical Therapy Training)	Health service students (interdisciplinary training that engages health students in preventive actions for vulnerable populations).
	University of Jean Monnet Saint Etienne	Teacher-researchers in the educational sciences	Health service students (interdisciplinary training that engages health students in preventive actions for vulnerable populations).
Portugal	Local Health Unit - Braga Hospital	Teacher-	Nursing students

		researchers of nursing students	
	Higher Health School of Santarém Polytechnic Institute	Teacher-researcher of nursing students	Professionals from a nursing home (Social Assistants, Technicians) Catholic voluntary organization of missionaries focused on help/ voluntary social work (doctors, lawyers, social workers, teachers, nurses)
	Senior University of Vieira do Minho	Technicians of Educational Sciences	Older people
	The Teachers' Social Solidarity Association - Guimarães Delegation	Teachers and retired teachers	High school students
The Netherlands	Bloeizone Appelscha	Community Initiative	Local residents and professionals involved in their community
	Bloeizone Grou	Community Initiative	Local residents and professionals involved in their community
	Knowledge lab	Partner network of education, knowledge, government and business	Professionals and volunteers involved in this alliance
	Leeuwarden Municipality	Municipal social domain	
	NLH Stenden University	Teacher researchers students innovation lab Digital Literacy	Teacher researchers students innovation lab Digital Literacy
	Regional Care and Knowledge Organisation	Professionals and volunteers working with vulnerable people	
	Libraries	Professionals and volunteers of multiple libraries	Volunteers of the libraries

3. LOCATING CULTURE AND PRACTICES IN DIFFERENT CONTEXTS

However, to implement the REACT concept, it is not enough to only identify the landscape of actors. There are also different norms and cultures concerning important questions of care and welfare provision in the varying countries, which play a role in shaping practices. (Pfau-Effinger, 2005).

3.1. THE DANISH CASE

In Denmark, where the public sector, i.e. on the local level the municipality, traditionally plays a dominant role in the provision of health and care, (Fersch & Jensen, 2011) a large organization landscape, tradition and strong culture of volunteering exist as well (Henriksen et al., 2008). In recent years, co-production between the public and the voluntary sector has been heavily promoted (Ibsen et al., 2021).

In this context, the REACT concept has mainly been implemented as a co-production between municipal organizations and established voluntary organizations. More specifically, due to the central role municipalities play in service provision in Denmark, it tended to be a municipality-driven initiative. However, in one pilot initiative, the pilot took place as a collaboration between local general practitioners and a voluntary group, and the role of the municipality was thus mainly to provide contacts. In this case the pilot was a volunteer-driven initiative (rather than, as in the other cases, a municipality-driven one). The concept worked particularly well here, which could point to some advantages of a volunteer-driven model.

Voorberg and colleagues (2015) describe three main types of citizens' roles in citizen-public sector collaboration in the provision of public services, that they have found in the co-creation and co-production literature. Either citizens acted as *co-implementers*, or as *co-designers*, or as *initiators* of public service co-production.

For the Danish pilot cases, we can describe the Nordfyn and Aabenraa pilot initiatives' citizen roles as co-implementers and partly co-designers, whereas the Haderslev pilot initiative can be described as a citizen-initiated initiative. Van Meerkerk describes challenges in the former, more top-down driven as, e.g. challenges concerning the motivation of the voluntary partner (van Meerkerk, 2020), which was an issue to be found in one of the pilot initiatives, whereas this was not the case in the volunteer-driven case.

The volunteers in the Danish initiatives were for the most part around the same age of the citizens they helped. This is because in two cases they were part of DanAge, the interest volunteer organization of older people in Denmark. This form of peer-help had some advantages, as some participants (both citizens and volunteers) reported that seeking this kind of help also included socializing aspects (see also Bavnbæk et al., 2025).

3.2. THE DUTCH CASE

The Netherlands is truly a volunteer country. About half of all Dutch people over the age of 15 volunteer once or more a year (Arends, 2024). Municipalities are responsible for

local policy on volunteering, but the implementation and coordination are mainly taken up by welfare organisations, libraries and volunteer centres. There are even job databases for volunteers, and many organisations tend to have a separate page on their website listing various volunteer vacancies. In addition to this structured way, residents work together in their own community to provide an environment where people help each other.

Accordingly, co-production in the Dutch context often takes the form of more bottom-up, citizen – or volunteer driven projects (Thuesen & Levinsen, 2022). It empowers local people to identify and address their own needs which creates a sense of ownership and better local outcomes. This bottom-up collaboration is a community-driven approach in which citizens are the primary initiators, rather than government or external authorities.

This was also the case in the Dutch REACT pilot projects. The Dutch REACT team sought collaboration with several (community) initiatives, organisations and other professionals active in the field of digital inclusion of older and vulnerable people. They talked with professionals and citizens in rural areas to find out what they needed in terms of digital support and assistance. As libraries do a lot in the field of digital skills, access to eHealth and on digital citizenship, they were involved where possible.

The main focus was on what is required to help digitally vulnerable citizens to participate in the digital world and have access to eHealth offers. Van Meerkerk remarks that one large advantage of community-driven organisations is that volunteers and activists tend to be very engaged and motivated by their connection to the local neighbourhood (van Meerkerk, 2020).

3.3. THE FRENCH CASE

In the French case, the service sanitaire, which is a programme for students in healthcare, is embedded within a healthcare system where the state and the social security system play a central role in organizing and financing care, while local authorities actively contribute to prevention and health promotion initiatives (Chambaud & Hernández-Quevedo, 2018). At the same time, the country benefits from a network of associations and a long-standing tradition of volunteerism, which support targeted actions for vulnerable populations.

The service sanitaire mobilizes health students to carry out preventive interventions (Kuenemann et al., 2023), particularly for at-risk groups such as older adults, individuals in precarious situations, and those with chronic illnesses. Through interprofessional and collaborative approaches, this initiative enhances public health awareness and promotes healthy behaviours, particularly in areas such as nutrition, physical activity, and infectious disease prevention. By engaging students in these initiatives, the service sanitaire helps address the specific needs of vulnerable populations while also equipping future healthcare professionals with essential skills in health promotion and interdisciplinary collaboration.

In this context, the volunteers have been students enrolled in health educations, and this is part of their educational training. Thus, this is a form of “obligatory” volunteering, and

it happens in the context of public institutions, i.e., university and service sanitaire. It can be described as a top-down approach, with students acting as co-implementers. As the evaluation shows, the fact that it is young people who have offered help to older citizens has been positively remarked by participants, who emphasized the intergenerational exchange. (See also Bavnbæk et.al. 2025)

3.4. THE PORTUGUESE CASE

In Portugal, digital inclusion for the elderly population is a significant challenge, as many older adults still lack basic digital skills, whether due to a lack of internet access, a lack of access to digital services, or motivational barriers.

Barriers exist, such as territorial inequality in internet coverage and training availability (Paisana et al., 2012; Ge et al., 2025), and also internet access costs, as devices and internet tariffs continue to be expensive (Calha, 2024). Limited skills are also a barrier, as even after initial training, the lack of continuous support leads to forgetfulness and frustration (Helsper & Reisdorf, 2017). There are also barriers related to non-inclusive design, as many digital services do not follow universal accessibility principles. Psychological and cultural barriers such as fear of fraud, perceptions of uselessness, and the belief that "it is too late to learn" (Selwyn, 2004) are recurrent, too.

To address this challenge, the Eu Sou Digital ("I am digital") program emerged in Portugal. It targets adults 45 or older with little or no internet experience. It operates through a network of volunteers and training centres (Digital Skills & Jobs Coalition, 2022), integrated into the national INCoDe. 2030 strategy, which seeks to develop digital skills across the population, including older adults (INCoDe.2030, 2021).

Some other good practices that have emerged in Portugal include training tailored to the needs of older adults, with a slower pace and relevant content (Digital Skills & Jobs Coalition, 2022), intergenerational learning and peer support, promoting trust and inclusion, local initiatives in community centres or nursing homes, which are more accessible to older adults (INCoDe.2030, 2021), and an emphasis on digital public services and practical tasks, such as healthcare, social security, and banking (Portugal Digital, 2021).

In this context, the REACT project in Portugal aimed to promote intergenerational learning (nursing students and high school students as eHealth facilitators), peer education (older people as volunteers), and the empowerment of professionals from nursing homes. Thus, the REACT project in Portugal could follow an existing co-production model of the Eu Sou Digital program.

4. GUIDELINES AND RECOMMENDATIONS

Having provided an overview of the welfare mixes available and a transnational overview of the four case country contexts and experience, we will conclude this strategic development concept report by providing some recommendations. To implement the organization of the REACT project, we point toward the guidance in the sections below.

4.1. MAP THE LOCAL WELFARE MIX

Most likely future implementers of the REACT project will be embedded in the respective welfare mix and thus among stakeholders, either within the public sector and/or the health sector or as a voluntary organization. The welfare mix will therefore most likely be very familiar and self-evident. Still, it can make sense to take a step back and think through who the "players" are, and which collaboration partners will make most sense. Who are the providers of the services, and who could be interested volunteers? How are volunteers organised, and are there relevant voluntary organisations to approach? If not, how can the voluntary effort be organized, for instance with students (FR and Pt) or e.g. Christian voluntary organisations of different variations or confessions (Pt, catholic, Dk, protestant)?

Practical advice:

Draw a map of relevant stakeholders and networks for the specific local context to locate collaboration partners.

4.2. ADAPT THE COLLABORATION TO THE LOCAL CONTEXT

Our pilot initiatives prove that both volunteer-led, bottom-up organised projects as well as public-sector or private-doctor led models are possible and do work well. Be aware of the different dynamics in these – all have advantages and disadvantages that you can strengthen (advantages) or counter (disadvantages). For instance, bottom-up initiatives might ensure motivation and commitment, but might prove to be unreliable or harder to move in the direction aimed at. On the other hand, more top-down and professional-driven initiatives might have a problem with securing commitment and motivation among volunteers (van Meerkerk, 2020). In both cases, this can be helped by open and clear communication.

Practical advice:

The adaption to/implementation in an existing co-production model (e.g. the service sanitaire in France) or voluntary service (e.g. DanAge existing IT volunteers) can be recommended.

4.3. ENSURE MOTIVATION AND A SENSE OF OWNERSHIP

Our pilot initiatives show that it is very important for the success of the concept that both the public and/or health frontline professionals and the volunteers are motivated and feel

a sense of ownership of the project. For frontline staff, this typically relates to the challenges they face when using digital technologies with the citizens they are in contact with. Thus, the experience that this project can provide help for a group of citizens they care about is really important. For the volunteers their experience that they help people, especially in their own local community, appears to be very rewarding. Communicating this possibility, as well as convincing them of the relevance and gravity of the problem of digital exclusion is crucial to both being able to recruit and retain volunteers.

Practical advice:

Engage with partners early and create enthusiasm around the project.

4.4. Be aware of social interaction effects

Different societal groups in rural areas are at risk of digital exclusion, e.g., older but also socially marginalized people. At the same time, there are different volunteer groups. Consider what social dynamics this could bring: Our pilot initiatives showed different positive effects, both with peer (both volunteers and citizens are of a similar age group, e.g. DK) and with intergenerational (young volunteers- older citizens, FR and Pt) help. The socializing aspect was emphasized regarding the peer help, whereas the benefits of the intergenerational exchange were emphasized with the latter.

Practical advice:

Be aware of which interaction effects are favoured and include thoughts about specific target groups in the early planning phase.

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