*sustainability*

MDPI

*Article*

# Depopulation, Ageing, and Social Sustainability: Institutionalized Elderly and the Geography of Care Between Rural and Urban Romania

**Dana Zamfirescu-Mareș and Sorina Corman ***

Faculty of Social Sciences and Humanities, "Lucian Blaga" University of Sibiu, 550024 Sibiu, Romania; dana.mares@ulbsibiu.ro

* Correspondence: sorina.corman@ulbsibiu.ro

## Abstract

Population ageing and rural depopulation are reshaping the social and spatial structure of many European regions, producing new forms of social risk and care dependency. This study examines how institutionalization among older adults reflects the broader dynamics of demographic decline, migration, and uneven territorial development. Using a qualitative design, semi-structured interviews and social network mapping (ecomaps) were conducted with residents of an urban elderly care facility in Romania. Guided by frameworks of social sustainability, social capital, and territorial resilience, the analysis explores how the erosion of informal networks and migration-driven care deficits affects the wellbeing and social inclusion of older people. Findings show that institutionalization operates both a consequence and as an indicator of depopulation and spatial inequality, highlighting the disconnection between aging populations and community-based care infrastructures. Yet, residents develop micro-level forms of resilience and relational stability within institutional life. The study concludes that sustainable territorial development must integrate care and ageing into regional planning, encouraging decentralized, community-based services that rebuild local networks and restore social cohesion.

**Keywords:** social sustainability; depopulation; ageing; social capital; territorial resilience; rural–urban imbalance; care drain; institutionalization

check for updates

Academic Editors: Radu-Dănuț Săgeată and Remus Crețan

Received: 20 October 2025
Revised: 16 November 2025
Accepted: 18 November 2025
Published: 20 November 2025

**Citation:** Zamfirescu-Mareș, D.; Corman, S. Depopulation, Ageing, and Social Sustainability: Institutionalized Elderly and the Geography of Care Between Rural and Urban Romania. *Sustainability* **2025**, *17*, 10419. https://doi.org/10.3390/su172210419

**Copyright:** © 2025 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (https://creativecommons.org/licenses/by/4.0/).

## 1. Introduction

This research directly addresses the social risks and spatial disparities emphasized in the Special Issue on 'Depopulation, Urban–Rural Dynamics and Sustainability.

Population ageing and rural depopulation are two converging demographic processes that are transforming the social and spatial fabric of European societies. Across Central and Eastern Europe, population decline has been driven by persistently low fertility, large-scale youth migration, and uneven regional development, leading to shrinking rural communities and growing social disparities [1–3]. These demographic shifts have deepened existing inequalities between dynamic urban centers and peripheral rural areas, revealing new forms of vulnerability and spatial injustice. These processes reshape social relations, care patterns, and community resilience, far beyond demographic or economic indicators [4–6].

In this context, the situation of institutionalized older adults offers a revealing lens through which to observe the combined effects of depopulation and ageing. Their dependence on formal care systems often mirrors the disintegration of traditional family

networks and the erosion of informal social support. Studies show that when younger adults migrate, elderly parents are left behind, often isolated and with limited access to essential services [7–13]. The decline of informal care networks, often conceptualized as a "care drain" [14], exemplifies the broader consequences of demographic transition for social cohesion. Yet the extent to which institutional care can substitute community-based care remains an open and contested question [14,15].

Research on social networks and ageing provides valuable insights into these processes. Convoy theory and socioemotional selectivity explain that ageing reduces network size but increases emotional depth, offering crucial support [8,9]. Strong networks enhance wellbeing and autonomy, while the loss of family or community ties increases vulnerability to loneliness and institutional dependency [10–12]. However, in depopulated rural areas, these protective networks are particularly fragile. Migration, declining local services, and the collapse of community life accelerate social isolation and the risk of institutionalization [13,14].

At the same time, debates on social sustainability emphasize that sustainable development must include the reproduction of social quality—participation, inclusion, and care—alongside its economic and environmental dimensions [1,2,4]. When welfare and care infrastructures become spatially uneven, sustainability itself is compromised. Scholars have argued that social sustainability depends on maintaining the relational infrastructures that sustain everyday life, especially for vulnerable populations [3,5,16]. Territorial resilience theory extends this argument by linking demographic stress to the adaptive capacity of communities and regions [15–17]. Still, resilience is unevenly distributed: depopulated territories often lack the institutional and human resources needed to sustain ageing populations, which deepens regional divides [16–18].

European assessments show that long-term care systems are under increasing pressure due to population ageing, labour shortages, and uneven territorial development, with rural regions facing the most acute service gaps [19]. According to recent demographic reports, Europe is experiencing a steady population decline and rapid ageing. Between 2010 and 2023, the EU population increased marginally from 501 million to 448 million, but the proportion of adults aged 65 and over rose from 17.4% to 21.3% [20]. The share of people aged 80+ is projected to double by 2050, reaching nearly 14% of the EU's total population [21].

Romania exemplifies these continental dynamics: its total population fell from 21.5 million in 2000 to 19.0 million in 2024, marking one of the steepest declines in the EU [20]. The old-age dependency ratio increased from 19.8% in 2000 to 33.2% in 2023, while more than one quarter of rural communes now have populations over 30% aged 65 or above [22]. These demographic trends illustrate the territorial imbalance between ageing rural areas and more dynamic urban centers, shaping the demand for care and the sustainability of social systems. These demographic indicators showing population decline and ageing trends are detailed in Table 1 below.

In Romania, these patterns are particularly visible. Since 1990, the country has experienced one of the steepest population declines in Europe, losing nearly one fifth of its inhabitants. Rural areas have been disproportionately affected, while urban centers have absorbed most economic growth and public services. The resulting concentration of elderly care facilities in a limited number of urban hubs illustrates how welfare provision follows patterns of urbanization rather than actual social need, thereby perpetuating territorial asymmetry [15,16]. Institutionalization thus emerges as both a consequence and an indicator of spatial inequality, translating demographic imbalance into everyday social experience.

**Table 1.** Key demographic indicators showing population decline and ageing trends in Romania and the European Union (2000–2024) [20–22].

| Indicator | Romania (2000) | Romania (2024) | EU Average (2024) | Source |
|---|---|---|---|---|
| Total population (millions) | 21.5 | 19.0 | 448 (EU total) | Eurostat, *demo_pjan* https://ec.europa.eu/eurostat/databrowser/view/demo_pjan/default/table (accessed on 30 January 2025) |
| Old-age dependency ratio (65+/15–64, %) | 19.8 | 33.2 | 33.5 | Eurostat, *demo_pjanind* |
| Share of population aged 65+ (%) | 13.9 | 21.4 | 21.3 | Eurostat, *demo_pjanind* |
| Population aged 80+ (%) | 3.4 | 6.5 | 7.3 | UN DESA, *World Population Prospects 2024* |
| Urban population (%) | 52.8 | 54.5 | 75.1 | Eurostat, *urb_cpop1* |
| Rural communes with >30% population aged 65+ (%) | 10.3 | 26.7 | — | Romanian National Institute of Statistics (INS), *Tempo Online POP107A* |

This research is designed as a qualitative case study focused on a single long-term care institution. This study explores how institutionalized ageing reflects the interplay between depopulation, migration, and social sustainability in Romania. By linking the micro-social dimensions of care and relational networks to macro-level territorial processes, it contributes to understanding how demographic decline and spatial inequality challenge social sustainability in Central and Eastern Europe. The research focuses on the lived experiences and social networks of institutionalized older adults in a region affected by rural–urban disparities, viewing their trajectories as indicators of broader demographic and spatial transformations. Through a qualitative approach grounded in the theories of social capital, social sustainability, and territorial resilience [6,14–18], the study seeks to uncover how social ties are maintained, reshaped, or lost within institutional contexts. In doing so, it situates institutional care at the intersection of demographic change, spatial justice, and sustainable territorial development—issues that stand at the core of the current debates on the future of Europe's ageing and depopulating regions.

## 2. Literature Review

### *2.1. Social Networks, Ageing, and Social Risk*

Research consistently shows that ageing and social connectivity are deeply interlinked. The quality and stability of older adults' social networks play a crucial role in determining their wellbeing, autonomy, and inclusion [8–10]. According to the convoy theory and socioemotional selectivity theory, as people age, their social circles tend to contract but become emotionally richer, concentrating on close family and trusted peers [8,9]. These ties provide both emotional and instrumental support, buffering the negative effects of ageing and enhancing psychological resilience. Conversely, the reduction or loss of these networks has been associated with poorer health, loneliness, and increased risk of institutionalization [9,10,12].

Empirical studies indicate that structural and contextual factors—such as living arrangements, education, gender, and mobility—shape the configuration of social networks in old age. Older individuals living alone, with limited mobility, or in depopulated rural areas are more likely to experience social isolation [10–12]. In contrast, married individuals, those with strong family relationships, and those active in community or religious organizations tend to maintain larger and more diverse networks [11–13]. The availability of family caregivers remains the strongest predictor of ageing in place [7,8]. However, under conditions of migration and demographic decline, this protective function weakens, leading to what researchers describe as a "relational deficit" in community life.

### *2.2. Depopulation, Migration, and the Erosion of Informal Care*

Rural depopulation and sustained out-migration of working-age adults define many Central and Eastern European societies. These processes, often accelerated by economic restructuring and labor mobility, have resulted in extensive demographic shrinkage and a transformation of local social systems [14–16]. One major outcome is the weakening of intergenerational care. As younger cohorts migrate to urban centers or abroad, elderly parents are increasingly left behind, with reduced family support and limited access to public services [14]. This has led to what researchers term a "care drain" [15]. The concept of "care drain" refers to the out-migration of younger adults—especially women—whose departure reduces the availability of traditional family caregivers and disrupts long-standing intergenerational support systems [15]. Originally associated with transnational care chains, the notion has particular relevance in the Romanian context, where large-scale labour migration over the past two decades has created significant gaps in family-based care provision. This process weakens informal networks, increases the emotional and practical burden on the older population left behind, and contributes to rising dependence on institutional forms of care. Yeates [15] describes this dynamic as part of a broader "care drain," a process through which the mobility of caregivers—especially women—creates transnational and intranational gaps in care provision.

In rural Romania, this phenomenon manifests locally through the collapse of family-based care networks and the emergence of fragile, community-dependent support structures. Remittances may ease financial strain, but cannot replace daily emotional or physical care. Studies suggest that community resilience can sometimes fill part of this gap, with neighbors or civil organizations stepping in to support vulnerable elders [17,18]. Yet, such adaptive responses are uneven and dependent on the presence of local resources, civic engagement, and institutional capacity [16]. Where these elements are missing, institutional care becomes the ultimate safety net, even when elders would prefer to age within their communities [13,17].

### *2.3. Institutional Care and Social Sustainability*

Institutionalization has an ambivalent role: it ensures safety for those without informal support but also reflects structural social and territorial failures [13,18]. The expansion of residential care centers can be seen both as a sign of modernization and as evidence of the disintegration of traditional solidarity networks. While institutions can offer professional services, they may also contribute to feelings of disempowerment and social detachment. The quality of institutional life depends not only on staff competence but also on opportunities for autonomy, social participation, and connection with the external community [11,23]. Contemporary analyses of care systems emphasize that long-term care must be redesigned through socially just, community-based, and territorially sensitive approaches, especially in contexts marked by depopulation and migration [24].

From a sustainability perspective, institutionalization raises questions about social inclusion and equity. Littig and Griessler [1] argue that social sustainability depends on maintaining participation and justice across generations, while Vallance et al. [2] emphasize the importance of "maintenance sustainability," which protects community cohesion and care relationships. If older people are separated from their communities due to spatial disparities in services, social sustainability is undermined [3–5]. This view is supported by theories of social capital [6–8], which frame networks of trust and reciprocity as the micro-foundations of sustainable social systems. The weakening of these networks, whether through migration, poverty, or demographic ageing, directly challenges social resilience and wellbeing. Recent theoretical advances stress that social sustainability requires not only meeting basic needs, but also strengthening trust, equity, and relational capabilities within communities [25].

### *2.4. Territorial Resilience and the Geography of Care*

Territorial resilience theory provides an essential framework for understanding how communities adapt to demographic and economic pressures [15–17]. Resilience, in this context, refers not only to recovery after shocks but also to the ability of territories to sustain social reproduction, care, and wellbeing under long-term structural stress [16,23]. However, resilience is unevenly distributed. Depopulated rural areas tend to lose both human and institutional resources, leading to a spatial concentration of services in urban centers and an increasing dependence of rural populations on distant infrastructures [15,16]. This dynamic creates a care geography characterized by centralization, inequality, and declining social cohesion.

In Romania, this pattern is visible in the clustering of elderly care facilities in a few major urban centers, leaving many rural areas without access to adequate services. Such territorial imbalances reflect broader processes of spatial injustice, in which the benefits of development are unevenly distributed [15,16]. Addressing these disparities requires policies that treat care infrastructures as integral components of regional development, not as peripheral welfare concerns.

### *2.5. Synthesis and Research Gap*

The reviewed literature reveals three key insights. First, demographic ageing and depopulation are mutually reinforcing processes that erode informal care networks and deepen territorial inequalities [13–16]. Second, social sustainability depends on the capacity of societies to sustain relational infrastructures of care and inclusion [1–5]. Third, the territorial distribution of services determines not only access to welfare but also the emotional geography of ageing—who receives care, where, and under what conditions [15–17]. Despite growing awareness of these links, few studies have empirically examined how institutionalized elders experience and reconstruct their social networks within these dynamics. Although existing studies have examined social networks in later life [6,11–13], the impacts of migration-driven care deficits [15], and territorial inequalities affecting ageing [16,17], very few have empirically analysed how institutionalized older adults experience and reconstruct their social networks within these demographic and spatial dynamics.

The present research addresses this gap by exploring the social networks of institutionalized older adults in Romania through a qualitative, relational, and territorial lens. By connecting the micro-social dimensions of ageing to macro-level processes of depopulation and spatial inequality, it contributes to the ongoing debate on how to achieve socially and territorially sustainable care systems.

## 3. Theoretical Framework

This study builds on an interdisciplinary theoretical foundation connecting the concepts of social sustainability, social capital and ageing networks, and territorial resilience, aiming to explain how demographic and spatial transformations affect the social reproduction of care and wellbeing. These frameworks together illuminate the link between individual trajectories of ageing, community dynamics, and the structural evolution of territories under depopulation and migration pressure.

### *3.1. Social Sustainability and the Reproduction of Social Quality*

Social sustainability has evolved from a marginal concept within the sustainability triad to a core analytical lens for understanding how societies reproduce themselves ethically and relationally over time [1–5]. Littig and Griessler [1] define it as the capacity of societies to reproduce human and social capital through inclusion, participation, and justice. Vallance et al. [2] refine this approach by distinguishing between *developmental*, *bridging*, and *maintenance* social sustainability, emphasizing the preservation of everyday social relations, trust, and care. Recent international research on age-friendly cities and communities highlights the need to strengthen social participation, intergenerational connection, and relational infrastructures to support ageing populations [26]. From a wider European perspective, community-based care practices can also be understood through the lens of transformative social innovation, which positions relational well-being and collective agency as core elements of sustainable territorial development [27].

More recent scholarship links social sustainability to the dynamics of risk and vulnerability, arguing that sustainability is achieved not only through material security but through the maintenance of relational infrastructures—networks of support and belonging that sustain life under uncertainty [3,4,16]. From this perspective, ageing populations test the ethical and institutional capacity of societies to sustain dignity, reciprocity, and care amid demographic decline. When care systems fail to provide equitable access or exclude certain territories, the social dimension of sustainability collapses.

### *3.2. Social Capital and the Relational Foundations of Ageing*

The concept of social capital connects macro-level sustainability with micro-level social interaction [6–8]. Following Bourdieu [6], Coleman [7], and Putnam [6], social capital refers to the resources embedded within networks of relationships that facilitate cooperation, trust, and mutual aid. In the context of ageing, these networks embody what Kahn and Antonucci [8] conceptualize as a *convoy of social relations*—a dynamic, lifelong structure of close and peripheral ties that provide emotional and practical support. Carstensen et al. [9] further demonstrate that social selectivity in later life enhances the emotional depth of relationships while reducing their number.

Empirical evidence confirms that dense and diverse networks improve quality of life, health outcomes, and social integration among older adults [10–13]. Conversely, the loss of ties through widowhood, declining mobility, or migration increases the risk of isolation and institutional dependency. Within shrinking rural communities, this dynamic is exacerbated by demographic ageing and youth emigration, which reduce the pool of potential caregivers and weaken the local ecology of care [14]. Social capital thus represents the micro-foundation of resilience and sustainability, transforming territorial and policy frameworks into lived experiences of inclusion or exclusion.

### *3.3. Territorial Resilience and the Uneven Geography of Care*

At the meso and macro levels, the concept of territorial resilience has become central to debates on how localities adapt to demographic stress, economic restructuring, and

social change [15–17]. Extending ecological and economic theories [23], territorial resilience emphasizes the capacity of communities and regions to absorb shocks and reorganize while maintaining essential functions and social cohesion [15,16]. In depopulated regions, however, resilience is often uneven and fragile. The out-migration of younger cohorts and the erosion of human capital undermine both care infrastructures and institutional capacity.

Scholars such as Davoudi [16] and Drobniak [17] argue that resilience must be understood not as self-sufficiency but as relational interdependence—the ability of territories to sustain wellbeing through multi-scalar and cross-sectoral cooperation. This perspective shifts the focus from adaptation to transformation: sustainable resilience entails not simply surviving demographic change but redefining the ways in which communities organize care, participation, and solidarity across space [17,18]. The concept of *territorial resilience* thus provides a bridge between sustainability studies and spatial justice, highlighting how demographic imbalance becomes a structural issue of development policy.

### *3.4. Integrative Model: Ageing, Care, and Territorial Sustainability*

Synthesizing these strands, the theoretical framework conceptualizes ageing as a relational, spatial, and ethical process. Social sustainability offers the normative dimension, emphasizing justice, inclusion, and the reproduction of social quality [1–4]; social capital explains the micro-relational mechanisms—trust, reciprocity, and care—that sustain wellbeing [6–10]; and territorial resilience captures the adaptive capacity of communities and regions facing demographic and social stress [15–17].

Together, these perspectives form a relational–territorial model of ageing sustainability. Depopulation and migration erode the relational infrastructures that underpin care, transforming the geography of wellbeing and exposing the uneven distribution of social risk. Institutionalization, in this sense, is not merely a welfare outcome but a spatial symptom of these transformations—a point where demographic, territorial, and ethical dimensions converge. By integrating these theoretical lenses, this study provides a comprehensive framework for analysing how population ageing interacts with spatial inequality and how sustainable territorial policies can strengthen the social foundations of care.

## 4. Materials and Methods

### *4.1. Research Design and Context*

This study employed a qualitative, exploratory design aimed at understanding the social networks and lived experiences of institutionalized older adults in the context of demographic decline and territorial imbalance. Qualitative methods were chosen for their capacity to capture the subjective meanings, relational patterns, and contextual nuances of ageing and care. The research was conducted in a residential care facility located in an urban center in Romania, within a region experiencing pronounced rural depopulation and migration-driven demographic change. The selected site provided a critical case for exploring how institutionalization reflects the disintegration of community-based care systems and the centralization of welfare services.

### *4.2. Participants and Sampling*

The study involved ten institutionalized elderly residents (six women and four men), aged between 68 and 87 years. Participants originated from both rural (n = 6) and urban (n = 5) areas. In terms of educational background, four participants had completed vocational school, two had completed general upper-secondary education (high school), two had completed pedagogical education, and two had completed only lower-secondary education (gymnasium). The average duration of residence in the care institution was 8.2 years. All participants were retired, having previously worked mainly in agriculture

and manual labor, alongside education, pharmacy, technical drafting, and personal care services. Participants' socio-demographic characteristics (age, gender, marital status, area of residence, length of institutional stay, education, and former occupation) are summarized in Table 2. Each participant was assigned a unique anonymized code (P1–P10), which is used throughout the analysis.

**Table 2.** Summary of participants' anonymized codes and socio-demographic characteristics.

| Subject Code | Gender | Age (Years) | Marital Status | Area of Residence | Length of Stay (Years) | Education | Former Occupation |
|---|---|---|---|---|---|---|---|
| P1 | Male | 68 | Single | Rural | 7 | Gymnasium | Farmer |
| P2 | Male | 70 | Divorced | Rural | 1 | Vocational School | Factory worker |
| P3 | Male | 70 | Divorced | Urban | 17 | High school | Factory worker and Driver |
| P4 | Male | 77 | Divorced | Rural | 3 | Gymnasium | Farmer |
| P5 | Female | 79 | Widow | Urban | 15 | Vocational School | Assistant pharmacist |
| P6 | Female | 82 | Divorced | Urban | 15 | Pedagogical Institute | Teacher |
| P7 | Female | 83 | Widow | Urban | 1 | High school | Manicurist/ pedicurist |
| P8 | Female | 83 | Single | Rural | 9 | Vocational School | Farmer |
| P9 | Female | 85 | Divorced | Rural | 12 | Pedagogical Institute | Teacher |
| P10 | Female | 87 | Widow | Rural | 2 | Vocational School | Technical drafting |

Participants were selected through purposive sampling, ensuring diversity in gender, marital status, length of institutional residence, and rural or urban origin. All participants were cognitively capable of providing informed consent and were able to articulate their experiences and social relationships. Participation was voluntary, and respondents could withdraw at any point without consequences. The small but information-rich sample allowed for analytical depth and the identification of recurring social and emotional patterns across cases rather than statistical generalization [28,29]. Inclusion criteria were age over 65, preserved cognitive capacity, and at least one year of residence in the institution. Validity was supported through methodological triangulation (interviews + observations), iterative coding, and peer-debriefing between the authors.

While the primary sample included only residents, informal contextual discussions with staff were conducted to better understand the institutional routines and care environment. These were not recorded or coded as data, but informed the interpretation of residents' experiences.

### *4.3. Data Collection*

Data collection was carried out between March and May 2023. It combined two complementary methods: 1. Semi-structured interviews, focused on participants' life histories, perceptions of social support, and experiences within the institution. Interviews lasted between 45 and 90 min, were audio-recorded with consent, and subsequently transcribed verbatim; 2. Ecomaps, a visual social-network tool used to map the participants' formal and informal relationships (family, friends, staff, community ties) and to assess the strength and

direction of these connections. The use of ecomaps allowed the identification of structural and emotional dimensions of support and exclusion in later life.

### 4.4. Data Analysis

Data was analyzed using thematic content analysis [28], assisted by the software NVivo (QSR International, Version 12 Plus). The analysis followed three iterative phases: (1) open coding and identification of recurrent themes; (2) grouping of codes into conceptual categories (e.g., loss of family networks, adaptation to institutional life, emotional resilience); and (3) synthesis of findings into analytical dimensions reflecting social sustainability and territorial context. Coding reliability was ensured through double-checking by both authors and iterative discussion of category definitions until consensus was reached.

To ensure narrative depth and transparency, participants' statements were presented verbatim, preserving their original wording except for minor grammatical adjustments to improve readability. The selection of quotations followed two criteria: representativeness of the identified themes and diversity of participant experiences. Short and long excerpts were integrated throughout the Results section to illustrate key patterns related to social isolation, adaptation, emotional sustainability, and institutional resilience. This approach aligns with qualitative research standards, emphasizing the authenticity of participants' voices as central evidence in thematic interpretation.

### 4.5. Ethical Considerations

The research was conducted with full respect for ethical principles of integrity, confidentiality, and voluntary participation. All participants were informed about the study's objectives, procedures, and their right to decline or withdraw at any time without consequences. Prior to each interview, written informed consent was obtained, ensuring that participation was entirely voluntary. Personal data were anonymized, and no identifying information was included in transcripts or publications. Audio recordings and transcripts were securely stored and used solely for research purposes. The study followed established ethical standards for qualitative research involving human participants, with particular attention to protecting the dignity and autonomy of older adults.

### 4.6. Research Integrity

The use of NVivo software for qualitative coding and data management ensured systematic and transparent analysis. All materials and anonymized data supporting the findings of this study are available upon reasonable request from the corresponding author, in accordance with ethical and privacy considerations.

## 5. Results

### 5.1. Institutionalization as a Reflection of Demographic and Territorial Change

The research reveals that institutionalization among older adults reflects not only individual vulnerability but also the structural effects of demographic ageing, migration, and territorial depopulation. Most participants originated from rural or semi-rural localities experiencing population decline, out-migration, and the erosion of family and community structures. For many, institutionalization occurred only after the collapse of informal care networks, when family support was no longer available.

Participants frequently associated their relocation with the absence of younger generations in their home villages. Many described how the departure of children or close relatives left them without support, leading to their move into institutional care. For example, one participant shared, "After my children left for Italy, there was no one to help me. The neighbors are all old; some can't walk. When I fell, they brought me here" (P2).

Another explained, "I have a son, he is in France. We only talk on the phone on Sundays" (P6). The emotional impact of separation is also evident in the words of a widow: "I am a widow, without children, but I have a nephew in England. I stayed with him there for a while, then I came here. Elderly people, just like children, need their own slice of space" (P8). Similarly, another participant reflected on profound loneliness: "I came together with my husband. He died at 88 years old. I am also an orphan of children, that's what I always say. My children are gone. My siblings are gone. I have no one left here" (P10).

Not only did the departure of children lead to institutionalization, but also the aging of the family itself. For participants without children, the aging or death of family members, as well as the lack of services in rural areas, contributed to their move to a care center for the elderly. For example, P1 shares that he has been in the institution for 7 years and came at the recommendation of his brother-in-law, who is also elderly: "Where I lived before, outside this city, I lived with my mother, my sister, and my brother-in-law. In the meantime, my mother died. Nine months later, my sister also died. I was left alone. I had nowhere to go in my village, so I came here".

Such narratives point to an increasingly common demographic trajectory in which ageing in rural contexts becomes unsustainable without external intervention. The transfer to an urban institution thus embodies both the outcome and evidence of territorial inequality. Residents' life stories reveal how macro-level processes—migration, rural decline, and welfare centralization—materialize in personal experiences of dislocation, dependency, and adaptation.

From a spatial perspective, the institution functions as a node in a regional care network that compensates for the disappearance of local infrastructures. The rising number of residents from rural areas shows a shift from family care to centralized institutional provision, redefining the geography of care.

This finding reflects the *territorial imbalance* and *spatial centralization of welfare* processes described by Davoudi [16] and Drobniak [17], where resilience becomes unevenly distributed between urban and rural systems.

### *5.2. The Structure and Dynamics of Social Networks Within Institutional Settings*

Analysis of ecomaps and interviews identified three major network typologies among residents, based on the density and diversity of their interpersonal relationships: 1. Integrative networks, characterized by active engagement with peers, caregivers, and occasional family contacts; 2. Fragmented networks, dominated by asymmetrical relationships with staff and minimal peer interaction; 3. Hybrid networks, combining sporadic family communication (often digital) with emotional attachment to select peers within the institution. To exemplify these results, we have created Table 3, which presents data regarding the typology of the network (integrative, fragmented, and hybrid), the main relationship types, and examples from the participants' networks.

**Table 3.** Types of social networks identified among participants and main relationship types.

| Network Typology | Main Relationship Types | Examples |
| --- | --- | --- |
| Integrative | Peers, staff/caregivers, family, some community ties. | Daily contact with staff/peers; weekly calls or visits with family; occasional community interaction (e.g., P1, P2, P4). |
| Fragmented | Staff/caregivers (asymmetrical), few peers/family. | Daily contact mainly with staff; rare or no family/peer/community contact (e.g., P6, P7, P9). |
| Hybrid | Family (remote), select peers, occasional community. | Weekly calls with family; close peer friendships; occasional community contact (e.g., P3, P5, P8, P10). |

These typologies indicate differentiated trajectories of adaptation. Residents embedded in integrative networks reported higher levels of emotional stability and satisfaction, often describing the institution as a "second home": "I used to meet friends around town, and I was embarrassed to tell them where I was. Well, I've gotten used to it here to the point that I feel like I wouldn't leave anymore. I mean, that's how I feel..." (P3). Conversely, those with fragmented networks expressed loneliness and resignation, perceiving institutional life as routine survival rather than meaningful engagement.

Peer interaction and staff empathy emerged as key mediators of wellbeing. Residents who maintained trust-based relationships with caregivers experienced institutional life as dignified and humane. Yet, the predominance of professional over familial ties illustrates the replacement of kinship-based support with institutional dependence, raising questions about the relational sustainability of formal care systems.

To reinforce the idea that interaction with the staff and other beneficiaries within the center strengthens the sense of belonging and appreciation, we have examples where interview participants related how being entrusted with certain tasks makes them feel valued and respected. For example, P4 shared: "I take care of the floor and everyone; if someone falls, they call me: 'Come, Mr. B., someone fell!' The director trusts me". This reflects a relationship built on trust and recognition. Similarly, the perception of staff kindness is highlighted by P10: "The staff is top-notch. All of them". Emotional support from specialists further enhances wellbeing. P10 recounted a moment of empathy from the psychologist: "I told Mr. A. [the psychologist], and he said: 'Tonight at 7, I'll come and take you.' We went together, saw the lights, and it lifted my spirits. It was beautiful". For some, staff members become surrogate family figures. P2 described: "I talk to Mr. A. as if we were brothers!". Staff are often the first point of contact in times of need, as P3 explained: "When I have a major problem in the home, I go to the director first". Peer relationships also play a crucial role. Daily interactions with roommates and participation in group activities contribute to a peaceful and supportive environment. P3 noted: "I talk most often with my roommates; there are three of us in the room, and we have similar discussions". Similarly, P1 said he gets along "very well" with his roommate. Peaceful coexistence is valued, as P7 described: "I get along perfectly with my roommates; they're like holy water. They sleep all day and don't disturb me in my craziness." However, the predominance of professional ties over familial ones highlights a significant shift in the support system for elderly residents. Many choose institutional care to avoid burdening their families, citing logistical and emotional reasons. P9 explained her motivation: "I didn't have children to weigh you down. How could I go, it's shameful? Here, I don't bother anyone". Institutionalization often relieves relatives of daily caregiving tasks. P1 moved to the home after his sister's death, as his brother-in-law "had to cook for everyone," and living in the home eliminated this pressure. Residents also contribute within the community, strengthening internal networks. P4 helps with laundry, and P1 does shopping for others, being seen as "such a trustworthy person" by the office staff. For those with limited mobility, staff become central. P2 shared: "I interact most with the people here, with the employees. The nurses help me change and get out of bed".

Emotional self-protection often leads to reduced family contact. P9 said: "I don't even like to talk, because if I talk about them, I get so sad I'm not good for three days. I had to get them used to calling less often". Many residents maintain family ties at a distance, often through phone or video calls. P10 shared: "I talk to my children all day on Messenger, but I want to touch you... I see you but can't even give you a slap".

This shift illustrates the transformation from bondingto bridging social capitaldiscussed by Putnam [6] and Coleman [7], showing how the structure of interpersonal trust changes in late life within institutional settings.

### *5.3. Social Risks and Protective Mechanisms*

Across participants, three categories of social risk were consistently observed: Isolation through spatial displacement, resulting from family migration and rural depopulation; Health deterioration and reduced mobility, limiting social participation; Economic insecurity, constraining access to additional services or private care.

These risks were not merely personal but reflected structural inequalities within the territorial system. Participants' vulnerability was often exacerbated by geographical distance from families, who could offer only symbolic or financial assistance from abroad. Although children are often away, contact is maintained—yet limited to digital communication or rare visits, with support frequently taking a financial form. For example, P3 is visited by his daughter, while his son in Germany calls him "on the phone, asking how I am, especially during the holidays and such. And when he comes to the country, of course he visits me". At the same time, P3 reassures his son: "Son, I have everything I need here", suggesting he does not require additional financial support. For others, assistance is primarily instrumental. P2 receives money from his nephew, who also helps with practical needs: "He sent me two or three pairs [of trousers]".

However, several protective mechanisms counterbalanced these vulnerabilities: emotional support from staff, peer companionship, involvement in collective activities, and the existence of religious or cultural rituals within the institution. These protective elements contributed to what can be conceptualized as micro-level resilience, enabling residents to maintain a sense of purpose despite systemic fragility.

Residents with strong affective ties, either inside or outside the institution, demonstrated greater psychological endurance and adaptability. Many participants demonstrate remarkable psychological resilience, drawing strength from meaningful relationships with staff and peers. For instance, P2 describes his connection with the psychologist as "like brothers," and P10 finds comfort and support in the staff. Adaptation to institutional life is often facilitated by a sense of purpose and belonging. P4 feels valued and trusted, actively contributing to the community: "I'm the most determined there, still strong... the director trusts me". Similarly, P3 shares how he overcame initial embarrassment about his living situation, eventually feeling so settled that he "wouldn't leave anymore". P7 is open to change, embraces life "here and now," and adapts quickly to new circumstances.

In contrast, individuals with minimal or exclusively hierarchical relationships reported decreased self-esteem and a sense of invisibility. For example, P6 relies on staff for basic needs, with little emotional connection, while P2 depends on nurses due to mobility issues. The sense of stagnation is palpable; P3 treats chronic pain "with indifference" and P9 avoids conversations with family to protect herself from sadness, preferring emotional self-isolation. The struggle against perceived uselessness is evident. P9 actively resists the notion that "the synonym for old is useless," advocating for recognition and respect: "Give them confidence that their opinions still matter". P8 avoids telling friends about her residence to escape pity: "I don't like to be pitied... Better not to tell them". Residents' experiences in institutional care reveal a complex interplay between emotional bonds, adaptability, and the challenges of maintaining self-esteem. Social isolation is a recurring theme. P8 notes her social contacts have "diminished" while P7 observes that many residents are "very rigid, very hard to engage, and most often they reject you", describing others as "scared, so withdrawn, isolated". Intellectual isolation is also present, as P10 remarks: "Here you barely have anyone to talk to. There are people with Alzheimer's, dementia". Overall, these narratives highlight that strong emotional bonds and a sense of purpose are crucial for psychological resilience and positive adaptation. Conversely, fragmented or hierarchical relationships can erode self-esteem and foster a sense of invisi-

bility, underscoring the importance of nurturing genuine connections and respect within institutional care.

Such structural vulnerabilities correspond to what Littig and Griessler [1] describe as the *erosion of social sustainability*, where care inequalities emerge from broader demographic and policy imbalances.

### *5.4. Emotional Sustainability and Everyday Relational Practices*

The emotional dimension of institutional life proved central to understanding subjective wellbeing and social sustainability. Despite objective limitations, many participants demonstrated a remarkable ability to construct emotional micro-communities through empathy, shared experiences, and small acts of care.

Expressions such as helping immobile peers, sharing food, or providing moral support during illness functioned as symbolic rituals of belonging. These gestures transformed the institution from a purely functional space into a moral and relational environment. As Tronto [23] argues, care is a moral practice that sustains democracy and social justice, extending beyond individual responsibility to collective ethics. Residents' narratives show how this collective ethic of care is co-produced in everyday life. Some assume explicit responsibility for monitoring and protecting others' wellbeing: P4 describes himself as "taking care of the whole floor", being called when someone falls or "something happens", a role acknowledged and trusted by the management. Similarly, P1 is recognized by peers as "a reliable, helpful man" who regularly does the shopping for residents who cannot go out. Care also takes collaborative and generative forms. P9 recalls how a fellow resident with mobility problems helped her gather materials and frames so she could prepare a literary-musical performance for Christmas, an event she associates with a calmer, less conflictual atmosphere in the home. Rituals of mourning further consolidate this moral community: as P3 notes, daily co-presence and good relations create a sense of obligation to "go and light a candle" when someone dies, while memorial services and religious rituals organized with the priest publicly affirm that residents' lives matter. Sharing food and other resources operates as another ritual of belonging. Residents circulate sweets, home-made food, and donated items, transforming individual gifts into shared goods. P4 humorously reports that "it's like a wedding" at his table, as he receives and redistributes food and sometimes money to others "in all respects," reinforcing reciprocity rather than passive dependency. Others contribute through practical services—such as acting as informal "couriers" for documents, medicines, or messages between offices and residents—or by exchanging books, which turns reading into a social rather than solitary activity. Taken together, these micro-practices of reciprocity, vigilance, mourning, and generosity show that residents are not merely recipients of institutional care but active participants in a situated moral order in which "we take care of each other; if someone is sick, we sit by their bed. It's like a family, but quieter" (P8)

Such narratives reveal that even within constrained settings, older adults exercise agency, creativity, and compassion. These micro-ethics of care reflect the "maintenance dimension" of social sustainability, preserving human connection amid social fragmentation.

Nevertheless, the same institutional routines that provide security also generate emotional uniformity: residents' lives follow predictable schedules, and individuality is often subdued. The balance between protection and autonomy thus remains fragile, pointing to the inherent tension between safety and agency in institutional contexts.

This aligns with the *maintenance dimension of social sustainability* proposed by Vallance et al. [2], emphasizing the preservation of empathy, trust, and belonging as integral components of sustainable community life.

Although the study did not aim to compare participants statistically, some differences emerged across coded interviews. For example, women (e.g., P6, P9, P10) tended to emphasize emotional and relational aspects of adaptation, while men (e.g., P1, P3) more often discussed independence and practical coping. Participants from rural backgrounds (e.g., P4, P8, P9) expressed stronger attachment to their former communities, whereas those from urban settings (e.g., P5, P10) highlighted the institutional environment as their main source of social interaction. These contrasts, while not generalizable, illustrate the diversity of individual experiences within the shared institutional context.

### *5.5. Territorial Inequality and the Redistribution of Care*

A key empirical finding concerns the spatial origins of the residents and the territorial concentration of services. Approximately two-thirds of the participants came from rural communities located 30–60 km away from the care facility. Staff interviews confirmed that the center serves as a regional hub, compensating for the absence of local institutions.

This spatial redistribution of care indicates a systemic urban bias in welfare provision. Urban centers, with stronger infrastructure and funding, absorb growing numbers of older adults from peripheral areas. Meanwhile, rural territories—already depopulated—lose both population and caregiving capacity.

Although staff members were not part of the formal sample, several informal observations and background discussions conducted during field visits helped contextualize residents' accounts. These insights were used solely to clarify institutional routines and complement the residents' perspectives, without being included in the coded data. Institutional staff emphasized the growing mismatch between local demographic realities and resource allocation:

"Villages have the people in need, but we have the services. It's not fair, but that's the system."

This situation exemplifies a pattern of spatial injustice, where the geography of care mirrors existing socio-economic disparities. Urban institutions mitigate immediate needs but inadvertently reinforce rural decline, as the continuous flow of elders from villages to cities depletes community resilience.

These findings illustrate that institutionalization operates not only as a social response to ageing but as a spatial process of redistribution, transforming demographic imbalance into geographical dependency.

This pattern exemplifies what Obrist, Pfeiffer, and Henley [18] define as *multi-layered social resilience*, where communities adapt to demographic stress through institutional rather than community-based solutions.

### *5.6. Summary of Empirical Insights*

Overall, the results show a multifaceted link between individual adaptation and structural transformation. Institutionalized elderly people negotiate daily life through strategies of resilience, empathy, and routine, while navigating the consequences of depopulation and spatial inequality.

The data suggest that: (1) Institutionalization is a consequence of demographic decline and welfare centralization; (2) Social networks within institutions are diverse and fluid, influencing wellbeing and adaptation; (3) Emotional resilience operates as a vital coping mechanism sustaining dignity and belonging; (4) Territorial disparities in care infrastructure reinforce both demographic decline and social exclusion.

These empirical insights set the foundation for the subsequent discussion, where the findings are interpreted through the theoretical frameworks of social sustainability, social

capital, and territorial resilience, and positioned within the wider European debate on demographic adaptation.

Overall, the patterns identified across interviews reveal how institutional life is shaped by broader socio-territorial dynamics. The weakening of family-based support networks observed among many participants reflects processes of social capital erosion described by Putnam [6]. Likewise, accounts of diminished intergenerational contact are consistent with the care drain phenomenon discussed by Yeates [15], whereby migration disrupts traditional caregiving structures in rural and small-town settings. At the same time, the ability of residents to cope collectively and recreate micro-communities inside the institution illustrates elements of territorial and social resilience theorized by Davoudi [16] and Obrist et al. [18]. These interpretive connections deepen the analytical understanding of the results and situate individual experiences within larger demographic and spatial transformations. Together, these results highlight that institutionalized ageing is not only a social phenomenon but also a territorial and ethical issue, requiring interpretation across multiple scales—from individual experiences to systemic dynamics of regional development.

## 6. Discussion

### *6.1. Interpreting the Findings Through Theoretical Lenses*

These findings invite a multi-scalar interpretation of ageing, care, and social sustainability. From the individual level of lived experience to the structural dynamics of demographic decline, the results illuminate how personal trajectories are embedded in broader systems of spatial inequality and welfare centralization. This discussion interprets the empirical evidence through the lenses of social sustainability, social capitaland territorial resilience [1–3,6,14–18], situating the Romanian case within the wider European debates on depopulation and social risk. Unlike previous studies focusing primarily on individual resilience, this study emphasizes the relational–spatial dynamics shaping institutional adaptation.

The results confirm that the institutionalization of older adults in Romania cannot be interpreted merely as an outcome of individual or familial circumstances but must be situated within the broader socio-territorial transformations associated with depopulation, migration, and welfare restructuring. This aligns with previous evidence from Central and Eastern Europe showing that the spatial redistribution of care reflects systemic imbalances between urban and rural regions [14–16].

Within the framework of social sustainability, institutionalization emerges as a relational indicatorof the capacity—or incapacity—of territories to reproduce social quality [1–5]. Littig and Griessler [1] emphasize that social sustainability depends on the preservation of everyday relations of reciprocity, belonging, and dignity. The erosion of such relations in depopulated rural areas reveals a deep moral and structural deficit: communities lose not only human resources but also their connective social tissue. The findings illustrate that when intergenerational care systems disintegrate, institutional care becomes the default solution, converting demographic loss into social dependency.

From the perspective of social capital theory, the transition from family-based care to institutional support represents a shift from bondingto bridgingforms of social capital [6–8]. Inside the institution, residents reconstruct partial networks of solidarity and trust—what Antonucci et al. [10] describe as "convoys of care"—but these networks are spatially bounded and emotionally fragile. The institutional microcosm offers safety but limits external social connectivity. These finding echoes Putnam's [6] argument that when civic and familial ties weaken, collective wellbeing deteriorates even if formal structures remain intact.

The application of territorial resilience theory [15–17] deepens this interpretation. The concentration of care facilities in urban centers creates an adaptive yet exclusionary resilience pattern: urban territories absorb the social costs of ageing, while rural areas externalize them. Drobniak [17] and Davoudi [16] argue that true territorial resilience requires not only institutional adaptation but also spatial justice and participatory governance. The data suggest that Romania's current model—urban-centered, reactive, and institution-heavy—maintains basic functionality but undermines long-term sustainability.

In summary, the findings affirm that the social sustainability of ageing depends on multi-level interdependence: individual emotional resilience, community solidarity, and territorial equity must co-exist. When one level collapses, others are overburdened. Institutionalization, in this sense, is not simply a social failure but a spatial signal—a visible symptom of how uneven development reshapes care and belonging.

### *6.2. Implications for Social and Territorial Sustainability*

The results have significant implications for how sustainability is conceptualized and operationalized in social policy and territorial planning. First, they show that care is not merely a welfare function but an infrastructure of social sustainability. When this infrastructure becomes territorially unbalanced—concentrated in cities and absent in rural zones—social inclusion and cohesion deteriorate. This finding supports Vallance et al. [2] and Eizenberg and Jabareen [3], who argue that sustainability must be evaluated through the capacity to maintain daily social relations and collective wellbeing.

Second, the study exposes the territorial paradoxof ageing: policies that expand institutional care in urban areas may appear efficient but simultaneously accelerate rural decline. As Yeates [15] observed in her research on "care chains," the migration of caregivers creates a structural vacuum at the origin, which then triggers further demographic contraction. In Romania, this internal care drain manifests spatially: rural communities "export" their elders to cities while losing both population and vitality.

Addressing this paradox requires integrating care and ageing into regional development strategies. Care infrastructures should be treated as critical territorial assets, comparable to transportation or education networks. Establishing community-based micro-centers, mobile care teams, and digital support systems in depopulated regions could prevent forced relocation and promote "ageing in place." The findings also highlight the potential of inter-municipal cooperation—what Drobniak [17] terms *resilience through networked governance*—to share care responsibilities across localities.

Furthermore, the emergence of emotional sustainability within institutions, manifested in residents' small-scale acts of empathy and mutual aid, suggests that even constrained environments can foster relational resilience. These micro-dynamics of solidarity should inform the design of institutional policies—encouraging participation, autonomy, and external community engagement. In practice, fostering participatory care environments could help re-humanize institutional life and restore older adults' sense of belonging.

These findings resonate with EU cohesion policy objectives, emphasizing the need to integrate demographic foresight into regional planning [30].

### *6.3. Comparative Insights and the European Context*

Placing these findings in a broader European context reveals that Romania's experience is part of a regional pattern of welfare transformation. Central and Eastern European countries share legacies of centralized welfare provision, uneven rural–urban development, and mass out-migration. As Lutz et al. [31] and Drobniak [16] note, demographic ageing in this region interacts with structural economic inequalities, producing a dual challenge: sustaining growth while maintaining social inclusion.

However, comparative research also highlights diversity within this pattern. In countries like Poland or Slovenia, local governments have developed hybrid care models that combine formal and informal elements, strengthening community capacity while reducing reliance on large institutions. These examples demonstrate that social innovation—through volunteer programs, intergenerational projects, or telecare—can transform ageing from a risk into a resource for community resilience.

Romania's challenge is therefore not unique but systemic: aligning its social policy with territorial cohesion objectives under the European Union's sustainability agenda. The European Green Deal and the Cohesion Policy 2021–2027 explicitly link social inclusion with spatial justice, calling for the integration of demographic foresight into regional planning. The results of this study directly contribute to this agenda, emphasizing that demographic adaptation must be conceived as a social and spatial process rather than a purely economic or demographic one.

### *6.4. Theoretical and Methodological Reflections*

The integration of qualitative and relational methods proved essential for capturing the subjective and territorial dimensions of social sustainability. The use of ecomaps alongside in-depth interviews enabled the visualization of social networks as lived structures of care, trust, and dependency. This methodological choice aligns with recent calls for *relational mapping* in ageing research, bridging the gap between individual experience and spatial analysis [8–10,28].

The findings also suggest that sustainability frameworks should adopt a multi-scalar perspective—connecting personal narratives of ageing with community dynamics and regional policy. The relational–territorial model developed in this study provides a conceptual bridge between these levels. By situating institutionalized ageing at the intersection of social capital, social sustainability, and territorial resilience, it demonstrates how demographic and spatial inequalities translate into everyday life.

### *6.5. Opportunities for Future Inquiry*

Future studies can expand these findings in several directions. First, comparative regional research is needed to explore how different governance systems and welfare regimes mediate the relationship between depopulation and care. Such studies could examine contrasts between Central, Southern, and Western Europe, identifying transferable policy innovations.

Second, longitudinal research designs could track how the social networks of institutionalized older adults evolve over time—documenting adaptation, emotional resilience, and potential reintegration into community life.

Third, mixed-method approaches combining qualitative and quantitative social network analysis could provide a more precise measurement of relational density, reciprocity, and geographic mobility among elderly populations.

Finally, there is a need to investigate community-based alternatives to institutional care—such as "age-friendly villages," intergenerational housing models, or digital care platforms—evaluating their effectiveness in sustaining both social and territorial resilience [26,32,33].

Such research would not only advance theoretical understanding but also contribute to evidence-based policy design, ensuring that demographic transitions are addressed as integral components of sustainable development.

### *6.6. Synthesis*

In sum, this discussion highlights that the institutionalization of older adults in Romania embodies the intersection of demographic, social, and territorial transformations.

Institutional care, while essential for survival, symbolizes the territorial inequality of development and the fragility of rural resilience. Yet within these constraints, the persistence of empathy, reciprocity, and micro-level solidarity points to humanity's enduring capacity for adaptation.

Ageing-society sustainability depends on policymakers recognizing care as both a social right and a territorial responsibility. Building sustainable futures thus requires bridging the divide between urban and rural, formal and informal, individual and collective—redefining resilience not as mere endurance, but as the capacity to sustain life, dignity, and connection across space.

## 7. Conclusions

This study examined the interconnections between ageing, depopulation, and social sustainability through the case of institutionalized elderly individuals in Romania, illustrating how demographic and spatial transformations reshape the geography of care. By combining semi-structured interviews and ecomaps, the research explored how older adults reconstruct or lose social networks in institutional settings and how their experiences reflect broader territorial inequalities.

The findings demonstrate that institutionalization operates simultaneously as a consequence and indicator of demographic decline. It translates macro-level processes—migration, rural depopulation, and welfare centralization—into personal experiences of dependency and relocation. Most participants originated from rural areas affected by the erosion of informal care systems, revealing how family fragmentation and spatial distance transform care from a community-based practice into a centralized institutional service. These dynamics confirm that demographic ageing in contexts of uneven development generates not only economic but also relational and territorial risks.

At the same time, the study shows that institutional life is not merely passive or dehumanizing. Residents display significant micro-level resilience, forming new emotional ties, practicing reciprocity, and creating small-scale communities of support within constrained environments. These relational practices represent the "maintenance" dimension of social sustainability, sustaining dignity and belonging even amid structural fragility. However, the overreliance on institutional care also reinforces spatial inequality, concentrating resources in urban centers while rural communities continue to lose both population and caregiving capacity.

From a policy perspective, these findings underscore the necessity of integrating ageing and care into regional and territorial planning. Sustainable development requires recognizing care infrastructures as essential components of territorial resilience—equally vital as transport or education systems. Developing decentralized, community-based services, investing in local human resources, and fostering inter-municipal cooperation could reduce forced migration of elders and preserve the social fabric of rural areas.

Conceptually, the study contributes to bridging the fields of social sustainability, social capital, and territorial resilience, proposing a relational–territorial model of ageing that connects individual experiences with structural transformations. Methodologically, it demonstrates the analytical potential of combining qualitative interviews with social-network mapping for exploring ageing and care in spatially diverse contexts.

The study highlights that addressing depopulation and ageing requires integrating social care, territorial planning, and sustainability policies—a core challenge for Europe's future demographic landscape

## 8. Policy Recommendations

The results of this study underline the urgent need to integrate demographic and social sustainability into the broader frameworks of territorial and regional development policies. In the context of depopulation, ageing, and persistent rural–urban disparities, the sustainability of communities depends not only on economic revitalization but also on the renewal of social infrastructures that sustain care, belonging, and participation. Policies must therefore transcend sectoral boundaries and recognize care as a strategic pillar of territorial resilience.

A coherent policy response requires that ageing and wellbeing become explicit priorities in regional and spatial governance. Territorial planning should not treat social services as residual elements, but as core components of sustainable development. Urban and regional strategies need to be redesigned so that ageing populations are understood as agents of social continuity rather than as passive recipients of welfare. This involves integrating the spatial distribution of care institutions, housing for the elderly, and community-based support systems into the logic of spatial planning. Strengthening small and medium-sized towns as nodes of proximity care could reduce forced mobility and sustain the right to age in place.

At the same time, the decentralization of care infrastructures is fundamental. Concentrating long-term care services in urban centers generates territorial dependency and social fragmentation. Policies should therefore encourage the creation of small-scale, locally managed facilities in rural and semi-rural communities, supported by inter-municipal cooperation and regional funding mechanisms. Decentralization must, however, be accompanied by professional training, capacity building, and digital support to ensure that local care provision meets qualitative standards.

Social innovation represents another key direction for enhancing sustainability. Community-based initiatives, intergenerational programs, and volunteer networks can revitalize the social fabric of depopulated regions, transforming care from a professionalized service into a shared civic practice. Supporting informal caregivers through training, respite care, and financial compensation can strengthen the hidden social economy of care, which continues to play a critical role in rural and peri-urban areas. Digital inclusion policies—particularly access to telemedicine, online communication tools, and remote participation platforms—should complement these efforts by reducing isolation and fostering connectivity between generations.

The integration of territorial "care hubs"—centers that combine social services, healthcare, mobility, and cultural participation—would promote a holistic approach to wellbeing. Such hubs could act as multifunctional spaces that bridge the gap between formal and informal care, enabling older adults to remain active within their communities. Similarly, investments in mobility infrastructure—accessible transport, walkable spaces, and digital mobility—are essential for maintaining participation and autonomy among older citizens in sparsely populated regions.

Equally important is the promotion of participatory governance in the design, implementation, and evaluation of care systems. Sustainable solutions cannot be imposed from above; they must emerge from dialogue among local authorities, residents, NGOs, and universities. Collaborative governance not only improves the quality of services but also restores the democratic legitimacy of territorial development. Universities and research centers should be involved in co-designing pilot models of community care and in monitoring their social impact.

Finally, demographic foresight must be embedded in spatial and social planning. Territorial strategies need to anticipate population decline, changes in age structure, and migration flows, adjusting housing policies, mobility systems, and service accessibility

accordingly. Data-driven regional planning—supported by social indicators of inclusion, isolation, and wellbeing—can help identify priority zones for intervention and prevent further marginalization of rural territories.

Altogether, these recommendations aim to reframe care not as a cost but as an investment in social cohesion and territorial sustainability. By recognizing the social infrastructure of ageing as a driver of innovation, solidarity, and resilience, policymakers can transform depopulation from a narrative of decline into a laboratory for sustainable territorial regeneration.

## 9. Limitations and Future Research Directions

Although this study provides a complex and multidimensional exploration of the relationships between ageing, depopulation, and social sustainability, several limitations should be acknowledged. Given the small sample size and the single-institution design, the transferability of the findings is inherently limited. These results should be interpreted as context-bound insights rather than generalizable outcomes. Future research should include comparative studies across institutions and regions to expand the analytical scope. These constraints are not weaknesses in themselves but reflect the empirical boundaries of the research design and indicate fertile directions for the continued development of this interdisciplinary field.

A primary limitation arises from the contextual and territorial scope of the study. The research was carried out in a single residential care institution located in an urban center, which, while situated within a depopulating region, represents a specific socio-spatial configuration. Consequently, the experiences and patterns observed here cannot be automatically generalized to other contexts—particularly those of rural isolation, peri-urban expansion, or metropolitan restructuring. Institutional and community care systems across Europe vary greatly depending on welfare models, governance capacities, and demographic pressures. Future comparative studies should therefore examine diverse territorial and policy environments to assess how structural differences mediate the relational and emotional dimensions of ageing.

A second limitation concerns the sample composition and methodological depth. The qualitative approach, based on ten interviews and corresponding social network maps, prioritizes depth of understanding over representativeness. However, this limited number of cases may not capture the full diversity of the institutionalized elderly population, particularly regarding gender, social class, ethnicity, and rural–urban origin—all factors that profoundly influence vulnerability, identity, and patterns of care. Expanding future research to include more varied participants, as well as professionals and family members, would enable a multi-actor perspective and illuminate the dynamics of interdependence between institutional actors and external networks.

The temporal dimension of the study also constitutes a methodological limitation. Conducted over a defined period, the research offers a cross-sectional image of institutional life rather than a longitudinal understanding of adaptation and change. Social networks, emotional resilience, and perceptions of belonging evolve over time, influenced by health, loss, and new relationships. Future longitudinal and ethnographic studies could trace these dynamics across the stages of institutionalization—from entry and adjustment to long-term integration—thus enriching our understanding of how resilience and sustainability unfold through time.

A further limitation stems from the subjective and self-reported nature of data. While semi-structured interviews and ecomaps provide invaluable insights into the lived and perceived aspects of social networks, they rely on personal interpretations that may omit latent tensions or unspoken dependencies. Integrating qualitative findings with quantitative

social network analysis (SNA) or participatory observation would strengthen methodological triangulation and allow for a more precise mapping of relational density, reciprocity, and spatial connectivity.

At the analytical level, the focus on residents' voices means that the institutional and policy dimensions of care remain partially unexplored. Including the perspectives of caregivers, administrators, and local authorities could reveal how institutional structures, governance frameworks, and funding mechanisms shape everyday experiences of ageing. Similarly, engaging with policy-level stakeholders could bridge the gap between micro-level findings and macro-level strategies, reinforcing the link between social research and territorial policy design.

Despite these constraints, the study lays important conceptual and empirical foundations for future work at the intersection of social sustainability, ageing, and territorial development. Future research should aim to explore comparative and multi-scalar perspectives, connecting micro-level experiences of care with meso-level institutional frameworks and macro-level territorial dynamics. Such research could examine, for example, how depopulation, migration, and rural–urban linkages reconfigure the geography of care across Europe.

Additionally, transdisciplinary collaboration is essential for advancing this agenda. Integrating approaches from sociology, geography, public health, and policy studies could foster a more holistic understanding of the interdependence between demographic change and spatial justice. Participatory research involving communities, local governments, and civil society actors could also translate empirical insights into co-designed policy solutions, thereby enhancing the societal impact of academic inquiry.

Ultimately, future studies must move beyond describing the effects of demographic decline and toward developing proactive frameworks for sustainable adaptation. Integrating demographic foresight, social innovation, and territorial planning can help build resilient and socially sustainable ageing societies—where demographic change becomes not a symptom of crisis but a catalyst for regeneration and solidarity.

**Author Contributions:** Conceptualization, S.C. and D.Z.-M.; methodology, S.C. and D.Z.-M.; software, S.C. and D.Z.-M.; validation, S.C. and D.Z.-M.; formal analysis, S.C. and D.Z.-M.; investigation, S.C. and D.Z.-M.; resources, S.C. and D.Z.-M.; data curation, S.C. and D.Z.-M.; writing—original draft preparation, S.C. and D.Z.-M.; writing—review and editing, S.C. and D.Z.-M.; visualization, S.C. and D.Z.-M.; supervision, S.C. and D.Z.-M.; project administration, S.C. and D.Z.-M.; funding acquisition, S.C. and D.Z.-M. All authors have read and agreed to the published version of the manuscript.

**Funding:** This work was supported by a grant from the Ministry of Research, Innovation, and Digitalization, CNS/CCCDI-UEFISCDI, project number PN-IV-P8-8.1-PRE-HE-ORG-2024-0233, within PNCDI IV, contract no. 92PHE/2025.

**Institutional Review Board Statement:** Ethical review and approval were waived because national legislation (ORDIN nr. 5.585 din 12 noiembrie 2021, Legea nr. 183/2024, Legea învățământului superior nr. 199/2023 și Regulamentul (UE) 2016/679 (GDPR)) does not require approval for non-invasive social research based on voluntary, anonymized interviews.

**Informed Consent Statement:** Informed consent was obtained from all subjects involved in the study. Participation was voluntary, and confidentiality and anonymity were guaranteed throughout the research process.

**Data Availability Statement:** The qualitative data generated and analyzed during this study are available from the corresponding author upon reasonable request. The data are not publicly available to protect participants' privacy and ensure compliance with ethical standards. Additional illustrative materials (sample ecomaps, interview guide) are available from the corresponding author upon request.

**Acknowledgments:** The authors express their sincere gratitude to the management and staff of the residential care institution who facilitated access and data collection, and to the elderly participants for their generosity and trust in sharing their experiences. The authors also thank the editors of the Special Issue for encouraging interdisciplinary perspectives on rural–urban dynamics.

**Conflicts of Interest:** The authors declare no conflicts of interest. The founders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

## Abbreviations

The following abbreviations are used in this manuscript:

| | |
|---|---|
| ULBS | Lucian Blaga University of Sibiu |
| APC | Article Processing Charge |
| NVivo | Qualitative Data Analysis Software (QSR International) |
| EU | European Union |

## References

1. Littig, B.; Griessler, E. Social Sustainability: A Catchword between Political Pragmatism and Social Theory. *Int. J. Sustain. Dev.* **2005**, *8*, 65–79. [CrossRef]
2. Vallance, S.; Perkins, H.C.; Dixon, J.E. What Is Social Sustainability? A Clarification of Concepts. *Geoforum* **2011**, *42*, 342–348. [CrossRef]
3. Eizenberg, E.; Jabareen, Y. Social Sustainability: A New Conceptual Framework. *Sustainability* **2017**, *9*, 68. [CrossRef]
4. Murphy, K. The Social Pillar of Sustainable Development: A Literature Review and Framework for Policy Analysis. *Sustain. Dev.* **2012**, *20*, 289–300. [CrossRef]
5. Boström, M. A Missing Pillar? Challenges in Theorizing and Practicing Social Sustainability. *Sustain. Dev.* **2012**, *20*, 167–175.
6. Putnam, R.D. *Bowling Alone: The Collapse and Revival of American Community*; Simon & Schuster: New York, NY, USA, 2000.
7. Coleman, J.S. Social Capital in the Creation of Human Capital. *Am. J. Sociol.* **1988**, *94* (Suppl. 1), S95–S120. [CrossRef]
8. Bourdieu, P. The Forms of Capital. In *Handbook of Theory and Research for the Sociology of Education*; Richardson, J., Ed.; Greenwood Press: New York, NY, USA, 1986; pp. 241–258.
9. Kahn, R.L.; Antonucci, T.C. Convoys over the Life Course: Attachment, Roles, and Social Support. In *Life-Span Development and Behavior*; Baltes, P.B., Brim, O.G., Eds.; Academic Press: New York, NY, USA, 1980; Volume 3, pp. 253–286.
10. Carstensen, L.L.; Isaacowitz, D.M.; Charles, S.T. Taking Time Seriously: A Theory of Socioemotional Selectivity. *Am. Psychol.* **1999**, *54*, 165–181. [CrossRef] [PubMed]
11. Antonucci, T.C.; Ajrouch, K.J.; Birditt, K.S. The Convoy Model: Explaining Social Relations from a Multidisciplinary Perspective. *Gerontologist* **2014**, *54*, 82–92. [CrossRef] [PubMed]
12. Wellman, B.; Wortley, S. Different Strokes from Different Folks: Community Ties and Social Support. *Am. J. Sociol.* **1990**, *96*, 558–588. [CrossRef]
13. Wenger, G.C. *Older People and Community Care*; Open University Press: Buckingham, UK, 1990.
14. Phillipson, C. *Ageing*; Polity Press: Cambridge, UK, 2013.
15. Yeates, N. Global Care Chains: A State-of-the-Art Review and Future Directions in Care Transnationalization Research. *Gender Place Cult.* **2012**, *19*, 1–22. [CrossRef]
16. Davoudi, S. Resilience: A Bridging Concept or a Dead End? *Plan. Theory Pract.* **2012**, *13*, 299–333. [CrossRef]
17. Drobniak, A. *Resilience and Regional Development: Evidence, Theories and Implications*; Routledge: London, UK, 2021.
18. Obrist, B.; Pfeiffer, C.; Henley, R. Multi-Layered Social Resilience: A New Approach in Mitigation Research. *Prog. Dev. Stud.* **2010**, *10*, 283–293. [CrossRef]
19. Eurofound. *Long-Term Care in Europe: Trends and Challenges*; Publications Office of the European Union: Luxembourg, 2022.
20. Eurostat. Population Structure and Ageing. 2024. Available online: https://ec.europa.eu/eurostat (accessed on 30 January 2025).
21. United Nations Department of Economic and Social Affairs (UN DESA). World Population Prospects 2024. Available online: https://population.un.org/wpp (accessed on 30 January 2025).
22. Romanian National Institute of Statistics (INS). Tempo Online—Population by Age Group and Area (POP107A). Available online: http://statistici.insse.ro:8077/tempo-online/#/pages/tables/insse-table (accessed on 30 January 2025).
23. Tronto, J. *Caring Democracy: Markets, Equality, and Justice*; New York University Press: New York, NY, USA, 2013.
24. Kröger, T.; Yeandle, S. *Reimagining Care: Policies, Practices and Social Justice*; Policy Press: Bristol, UK, 2023.

25. Missimer, M.; Robèrt, K.-H.; Broman, G. A Strategic Approach to Social Sustainability—Part 2: A Review of Frameworks. *J. Clean. Prod.* **2021**, *292*, 125–134.
26. Rémillard-Boilard, S.; Buffel, T.; Phillipson, C. Developing Age-Friendly Cities and Communities: Eleven Case Studies from Around the World. *Int. J. Environ. Res. Public Health* **2021**, *18*, 133. [CrossRef] [PubMed]
27. Avelino, F.; Wittmayer, J. Transformative Social Innovation and the Governance of Change. *Sustainability* **2021**, *13*, 5674.
28. Folke, C. Resilience: The Emergence of a Perspective for Social–Ecological Systems Analyses. *Glob. Environ. Change* **2006**, *16*, 253–267. [CrossRef]
29. Braun, V.; Clarke, V. Using Thematic Analysis in Psychology. *Qual. Res. Psychol.* **2006**, *3*, 77–101. [CrossRef]
30. European Commission. *The EU Action for Smart Villages*; Publications Office of the European Union: Luxembourg, 2019.
31. Kröger, T.; Yeandle, S. *Care Poverty and Unmet Needs: Multidisciplinary Perspectives*; Policy Press: Bristol, UK, 2023.
32. Schröder-Butterfill, E. Emigration and the Care of Older People "Left Behind": The Changing Role of Neighbourhood Networks, Ethnicity and Civil Society. *J. Ethn. Migr. Stud.* **2022**, *48*, 3561–3579. [CrossRef]
33. World Health Organization (WHO). *The Global Network for Age-Friendly Cities and Communities: Looking Back over the Last Decade, Looking Forward to the Next*; WHO: Geneva, Switzerland, 2018.


**Disclaimer/Publisher's Note:** The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.