Regional care provision is seen as a promising solution to the shortage of health workers, aiming to keep care affordable and accessible, especially in rural areas. As the belief in 'regionalization' and regional collaboration grows, understanding how regions are conceptualized and practiced in healthcare becomes crucial. This book introduces a relational approach to caring regions, exploring how care practices are linked to regional perceptions, whether as disadvantaged or innovative places.

Using ethnographic research, Nienke van Pijkeren studies regional initiatives in depth. She analyses, for example, a triage system in nursing home care and shadows regional care teams in their daily work. She reveals how caring regions require ongoing work and replacements which affect care relationships and challenge notions of time, distance and proximity. Highlighting the work of caregivers, this thesis calls for greater visibility and structural support for their efforts in (regional) policy and practice. As such it contributes to scholarly and policy debates about regionalization.

CARING GEOGRAPHIES Nienke van Pijkeren

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The Region as a Place of Care

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Caring Geographies
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Caring Geographies

The Region as a Place of Care

Zorgende Geografieën

De Regio als Plek van Zorg

to obtain the degree of Doctor from the

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Prof.dr.ir. A.J. Schuit

and in accordance with the decision of the Doctorate Board.

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by

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born in Nieuwegein

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1.

Introduction: placing the region as a caring geography

Introduction: placing the region as a caring geography

[Groningen, The Netherlands, 2019] Looking out of the car window, I see meadows and the typical head-neck-hull farmhouses. The driver, a healthcare manager who has just picked me up from the train station, tells me about the farms and villages tucked away in this vast landscape of the northern Netherlands. 'Now you see all the amenities disappearing,' the manager lamented. 'All the little shops, bakers, butchers – they're all gone. A city-centre like Veendam will be fine. But the surrounding villages, farther away, that's where the difficulty lies for us. Our home care workers, they're on the road a lot. To visit that farmer in Termunterzijl, we now have to drive 45 minutes from here.' Due to demographic changes, it is no longer tenable to organize care the way they used to do here; single healthcare organizations do not have enough care workers to fill the shifts and attend to changing care needs. I accompany the healthcare manager to a meeting on 'future-proof living and care in shrinking areas'. That afternoon, I learn about villages that are developing 'alternative' types of care, such as offering daytime care at a church with volunteers. As one of the participants points out: 'Our area shouldn't be called "shrinking", that's far too negative a phrase, we just do things differently around here.' The gist of the meeting is that the solution lies in regional collaboration between municipalities and healthcare organizations.

This research is exploring how (medical) care for older persons is increasingly organized in 'regions' and what this does to how regions and care are shaped and reconfigured. Above vignette recalls fieldwork in the Netherlands in an area where the population is declining and there is a growing shortage of medical specialist in older person care. Dutch healthcare policy encourages healthcare providers to collaborate and develop (or 'experiment with') new types of care to respond to workforce shortages and changing care needs. Healthcare professionals no longer provide care on one location, but increasingly care is organized in 'regions', connecting various places of care (e.g. nursing homes, homes, hospital, general practitioner offices). This shift to the region, or in policy terms 'regionalization', should keep care affordable and accessible – even, or especially, in places where the amount of care services is declining.

The trend of regionalization is not only noticeable in the healthcare sector. Over the past decade, scientists and policymakers have shown renewed interest in geographical regions. A strong and well-organized region is thought to be the solution for climate change, housing, migration and many other national and global challenges (MacLeod and Jones 2001). Regions are being rediscovered as sites for scaling up and organizing services, for decentralizing policies and for capacity-building in response to local needs (Lorne et al. 2019a, Jones, Fraser, and Stewart 2019). The belief in the region, and regional organizations, has fuelled a need to study how regions are perceived and conceptualized in healthcare, both theoretically and empirically.

In healthcare policy, regions are usually imagined as tools of governing in a very practical sense, for example in facilitating care integration and overcoming shortages of healthcare professionals by distributing and deploying their tasks efficiently over a larger area. Within these representations, the region itself can appear as a given: it may be defined either by shrinkage[1] or high rates of economic growth; by ageing populations in need of complex care or by innovation hubs for young professionals. Such definitions overlook that regions are made up of social, material and institutional elements and choices, however, and that they are always formed in relation to one another (Allen and Cochrane 2010, Massey 2001).

This thesis examines what are sometimes contrasting images and representations of regions and how they are intertwined with practices of regional health care. I aim to show that regions are not stable entities but are formed and reformed, made and remade, and that some practices and versions dominate others in this continuous process, depending on who is speaking or which practices are foregrounded (Allen, Massey, and Cochrane 1998). In this first vignette, the region consists of a network of organizations collaborating to address a shared concern as well as the links (or lack thereof) between them. This representation requires a level of ingenuity to counter prevailing narratives of decline: 'Our area shouldn't be called "shrinking".'

[1] In Dutch, *krimp*, literally shrinking or shrinkage, means population decline (Haartsen and Venhorst 2010, 219)

While in reality, the definition of a region is much more ambiguous than the one-sided narratives about shrinkage or innovation hubs, this does not mean that those narratives are neutral. Inevitably, the stories told about regions determine how the actors there, such as healthcare professionals, provider organizations, and policymakers respond to 'the region', as witnessed by such Dutch projects as 'De Achterhoek Zorgt Voor Morgen' (The 'Achterhoek' Cares for Tomorrow) (Suurmond and Geerse 2020) and 'Zorg in de Mijnstreek' (Care in the Mine Region) (Smulders 2024), focussing on how to improve care within 'shrinking' areas. For those living and working in regions, the stories told about them invite a range of consequences though. A region defined as 'a shrinkage area' may become unpopular, fuelling even more shrinkage, as research has shown (Eriksson 2008).

The reverse also holds, with stories emphasizing the solutions that regions represent, for instance, creative interventions developed to provide care 'remotely', or landscape features, such as diverse flora and fauna, clean air, and strong social cohesion, which allow people to age pleasantly (think of places that self-identify as 'blue zones', where people are said to live longer in better health). In my research, I found that rural regions are sometimes-positioned and described as 'caring' and 'attentive', depicting a more prosperous image of care delivery in those areas. These words enact a sense of (geographical) belonging and emphatically caring for a neighbouring other. The second vignette below, which offers a more positive description of

regional life, was recorded during my fieldwork in Norway and resonates with such images:

> [Rogaland, Norway, 2020] We are sitting on the dock near the ambulance boat where the nurse is working. The fog reaches across the fjords. Visibility is poor today; it is raining, and the sky is grey. The nurse wears a thick suit, coloured bright red and yellow, more visible from afar. He points out where the islands are, yet through the fog I can hardly see land. Inside the ambulance boat there is a computer screen, where the islands are projected on a digital map. The nurse tells me: 'When people from this area call, they *really* need help. Some of them are farmers and what we say on board is: When a farmer calls and asks for help, he is badly injured. For instance…they say "Oh it's just a scratch", and then we get there and it is a wound ten centimetres deep...or something like that and then we say: "You must be seen by a doctor." Or the patient has almost passed out and they say: "It's just a slight fever." But it can also be a neighbour who calls for them, or a family member, so people look after each other.'

In Norway, more so than in the Netherlands, care is organized in places accustomed to dealing with scarcity that have longstanding social and technical infrastructures to help them manage it in operation. One of the home-care organizations I visited during my research delivers care on two islands that are an hour away from the mainland by ferry, impacting the

organization and practice of care. The differing challenges that regions face, such as driving distances, difficult and changing weather conditions and reduced access to medical equipment, are part of the organization of care and the culture and knowledge of communities (Wiig et al. 2019a, Prior et al. 2010). The culture and history of an island community (e.g. not being too quick to call for emergency help) shape care practices (e.g. be alarmed when a farmer calls).

In this thesis, I study how 'the region' is becoming a new organizing principle in the organization of long-term care for older persons. I focus on how 'a regional approach' to dealing with personnel shortages in older persons care is affecting 1) practices of care, and 2) the region as a geographical place. While researchers have so far highlighted the organization of acute care, in particular the problem of disappearing hospitals (Pollitt 2008, Stewart 2019) or emergency departments (Gakeer 2019), they have paid less attention to long-term care, which is just as important to the liveability of regions. Several reports show that older people in the Netherlands, as well as in other European countries, will live – and are cared for – at home longer (Klerk et al. 2019, Ministerie Volksgezondheid Welzijn en Sport 2018a). Reports by the 'Dutch Environmental Planning office' (PBL) calculated that regional disparities in older person care will increase in the future, with demands rising particularly in rural regions, which are 'shrinking'[2] and ageing relatively faster than

[2] In many EU countries population decline can be found in the countryside rather than in the city. The main cause of this 'rural depopulation process' is the exodus of young people to cities. Besides rural shrinkage, urban shrinkage

urban areas (te Riele et al. 2019, Daalhuizen, Groot, and Amsterdam 2018, Hospers 2012). Moreover, studies point out how scarcity issues in terms of healthcare workforce manifest themselves earlier in rural areas, especially in employment sectors, such as older persons care, that have more difficulties attracting (specialized and qualified) professionals (Connell and Walton-Roberts 2015, Daalhuizen, Groot, and Amsterdam 2018, WRR 2021) - making older person care in rural areas an interesting context to consider how healthcare organizations and local communities deal with scarcity.

To investigate this, I combine literature from human geography and sociology of care. This allows me to approach regions not as static entities, but rather to study how the (physical) environment, images and care practices there come together as an assemblage (Willett and Lang 2018, Lorne et al. 2019a). By focusing on the assembling of regions, I try to avoid a common pitfall: making regions a neutral spot on the map. In my analysis, I consider the 'doing' of regions in the organizing work of older person care organizations and local communities. By this, I mean that I am interested in the work that these actors do to deal with shortages of healthcare professionals in rural settings and examine this by tracking regional initiatives concerned with the 'regionalization' of care. Among other things, these initiatives involve collaboration between healthcare organizations, the

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is also a topical issue. In terms of urban structures, shrinkage and growth in cities usually go hand in hand, in which some neighborhoods shrink at the expense of other areas in the city. (Hospers, 2012)

setting up of new healthcare facilities, or the development of new professional roles.

I study some of these regional initiatives in depth, for example a triage system in nursing home care and regional mobile teams in which nurses establish a new professional role. I explore tensions between forming regional care infrastructures in healthcare practices and policies and striving for regional uniformity on the one hand while delivering person-centred and timely care that draws on local know-how on the other. It is in the work of professionals that discrepancies between different logics of care and caring ultimately become visible, and this work therefore offers the perfect lens through which to examine inherent tensions of regionalization. In addition to looking into the development of new organizational practices, then, it is also important to examine what happens on the 'sharp end' of healthcare—in the clinical and caring settings where care is done by healthcare professionals.

The region is thus the main locus and object of study in this thesis; something that is cared for and with. In line with Gieryn (2000), I understand regions as 'doubly constructed' in the sense that they are materially shaped and administratively bounded, and also named, interpreted and imagined. In the sections below, I explore how regions are conceptualized and problematized. I begin in Part I by exploring the region as an empirical object, showing different versions and framings of regions in relation to healthcare. In Part II, I elaborate on the region as a policy construct. In Part III, I employ theoretical perspectives to

illustrate the notion that regions are constructed rather than inherently given. Finally, Part V describes the empirical set-up of the study and the chapters to follow.

Part I: The region as a physical place

The pragmatist sociologist Sennett (2019) has studied how people live in cities and how the structures of the city interact with how people live, use and dwell in spaces. Sennett understands 'ville' as these urban structures and 'cité' as the experiences and dwelling of people. The sociological lens he provides on urban planning is important for understanding how physical spaces and structures are not only inhabited, but can change the way people interact, meet, move and perceive—and vice-versa. In his book Building and Dwelling, Sennett argues that cities should be built in an 'open way', making it possible for people to meet and create. Sennett shows how certain urban structures, such as the forest of towers in Shanghai, the functionalist structure of Brasilia or the new smart cities in Asia, do not invite inhabitants to meet and to care. This leads to people becoming detached from places and creating what he calls 'Ills of Isolation', possibly stirring feelings of depression and loneliness (Sennett 2019, 274 - 275). Sennett's approach to the 'cité' is valuable for studying the ways in which regions are (re)built and cared for, and the ways in which the assembling of regional care affects how and where professionals and patients meet, exchange and interact.

Importantly, as Sennett points out, ways of planning and structuring environments make certain ways of living (and

caring) possible. A lack of healthcare professionals and care capacity is part of a larger set of problems that rural regions face (RLI, ROB, and RVS 2023). Often, regions struggling with care-related shortages also face a lack of investment in other domains, resulting in libraries, schools, shops and other public services being closed. These trends have led to the representation of these regions as 'shrink[age]' and 'peripheral' areas (Souza 2018, Kühn 2014). Yet studies on spatial inequalities and accessibility of services foreground that peripherality is not defined by context-independent criteria of shrinkage, but should be seen as a process driven by the choices made in and the framing of regional identities (Willett and Lang 2018), by media outlets (Eriksson 2008), and by policy choices (Kühn 2014, Beetz, Huning, and Plieninger 2008). In a series of Dutch publications, geographer Floor Milikowski has shown how Dutch policies from the 1980s onwards have focused on the growth of cities, rendering it more worthwhile to invest in places where things are already going well (Milikowski 2020). The policy rationale behind this was a 'trickle out effect'[3] suggesting that surrounding areas, or 'regions' or 'outskirts', would profit from the growth of cities. Researchers have shown, however, that this did not happen; instead, these policy choices exacerbated inequalities between areas (van Vulpen 2022).

[3] This approach relies on the prosperity generated in big cities to reach their surrounding towns and villages. Critics have sometimes labelled this 'trickle out' economics and have argued that it doesn't work – the prosperity generated in the city, they claim, will stay in the city and will not benefit the places around it.

In the Dutch case, Milikowski (2020) cautions that there is a widening gap between the privileged and the underprivileged, between 'the centre and the periphery', or 'the region and the Randstad'[4]. She shows that highly educated people and jobs are concentrated in the Randstad, while towns and villages in the region, such as Sittard in the South-East or Emmen in the North-East, are decaying and becoming increasingly less attractive as places to live. She argues that more careful consideration should be given to the future of towns and villages that are experiencing population and economic decline. Viewed from this perspective, the region is a focal point in discussions about disparities and inequalities in policymaking and spatial inequalities. These inequalities have also become a subject of debate amongst politicians, with populist parties in particular giving voice to a growing sense of discontent and turning the urban-rural divide into a new political divide as well (Rodríguez-Pose 2018).

Potential places for experimentation and possibilities

Even so, the above developments are also giving rise to new perspectives and changes in rural and 'peripheral' regions. One argument is that these areas should not be considered insignificant or solely dependent on the centre – and should therefore not be called 'peripheral' at all. In fact, they play a vital role in landscape developments and in (global) transitions. In his essay titled 'The Emancipation of the Periphery', Floris Alkemade[5] contends that an exclusive focus on growth tends to

[4] The Dutch term for the Amsterdam-Rotterdam-Utrecht conurbation in the west of the Netherlands

[5] Former Chief Government Architect of the Netherlands.

obscure the unique needs and potential of peripheral areas. Consequently, he redirects attention to these 'often-neglected regions', aiming to foster dialogue and awareness regarding their development and significance. With the region as a site for the energy transition, climate buffers, the production of circular materials and sustainable food, they become, in Alkemade's analysis, spaces of exploration or overflow. From this perspective, the challenge lies in finding the balance between urban and rural areas, or on a national scale, in the Netherlands, between 'the region' and 'the Randstad' without presuming some sort of hierarchy between them.

There are also calls within 'peripheral' areas themselves to jettison the 'shrinkage' label because of its negative connotations, according to researchers cited in the report Kijk voorbij de krimp (Look beyond shrinkage 2020). The term does not do justice to differences between areas and existing opportunities, policymakers from shrinkage areas argue. Researchers agree, contending that more attention should be devoted to differences between areas; in some cases, for example, people buy a second home in a rural area and become seasonal residents (Žafran and Kaufmann 2022). While there may be a general decline in social cohesion and the economy, other changes are occurring that are quite specific to areas. The argument is that analysing what is happening in these regions can help us understand which solutions might benefit other places as well, for example those that will also be dealing with workforce shortages in the near future (Souza 2018, Nel and Pelc 2020b). The region can then be regarded as a place where

creative solutions are developed for dealing with scarcity and as sources of knowledge about differences within and between areas and the creativity that they possess (or lack) (Hospers 2013).

The region is thus simultaneously conceived of as 'areas of need' and as a place for pioneering, as 'peripheral' and as 'places for creativity and learning'. These conceptual dualities become even more complicated when we consider the meaning increasingly being assigned to 'the region' in healthcare policies. Long-term care policies view 'the region' not only as a 'non-urban' or rural space, but also as a collaborative platform, and as a solution to social problems (van der Woerd et al. 2024). This raises the question of how to define healthcare regions that 'exist' as a geographical space, and how to delineate regions formed through collaboration (an 'organizational space'), as well as how these two notions of the region interrelate. In this thesis, I aim to understand how regions are assembled and created within healthcare, and how care delivery and the perception of care are intertwined with the regional structures that are made.

Part II: The region as a policy construct in long-term care

The region as an administrative space increasingly features as a prominent focus and even-solution in national healthcare and welfare policy visions issued by both the national government and parties in the field, such as healthcare providers or healthcare insurers. Through programmes such as 'The right care in the right place' (Dungen and Koesveld 2018) and national programmes supporting 'Ageing in place' (VWS 2018 - 2022), the

Dutch government aims to provide as much care as possible at home, with an active network of informal care providers supporting the older person. In this approach, older persons practise self-management and care providers proactively help clients give shape to their care. Here, the organization of care at the regional level is seen as pivotal because individual local authorities and care organizations are not always able to develop adequate policies or to procure sufficient and appropriate care and support. Better integration of services is also thought to lighten workloads and the unnecessary transfer of older patients to hospitals and/or other locations in a region.

Responsibility for local and regional implementation of these government programmes lies with care organizations and partnerships between healthcare and social welfare organizations. As a result, a jumble of regional care constellations is emerging in the long-term care landscape (and beyond), from administrative regions (such as the regional care offices, integrated elderly care regions, or the regional organizations for acute care), to regional visions developed by stakeholders to shape future care in an area 'in coherence'(RVS 2022). In Dutch healthcare policy, the emphasis is on regional stakeholders taking the initiative in fostering collaboration, suggesting that such collaboration among organizations could optimize the utilization of available workforce capacity by sharing human and technical resources.

The Dutch government provides funding and quality programmes to encourage healthcare organizations to anticipate workforce

shortages and the growing demand for care in the near future. For instance, in the case of long-term care, if nursing homes were to 'share' older person care physicians, and collaborate more closely with general practitioners, available clinical capacity could be more equitably distributed within a region (Hoek et al. 2003). Yet, this move towards regional collaboration clashes with the previous government emphasis on regulated competition, which has dominated healthcare policy from the 1990s onwards and is still embedded in the laws and instruments governing the healthcare systems, underlining the layering of policies and policy instruments that characterizes much of healthcare policy (van de Bovenkamp, de Mul, Quartz, Weggelaar-Jansen, et al. 2014).

The need to organize healthcare at regional level became even more pertinent during the Covid-19 pandemic, when medical capacity grew scarce throughout the whole country and regional acute care networks were set up to coordinate beds, materials and personnel in and between regions (de Graaff, Bal, and Bal 2021). This highlighted the idea that regions can unite two seemingly opposing aspirations in healthcare: to provide care close to the patient while addressing larger systemic issues (RVS 2022). The Covid-19 pandemic sparked a possibly deeper trend in the Dutch healthcare system, and healthcare regions were identified as the scale at which healthcare could be kept available and accessible.

Consequently, the region has become a focal point for governance constructs in the healthcare landscape, yet little

attention has been paid to the implications this may have for care practice and for the professionals tasked with implementing these policies. In the policy rhetoric, it has so far remained unclear how regional initiatives are taking form, and what they mean for how and where care is provided and by whom. This is significant, as earlier research shows how government actions and the re-placement of care are never neutral but always accompanied by unknown consequences and effects. The re-placement of health facilities or healthcare professionals to a 'regional scale' can, for instance, lead to coordination challenges between organizations and health professionals (Oldenhof, Postma, and Bal 2016b). In the context of long-term regional care, working practices are also changing and we are justified in asking how regional care will be done and by whom – and what impact this will have on professionals, patients, care delivery and the quality of that delivery.

Part III: Caring for and with regions

Before moving along, it is important to consider how the region can be understood theoretically as a caring geography. To this end, I draw on concepts at the interface between human geography and the sociology of care. Within the field of human geography, there is a growing body of work concerned with care. Geographers have elucidated how care practices, access to care and the experience of care are shaped by and influence the physical and social spaces in which they occur (Milligan and Wiles 2010, Andrews 2018, Meijering 2023). At the same time, the sociology of care has focused on the growing attention on place and the spatial-temporal aspects of care to understand how care

evolves over time and what consequences this has, for example, for accessibility and quality of care, and for the role development and work of healthcare professionals (Oldenhof, Postma, and Bal 2016b, Ivanova 2020, Oudshoorn 2012). There are nevertheless both differences between these two strands of literature and complementary elements. I discuss this in more detail in this section.

Human geography provides a valuable lens for understanding how care takes place across space and how it can change the very meaning of space (Kearn and Moon 2002). Within early geographical literature, regions are generally approached as a 'fixed' place, or a single entity, an object. Later work however rejects this notion of space and place as a flat, static surface. Instead, it recognizes that space is lively, dynamic, and socially produced (Massey 2001, Lorne et al. 2019a, Ivanova 2020). To explore this further, researchers have turned to the concept of place to unfold how cities, regions, islands, homes or hospitals carry symbolic meaning beyond their physical attributes. This body of work shows how places are imbued with layers of meaning over time. It illuminates how a hospital (Prior et al. 2010) or nursing home (Ivanova 2020) holds other significances for individuals and communities than merely a physical care location, but also fosters a sense of purpose, stability and autonomy for individuals living in an area, explaining why people may resist or protest the closure of such buildings (Pollitt 2008).

Following this view, space is not 'abstract geometry'; regions are socially constructed and relational (Jones, Fraser, and Stewart

2019, MacLeod and Jones 2001, Lorne et al. 2019a, Massey 2001). In her book Rethinking the Region, Massey shows how manners of conceptualizing a region are intimately bound up with the wider debate about the conceptualization of spaces and places. Using South-East England in the UK as a case study, she shows how in the 1980s it was a growth region and stood in contrast with 'the rest of the country', which was in decline. This was reflected politically, as other regions were urged to become more like the South-East, which was seen as 'a blueprint of success' (Massey 2001, 9). These dynamics touched specific groups and places; parts of the region were included, and parts were excluded. In other words, regions are part of a system of representation which, among other positionings, refer to 'core regions', 'peripheral regions', 'high-tech regions', or 'wrecked regions'. This thesis is partly situated in this literature as I explore how struggles over space/place play an active role in the changing shape of caring and how—vice-versa—practices of caring give shape to regions.

In terms of healthcare, regions involve movement and connectivity requiring links between various places, such as rural and urban areas, centres and peripheries, or home and the clinic. To understand and study these dynamics and how they take shape in their cultural, professional, and material surroundings, researchers have depicted regions as an assemblage. Lorne et al. (2019a) argue that the boundaries of regionalization are fluid – caring for a region crosses borders and is an assemblage of actors, arrangements and places. Following the relational movement, Lorne et al. (2019a) emphasise to study regions as

networks and activities that transcend places. Allen and Cochrane (2010) describe the region as a political assemblage: the region is run by a new professional elite, it is no longer traditional state governance; consultants and companies organize activities in the region and provide social and economic capital. The region is made and remade by political processes that stress beyond it and impact care unevenly; not only are the region's boundaries changeable and unclear, but also who is driving the region; the political actors and hierarchical structures are dynamic. Regional assemblages are an essential factor in studying regional distinctiveness and in understanding how regional healthcare structures and infrastructures are enabled and built or rebuilt – and what this does to how care is provided in, or between, places.

Geographies of care have been valuable in extending caregiving practices into spatial and geographical dimensions. This strand of literature explores how care practices, access to care and the experience of care are shaped by and influence the physical and social spaces in which they occur, for instance the movement of care from the clinic to the home (Milligan 2005, Milligan and Wiles 2010, Meijering 2023). Simply put, local knowledge, routines and norms (or 'ways-of-doing') play a role in shaping how care is provided and received in different geographical locations. Yet, in both the policies and literature on geographies of care, the focus is still predominantly on the physical structures (e.g. the built environment, materials such as tools and medication) and geographical settings, and less on the 'workers' and how these physical structures and context are not only

present but are constructed, made and cared for (Milligan 2005). This is where human geography and sociology of care intersect.

The sociology of care looks at care as a dynamic process where care is a shared, evolving co-production between people and their surroundings (Buse, Martin, and Nettleton 2018, Langstrup 2013, Ivanova 2020). Significantly. scholars in the sociology of care point out that we all carry out health work, which may take the form of caring for older relatives, children, partners and ourselves (Twigg 1999, Roberts, Mort, and Milligan 2012, Danholt and Langstrup 2012). Yet the nature of care is multi-layered. First, it encompasses direct actions of nurse aides (personal and professional efforts to care for someone's health and well-being, the practical side of caring). Second, the concept has been broadened to include societal, institutional and environmental dimensions (Puig de la Bellacasa 2017). This perspective emphasizes that care is not 'just' about individual acts but about broader social responsibilities. In the caring region, I also approach care in these two layers: how care for older persons is enacted and done in practice (how a region supports its citizens), and how people, in turn, care for their region (and its future). Studying care practices is very much about doing, by studying how care is done. We learn to understand 'situated practices' (Mol, Moser, and Pols 2010) and what is happening on the ground. The sociology of care, for instance, looks at the invisible work of nurses, which involves not merely direct patient care but also the organizing work that is often hidden but vital to ensuring that patients receive care in a particular place at 'the right time'. Davina Allen has helped make

this work less hidden in everyday nursing in the hospital setting and has shown how 'nurses operate in the interstices of health systems, aligning the constellation of actors through which care is delivered, making connections across occupational, departmental and organisational boundaries and mediating the "needs" of individual patients with the "needs" of whole populations' (Allen 2014, 303).

Scholars in the sociology of care have studied care in various environments, such as hospitals, homes, clinics or public spaces. This research has done a great job at looking at materialities, the design or redesign of hospitals (Buse, Martin, and Nettleton 2018), the re-placement of care from clinics to homes (Roberts, Mort, and Milligan 2012, Langstrup 2013) and the technologies that may, or may not, support this (Oudshoorn 2012, Pols and Moser 2009). In the region, we see a more pressing need to connect different working environments with different geographies, values, cultures and work routines. Yet we know little about what this spatial-temporal distribution of care means for both nurse aides and care receivers and how they co-produce care.

Bringing together these two literatures allows me to conceptualize care in and with regions as a relational practice and thus to advance the theoretical and empirical debate on the region as a caring geography. This makes it possible for me to study, and be attentive to, the work, experiences, materialities and politics that enact caring regions. In doing so, I hope to consider them as intertwined practices and possibly go beyond

the contradictions or binaries that are magnified in the political debate on healthcare and other social and spatial issues.

Research aims and questions

Based on the above explorations, I can now articulate the aim of this thesis and the questions it addresses. The aim of this thesis is (1) to analyse how regions and regional structures are made as places of care, (2) to explore what this does to both actual care practices and (3) to envision the reconfiguring of regions. The central research question is:

How are caring regions shaped in the everyday practices of organizing and doing care?

This main research question can be broken down into three sub-questions:

1) *What organizing and professional work is involved in building or rebuilding a regional care landscape?*
2) *How does regional care delivery affect practices of caring?*
3) *How does regional care delivery contribute to the reconfiguring of regions?*

The application of ethnographic methodologies makes it possible to examine how regions are portrayed in healthcare and care practices, and how these representations of regions may evolve through these caring practices.

Research methods

An ethnographic approach was employed to study the assembling of regions as caring geographies. The general research aim was to study how regions change and take form through practices of care, and how a regional approach to care changes care practices. The study design was therefore exploratory, tracking healthcare initiatives that involve practices of 'regionalization'. The initial focus on examining healthcare regions stemmed from the scholarly trend (Lorne et al. 2019a, Ivanova 2020, Jones, Fraser, and Stewart 2019) of questioning regions as appropriate spaces for solving healthcare problems – in other words, approaching regions as more than a static entity in the Dutch healthcare and political landscape by studying 'how they come into being through collaborative practices, just as any place does' (Ivanova 2020, 165).

This research contains two methodological outlines. First, I wanted to gain a better understanding of how regions are conceptualized in healthcare (see Chapter 2, 'What makes a health care region'). To pursue this aim, together with two colleagues, I conducted interviews with physicians, administrators, directors and project leaders in older person care who were involved in regional collaborations. These interviews provided a broad overview of how regions are imagined and enacted in the Dutch context of long-term care. In this part of the research, I found that the administrative health regions often did not correspond with the geographical or cultural notion of 'regions' held by the care organizations (regional collaborations often crossed borders and were multi-scale). The multiplicity of

regions and regional constellations became an explicit part of my research. Through the use of multi-sited ethnography, I was able to study how regions are assembled in different contexts (Marcus 1995). Multi-sited ethnography makes it possible to study how care is provided, moved and connected in different places (e.g. domestic places, nursing homes, regional call centres), something that is increasingly taking place in processes of regionalization. Approaching places as open (Ivanova 2020) and regions as assembled (Allen, Massey, and Cochrane 1998, Lorne et al. 2019a) led me to consider the meaning people give to regions and how regions are made in healthcare practices.

Multi-sited ethnography made it possible to move around and explore different regional contexts, both in the Netherlands and in Norway. This study is not about comparing different areas or regions, but about understanding how the way in which regional care is provided and perceived is intertwined with the regional structures that are made (inspired by Sennet (2019)). This may be done differently in an area that is 'remote' from other areas than it would be in an area where care is provided closer to the 'centre'. I wanted to understand how the geographical context influences the challenges faced by care organizations for ageing populations. In cooperation with colleagues from the University of Stavanger in Norway, I was able to research care organizations in rural and peripheral areas and how these deal with challenges. This is interesting because the geographical context in Norway is different (in terms of distances, resources, weather conditions), but the experience of peripheralization is similar. Together with the University of Stavanger, I was able to extract data from the

databases of two research projects on older person care, to see how geographical context creates challenges in older person care and what kinds of solutions care organizations adopt. We also compared what kind of policy decisions at the national level are made for care in such areas and how these impact care in the region.

Importantly, I am not looking for a clear a priori definition of 'rural', but for how rural, peripheral, shrinking, are enacted in the context of healthcare. I therefore use 'situated definitions' (e.g. rural in Norway is different from rural in the Netherlands) and employ ethnographic research methods in different places to help me understand how a knowledge of geography and a knowledge of different contexts, for example rural ones, are differently understood. Viewing matters through this lens does not produce a homogenous, hegemonic form (Scott 1998) of 'regionalization', but helps to shift the focus to the work being done by health professionals and others to help or hinder regions coming into being.

The second part of my research contains the studying of pilot projects. The pilot projects I tracked in my research all concerned regional collaborations in long-term care, sometimes intersecting with acute care (which, as we will see, became a theme in and of itself). The initial impetus for long-term care stemmed from nursing care organizations experiencing shortages of older person care physicians and consequently struggling to organize medical care for their older person population (Schuurmans, Wallenburg, and Bal 2019). Care organizations were encouraged,

partly through funding from regional care offices[6], to seek partnerships with other care organizations in their 'health region' (see figure 1 for the map of 'health regions', which are linked to a particular health insurer that manages the care office in a region and funds long-term care there).

Figure 1: Map of the Regional Care Offices in the Netherlands source: www.regioatlas.nl

[6] Regional care offices purchase care from care institutions such as nursing homes and institutions for disability care (GZ) and mental health care (GGZ). Together with these healthcare providers they make agreements on the price, volume and quality of care.

I was part of a research programme (2018-2025) in which we joined forces with Vilans, a Dutch knowledge organization for long-term care, to track and study how 'regionalization in long-term care' was carried out in practice and what the consequences of this were for policy and practice. The initial set-up of this programme was multi-sited, moving between, and working with, nursing homes administrators, physicians, nurses and nurse practitioners, as well as policymakers at the Ministry of Health, Welfare and Sport and the regional care offices (Schuurmans 2021).

As a researcher, I accompanied regional project groups and studied the pilot projects in daily care practice 'from the inside' while also looking at the formation of regional structures. In this study, these structures are institutional (i.e. the demarcation of administrative regions), financial (with specific financial arrangements and instruments for long-term and acute care), material (such as setting up a regional call centre in a building with computers, telephones, triage protocols, etc.) as well as professional (with the formation of new professional roles) and managerial (e.g. organizing care in different ways). In three pilots, I conducted research that involved tracking the pilot actively for three months (at least) using extensive ethnographic fieldwork methods. Other data was collected through interviews or meetings with various partners in the programme. Also networking meetings (organized between regional partners in which experiences and problematizations were exchanged) and evening meetings were important moments of data collection, as was walking around and 'dwelling' with healthcare professionals.

Throughout the pilots, I was often able to reflect on my data and analyses and conduct member checks with the care home staff, regional managers and policymakers, sometimes in presentations to project groups, sometimes through reflection sessions (both on local, regional and national level). During the triage pilot (Chapter 4), I was part of a learning programme in which we worked together on how to involve nurse practitioners in the triage learning trajectory, which I describe in the chapter as a formative evaluation (Bal and Mastboom 2007). During the Covid-19 period, however, reflective moments became more difficult or took place online. The focus of the ethnographic research then shifted slightly to interviews and away from 'on the ground' participation and shadowing or tracking the actors (this is particularly true of the case described in Chapter 3).

Although the pilot projects initially specifically focused on a (different) employment of older person care specialists (as this was the main concern and reason for starting up those pilot projects), I became particularly interested in broader solutions during my research. Working on regional infrastructures also creates space for other professional groups and ways of providing care (Langstrup 2013). I was especially interested in how the work of health professionals became increasingly networked in nature and how this is affecting notions of distance, proximity and intimacy as well as ideas about the relations between long-term and acute care. Although these themes are more explicit in one chapter than in another, they are a common thread throughout my thesis and also important recurring

discussion topics. Much of my ethnographic work was therefore focused on tracking professionals as they go about practising care, accompanying them in the car between different places, sometimes assisting them with small tasks such as care duties, taking notes or moving a bed. This gave me an intimate understanding of the work they do in connecting places, materialities and people. This shadowing work allowed me to develop a comprehensive picture of the work that goes into creating a healthcare region and focused my attention on the role of various health professionals.

Structure of the thesis

Chapter 2 explores how regions are formed and assembled, both empirically and conceptually, as places of care. I draw on the ethnographic research that I conducted, together with our research group, in 14 regions in the Netherlands involving 273 in-depth interviews. In this chapter I challenge the notion of a health region as a clearly bounded topological area and show how organizations and professionals collaborate in a variety of different regional networks in older person care. I build a theoretical framework based on the concept of place and assemblages in order to study caring regions, and discuss factors that contribute to the assembling and disassembling of regions.

Chapter 3 reports on an explorative study comparing data taken from case studies in peripheral areas, part of two major research projects on older person care in the Netherlands and Norway. I focused on the role of creativity in improving the quality of care, conceptualized as ‘creativity at the margins’. This allowed me to

identify different strategies for dealing with peripheral processes in regions in Norway and the Netherlands, i.e. scaling up, brightening up and opening up. I argue that policy blindness to peripheries should be overcome by supporting creativity at the margins.

Chapter 4 continues to build on this explorative study, focusing in more depth on two regions in an effort to understand the liveability of areas in relation to discursive peripheralization. The research involved interviews as well as site visits. I zoomed in on the work of care practitioners and how they, in relation to care organizations and local authorities, aim to organize care for patients in 'the periphery' and how this contributes to more diverse and alternative narratives and practices of healthcare in these areas.

Chapter 5 recounts how I 'zoomed in' on the daily work of nursing by shadowing doctors, triage nurses and nurse practitioners in a nursing organization. Here, doctors and triage nurses were responsible for implementing the triage system to support doctors in working 'flexibly' (scaling up) across more care sites. My shadowing work allowed me to develop a comprehensive picture of the infrastructural work that goes into creating a healthcare region and focused my attention on the important role of healthcare professionals in shaping a geography of care. In particular, I focused on how healthcare professionals exchange care between different care settings, and how they share information, care materials and resources to make care work.

In Chapter 6, I report on my observations of a regional district nursing team that provides acute and sub-acute care to older people and that visits and moves between care homes, primary care centres and patients' homes, making the region a physical place of work and care. I used the notion of temporal orders to study how a regional temporal order is created to divide care tasks over a region and studied how nurses do 'repair work' and temporal work to care for this regional care infrastructure.

Chapter 7, then, finishes of the book with a discussion of the main results, a reflection on the methodology and an agenda for further research.

2.

Regionalization in older person care: what makes up a healthcare region?

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Introduction

Speaking on a Sunday morning news and political commentary programme in early March 2019, the Dutch Minister of Health announced the launch of a regional approach for combatting the increasing problem of staff shortages and inadequate quality in older person care. Regions, the minister said, would stimulate collaboration among local organizations, practitioners and policymakers. Funds were subsequently made available to older person care providers to support joint initiatives with neighbouring healthcare organizations focussing on the design and implementation of promising solutions to the problem of medical staff shortages. In addition to requiring organizations to collaborate to obtain these funds, officials from the Ministry of Health used active persuasion to encourage older person care providers, for example in consultations.

Besides these “soft” strategies, the Ministry had no other mandate to enforce regionalization in older person care. The public (and authoritative) appeal for regional collaboration was surprising in the light of over a decade of market- driven policies in healthcare, which the minister now openly declared to be inadequate to the task of resolving contemporary problems in older person care. The shift in focus from competition to regional collaboration, however, fits in with a broader (re)discovery of “regions” as places for care (Lorne et al., 2019; Ivanova et al., 2016; Jones et al., 2019; Oldenhof et al., 2015; Lorne et al., 2019).

Regions have become popular places for healthcare policymaking, although the trend is not a global one, with some countries seeing a growing level of consolidation and concentration of healthcare providers (Kapp, 2016). The renewed emphasis by policymakers on regionalization more or less implies that regions constitute singular and bounded geographical spaces that are well defined, tangible and "useable" for developing a policy strategy, and it assumes that regional actors feel a sense of regional engagement and a willingness to cooperate in regional care delivery. Regional geographical boundaries are in fact often taken for granted in the organization of healthcare and are seldom a topic of research enquiry. The delineation of regions as primordial and clearly bounded geographical areas is open to question, however, both empirically and conceptually. The socio-political literature on regions shows that they are not just "out there" but emerge from multiple (and often contested) geographical constituencies (Lorne et al., 2019; MacLeod and Jones, 2001). Rather than being clearly demarcated, regional boundaries may be fluid or overlap, with multiple (functional, administrative, cultural and professional) regions being contained within the same geographical area.

Increasingly, scholars have come to understand (healthcare) regions as "assemblages" comprising a diverse set of institutional actors tied to provisional allegiances (Ivanova et al., 2016). Rather than a given or based on formal agreements, relations between institutional actors within a regional assemblage are fragile and conflict-ridden. As a result, assembling a region is a

continuous process that requires “work” (Lorne et al., 2019). We know little about why such formations are rife with conflict and require continuous maintenance. To fill in this recurrent hiatus in thinking about geographical space relationally, scholars must embrace a richer pallet of conceptual tools that will enable them to understand the “forces that restrict, constrain, contain and connect the mobility of relational things” (Jones, 2010, p. 249). In this paper, we take on this challenge. A total of two questions have guided our research: (1) What is a healthcare region? and (2) What mechanisms inform institutional actors’ decisions to form, maintain or abandon collaborations with neighbouring organizations within an administrative region?

We draw on a large and ongoing action-oriented research programme in the Netherlands (2019–2021) in which healthcare providers, policymakers and researchers jointly develop and implement solutions to the entwined problems of a burgeoning elderly population and an increasing shortage of staff, particularly of older person care physicians. In the pilot projects undertaken within this programme, healthcare providers operating within a care office region are encouraged to collaborate on devising and implementing “promising solutions”, such as integrated services, practitioners working for several healthcare providers in the region, shared instruments of triage and shared technological tools. In total, 14 of the 32 care office regions – the administrative area linked to the largest healthcare insurer within a constituency – are represented in the project. The project is innovative in encouraging healthcare providers to cooperate rather than to compete with healthcare organizations

in their geographical proximity. As researchers, we study, evaluate and, through our research, contribute to the experiments, elucidating how they impact older person care and traditional ways of organizing care (e.g. use of triage, integration of GP and nursing home care). By participating actively in healthcare providers' efforts to cooperate regionally, our team obtained an in-depth understanding of the dynamics through which practice and policy networks in older person care are assembled and disassembled.

We begin this paper by providing a conceptual framework for (healthcare) regions and discuss recent work on socio-spatial formations and valuation practices, a concept that we used to understand the mechanisms shaping institutional actors' work within the networks studied. We then describe our research methods and go on to present our results, arguing that healthcare regions, rather than clearly bounded topological entities, can be better understood as an assemblage comprising a variety of dissimilar actors tied to uneasy allegiances and in a constant state of flux. An analysis of the regimes of valuation embedded in the healthcare sector helps to explain the dynamics through which such socio-spatial formations are assembled and disassembled.

What is a healthcare region? A conceptual framework

The focus on regions as a valuable site for organizing care has seen a recent upsurge in the medical sociological literature (e.g. Lorne et al., 2019). Whereas scholars in this discipline have proposed few theories as to what a healthcare region entails

conceptually, a vast body of work on “new regionalism” has emerged in social geography discussing the conceptual understanding of a region and of regionalization (Agnew, 2013; Allen and Cochrane, 2007; Amin, 2004). We first turn to this body of work for conceptual tools that allow us to grasp what a healthcare region comprises and then move on to the concept of valuation regimes to shed light on the different evaluative principles that underpin processes of regionalization.

In the late 90s, the interest in new regionalism was understood as a reaction to a “failing” centralized state in a globalizing world (Keating, 1998), with regions being seen as a more appropriate bureaucratic level to manage societal challenges and accelerate economic prosperity. New regionalism cemented the idea of regions as more or less delineated geographical areas managed by clearly identifiable politico-administrative institutions (Macleod and Jones, 2007, p. 1,180). This conceptualization has also prevailed in health and healthcare research, for instance in quantitative investigations into the effects of place, or the specific conditions of a place, on the health of its denizens (Hazen and Anthamatten, 2012). Such conceptualizations of place have increasingly come under attack, as they falsely assume a bounded topological area with bureaucratic institutions operating on different scalar levels (Cummins et al., 2007). Instead, a relational perspective has been suggested to conceptualize regions and regionalization processes (Allen and Cochrane, 2007; Amin, 2004), shifting the analytical focus to the (symbolic) relations between diverse institutional actors that constitute a particular region (MacLeod and Jones, 2001).

Recent work conceptualizes regions as assemblages of diverse sets of institutional actors (Allen and Cochrane, 2007; Lorne et al., 2019). This line of work emphasizes the fluidity and heterogeneity of the institutional networks that make up regions and argues against the conceptualization of regions as clearly bounded geographical spaces. Assemblages should be understood as loosely knitted, temporal and entwined relational networks among heterogeneous institutional actors, such as local, regional and central state entities, interest groups and private and public organizations (Allen and Cochrane, 2007; Amin, 2004). These spatial-temporal networks are often "problem driven forms of coordination through partnerships and policy exchange" (Gualini, 2006, p. 889), meant, for example, to further economic development within a geographical area (Allen and Cochrane, 2007) or in the provision of healthcare. A region, then, can be conceived as a web of relations tied to a provisional allegiance, constantly changing and drawing in institutional actors that operate in various domains and in different geographical constellations.

(Dis)assembling healthcare region: regimes of valuation

Perceiving a region as an assemblage allows us to scrutinize the ongoing practices of assembling (new) actors, resources and policies and disassembling others to arrange healthcare systems and services into new and meaningful but potentially also conflict-ridden practices of regional care (Lorne et al., 2019). Assemblages are laden with conflictual dynamics; hence, various actors must work to keep the formation together. Lorne et al. (2019), for instance, show that in the context of initiatives to

enhance regional collaboration among healthcare providers, austerity triggers a centrifugal dynamic in which healthcare managers prioritize the survival of their own organization above regional collaboration (2019, p. 9). As a result, work is required to sooth the tensions and to keep the formation together. How assemblages come into being and which dynamics galvanize the assembling and disassembling of socio-spatial formations often remain unclear. As Jones (2010) points out, this is a recurrent hiatus in thinking about geographical space relationally, and to fill it in, scholars must embrace a richer pallet of conceptual tools that enable them to understand the "forces that restrict, constrain, contain and connect the mobility of relational things" (2010, p. 249).

The work of (re)assembling socio-spatial formations depends, among other things, on the strategies, interests and actions of actors, for instance whether they value collaboration or prioritize competition. Such decisions are underpinned by certain evaluative principles, cultural logics or sets of norms on which actors draw to critique or legitimize existing arrangements and justify their decisions (Boltanski and Thevenot, 1999, 2006). Managers, for example, often base their strategic decision-making within organizational contexts on a market principle that values self-interest and competition (Kornberger, 2017). It should come as no surprise that such actions often hamper collaboration between organizations. However, as numerous scholars in the field of Science and Technology Studies (STS) have pointed out, the act of valuing is not based solely on ideational cultural logics from which human actors draw their strategic

actions and justify and critique arrangements (Kornberger, 2017; Rushforth et al., 2019; Zuideren-Jerak and van Egmond, 2015). What is rendered valuable is, among other things, produced by concrete practices that are embedded in the organizational infrastructure. In the STS literature, these arrangements are often referred to as "valuation devices" (Callon et al., 2007). Rankings and reviews are pertinent examples; they have pervasive performative effects, trigger certain types of strategic actions and produce ideas of what is valuable (Kornberger, 2017; Rushforth et al., 2019; Zuideren-Jerak and van Egmond, 2015).

These two strands of valuation literature have opposing views on how to study valuation practices. One body of work focuses on the concrete valuation devices and construes organizational culture as a product of these arrangements (Kornberger, 2017; Rushforth et al., 2019). The other strand analyses the cultural logics within organizations and sees valuation devices as an outflow of these evaluative principles (Fourcade, 2011). We draw on the concept of "regimes of valuation" to resolve this conundrum (Fochler et al., 2016). The concept refers to systems of cultural evaluative principles and enmeshed organizational infrastructures, such as valuation devices, organizational routines, discourses and governance and accountability structures that value and galvanize particular strands of strategic action within organizations. Within academia, for instance, the (e)valuation of academic excellence is grounded in a whole organizational apparatus that includes such valuation techniques as citation scores, grants and funding, the number and performance of PhD students, tenure tracks and other

organizational routines and the subjectivity of an entrepreneurial self (Fochler et al., 2016; Stark, 2011; Rushforth et al., 2019). It is this amalgamation of instruments, identities and values that makes up the regime of valuation.

Institutional domains may have multiple regimes of valuation that, at times, contradict one another and trigger conflicting practices of assembling and disassembling networks. Scholars have distinguished between fields in which one evaluative principle is dominant (hierarchies) and fields in which multiple principles coexist in a non-hierarchical relation (heterarchies) (Stark, 2009). This distinction helps to conceptualize the relationship between different regimes of valuation and directs the analysis towards understanding how these regimes interact and to what effect. Writing about valuation practices in academia, Fochler et al. (2016) argue that although there are multiple regimes of valuation through which scholars value their work and act strategically, one regime of valuation, which is of competition and productivity, is dominant within the field. The normative power of such a regime is in fact determined by the degree to which it is institutionalized within a particular field (Fochler et al., 2016, p. 180). The regime of competition and productivity within academia, for instance, is powerful because it is grounded in a whole infrastructure of citation indexes, grants, hiring procedures, tenure tracks and university rankings. In analysing the strategic decisions actors make in valuing particular chains of action, scholars should consider the whole organizational apparatus in which these evaluative principles are rooted. In this paper, we show that the assembling and

disassembling of socio-spatial formations is shaped by multiple regimes of valuation, and that calls for closer regional collaboration are not necessarily effective when a dominant regime of valuation emphasizes competition over collaboration.

Research methods

The research presented in this paper is part of an ongoing action orientated research. Between November 2018 and July 2020, we conducted a total of 273 semi-structured interviews with managers of nursing homes, older person care physicians, specialist nurses, welfare workers researchers and policymakers. Respondents participated in various projects aimed at initiating "promising solutions" for the ongoing shortage of medical staff. During the interviews, respondents were asked to reflect on their organization's collaborations, on the organization itself and the quality of older person care it provided, on initiatives to alleviate the shortage of medical staff and on organizational bottlenecks in current older person care. Most interviews lasted between 45 and 60 min and were conducted in person. All interviews were audio-recorded with the consent of the interviewees and were transcribed verbatim.

Besides these interviews, we drew data from various ethnographic observations. We attended meetings of regional working groups charged with developing and discussing the various pilots. A variety of different actors participated in these working groups, from healthcare managers and consultants to physicians and nurses. The first pilot in our research project, which ran from January to March 2019, involved four nursing

homes experimenting with a nurses' triage model. Over the course of this pilot, two of our researchers shadowed nurses and clinical practitioners (physicians and nurse practitioners) and managers who worked with the triage model. They also participated in the regional project group, providing feedback on their research findings and helping to refine the pilot. The second pilot, which ran from September 2019 to January 2020, reallocated the tasks of an older person care physician and a general practitioner working in a nursing home in small rural community. In total, two researchers shadowed both professionals in the nursing home over the course of pilot. In total, we conducted over 1,000 h of observations for the whole project.

We analysed our data using an abductive approach (Timmermans and Tavory, 2012). Our research produced "surprising empirical findings" (p. 169) that we analysed against the backdrop of different social theories discussed in the theoretical section above. The first was the dissimilarity between the formal, administrative understanding of a region as a clearly geographically bounded entity, espoused in project plans and policy documents and the actual fuzzy, unbounded spatial formations of collaborating organizations on the ground. Additionally, we found that the process of building partnerships between different actors in the field of older person care was anything but neat and simple. The partnerships were often fragile and rife with conflict, with participating actors having to juggle differing interests and values, some of which collided, or at times opposing the move towards further collaboration with

partner organizations. In the analytic process, we coded our data and "revisited" the phenomena under study, weighing and fitting different theoretical explanations to the aforementioned surprising findings (Timmermans and Tavory, 2012). Additionally, we "defamiliarized" our data by comparing the neat and orderly idiom of regions in policy discourse with the messy, complex and fluctuating web of connections between the actors in our study (Timmermans and Tavory, 2012). We then proceeded to debunk and refine our emerging concepts, comparing our explanations with ill-fitting data and deviant cases. After intensive coding, we identified two "core categories" (Corbin and Strauss, 1990): the composition of socio-spatial formations, referring to the geographical spread of the various practice and policy networks in which our interlocutors operated and the underlying mechanisms of assembling and disassembling these practice and policy networks, referring to the forces that contributed to the formation, maintenance and disintegration of these networks.

Findings

In the remainder of the paper, we explore the composition of "healthcare regions" empirically and analyse the dynamics of assembling and disassembling practice and policy networks. First, we argue that healthcare regions are not clearly bounded topological entities but should rather be conceptualized as multi-layered webs of relations tied to a provisional allegiance. Some of these webs are formalized in institutionalized networks, and others are informal collaborations in which heterogenous actors, such as healthcare managers, medical professionals, policymakers and consultants, cooperate. This web of relations is

constitutively dynamic. Some actors might disconnect from the assemblage while others might join the processes that apply even to the more formalized networks. As a result, the region is always in flux and its geographical reach changes over time. Second, multiple regimes of valuation exist within the healthcare field and shape the dynamics in which of socio-spatial formations are assembled and disassembled.

The region as a multi-layered assemblage

In the Netherlands, healthcare is delivered by private non-profit and for-profit organizations on a heavily state-regulated healthcare market. Long-term older person care is covered by the Act on Long-term Care (Wet Langdurige Zorg, Wlz) and is the responsibility of the Ministry of Health. The Ministry has devolved its responsibilities to 32 "care offices" that are linked to the largest healthcare insurer in a particular geographical area. The care offices finance long- term care in a particular area by purchasing care from private, long-term care providers (particularly nursing homes). The care offices also provide funds to organizations in their constituency allowing them to devise promising solutions to the entwined problems of a burgeoning older person population and a shortage of staff.

Our initial assumption was that the various collaborations between the healthcare providers with which we engaged would be situated largely within the geographical boundaries of the administrative regions covered by the care office. However, this was not the case. In the first round of interviews, we asked our respondents to delineate their region geographically. It turned

out that, by and large, our respondents' understanding of "their region" did not correspond to the care office constituency. Many respondents referred to multiple regions that depended largely on the various existing collaborations in which they and their organizations operated. Some of these collaborations were institutionalized in formal networks of professionals and managers of other, often neighbouring, organizations dedicated to specific themes (e.g. "dementia networks") or specific arrangements (i.e. stroke care). The institutional actors in our study took part in numerous such collaborations. Other collaborations occurred in practice networks, for instance around particular care paths for the older person. In this multiplicity of networks, the region was a three-dimensional web of relations spreading out across space. In the following, we illustrate this understanding of the region as a multi-layered assemblage by focussing on our research in de Achterhoek, an area on the border between the Netherlands and Germany.

De Achterhoek was not an administrative care office region. The care office region to which it belonged (led by the largest healthcare insurer in the region, Menzis) covered a much larger geographical area, including numerous other municipalities in the east of the Netherlands, but excluding two municipalities considered part of de Achterhoek in "demotic discourse" (as the discourse of local residents opposed to the "official" idiom of policymakers) (Baumann, 1996) and belonging to the administrative area of another regional care office (led by another insurer). A total of six older person care organizations in de Achterhoek collaborated in designing and implementing a

pilot aimed at providing sustainable medical care for the older persons. The nature of these organizations differed from the three large care providers that ran ten or more nursing homes scattered throughout the east of the Netherlands, offering such specialized services as geriatric rehabilitation and observation and diagnosis. The latter three organizations had large medical teams consisting of older person care physicians, nurse practitioners and paramedics working both intramurally and extramurally. The other participating organizations were smaller care providers with a few locations offering clustered living facilities and without their own medical teams; they depend on collaboration with other nursing homes and general practioners (GP's) to deliver medical care to their residents. Most of these organizations' facilities were located within the geographical area under the jurisdiction of the Menzis care office. One participating organization formed an exception; it had a large nursing home located in a municipality under another jurisdiction and was not considered part of de Achterhoek even in demotic discourse. Unsurprisingly, our team and all our interlocutors had difficulty in grasping what the geographical area of de Achterhoek actually was. The collaborations that had emerged historically within formal and informal networks did not necessarily match the geographical boundaries of the care office's administrative "region".

To make this more concrete, the managers of the different older person care organizations often met as the "management council", which also included managers from a hospital (the result of a recent merger between two hospitals in the two

largest towns in de Achterhoek), a large organization providing mental healthcare in the east of the Netherlands and a municipal general practitioner association. The management council decided on the funding and continuation of projects developed in various other dependent networks. There were eight of these dependent networks, some focussing on palliative care and care for 'fragile elderly'. Each of these dependent, thematic networks had an East Achterhoek and a West Achterhoek branch, the legacy of the former division of hospitals in the area (de Achterhoek originally had two hospitals, one in the west and one in the east). The thematic networks were organized around these hospitals and included representatives from healthcare organizations and municipalities that operated in the catchment area of one of these two hospitals. The policy networks, formed around policy programmes (Kickert et al. (1997), and practice networks, formed around communities of practice (Addicott et al., 2006), in which our interlocutors operated were not conterminous with the care offices' administrative "regions".

The region as a dynamic assemblage

The constituencies of these healthcare assemblages were by nature unstable. Provisional 236 allegiances could easily dissolve and new relations form. Such instability also had consequences for the spatial reach of these assemblages, as they fluctuated with the changing institutional relations within networks. Returning to the example of de Achterhoek, managers of older person care organizations participated in a policy network called the "Healthiest Region", the outcome of administrative collaboration between eight municipalities (spanning a

geographical area smaller than the region as understood in demotic discourse). Besides the older person care organizations, the Healthiest Region network consisted of mental care organizations, a nearby hospital, numerous businesses in the healthcare domain and seven municipalities in de Achterhoek. Originally, most of the administrative, formal collaborations between the municipalities in de Achterhoek had involved eight stakeholders, including the municipality of Montferland, recently formed by the merger between the municipalities of Bergh and Didam. After the merger, the executive councillors of the new municipality initially sought to collaborate and participate in policy networks with their counterparts and policymakers in the seven other municipalities in de Achterhoek. This changed, however, when a new administrative collaboration emerged (SAN) between two larger cities located to the west of de Achterhoek that had far more resources. The executive councillors and policymakers of Montferland increasingly participated in the new regional SAN networks and withdrew from numerous networks centred around de Achterhoek, including the Healthiest Region network. Healthcare initiatives devised in this network were therefore implemented in the seven remaining municipalities. The actors participating in these socio- spatial formations fluctuated over time, depending on administrative changes (merging communities), geographical allegiances and resources. As a result, the geographical reach of these assemblages was in flux.

Regimes of valuation: understanding the assembling and disassembling of socio-spatial formations

The above examples taken from de Achterhoek highlight our understanding of healthcare regions as multi-layered and dynamic assemblages that were compositionally fluid. Actors within the analysed networks continuously assembled and disassembled the socio-spatial formations to which they belonged. This "work" did not occur in a vacuum but, as we will show, emerged from the regimes of valuation embedded in the field of older person care. These regimes consisted of evaluative principles grounded in infrastructures comprising valuation devices, governance and accountability structures and organizational routines. We delineate four such regimes: the efficiency regime; the market regime, the historic regime and the organizational identity regime, which jointly shaped the formation of the healthcare assemblages (see Table 1).

1. Assembling the region: the efficiency regime of valuation

The managers and professionals interviewed were almost unanimous in seeing closer collaboration and joint initiatives with colleague organizations as a strategy for maintaining high-quality care in the face of a severe and worsening shortage of medical personnel. This reasoning echoed the main tenet of policy discourses on "regionalization". Joint initiatives and closer collaboration in older person care allegedly result in a more economical deployment of scarce resources, such as medical personnel. This logic is what we mean by the efficiency principle, and it is tied to a project-based financial infrastructure. In the

following, we illustrate this by focussing on our research in the administrative area Flevoland.

In administrative area Flevoland, four older person care providers long had difficulty in delivering high-quality medical care to their clients. They consisted of three larger organizations (Sea-Care, Residence and Lowlands), which had their own medical teams, and one smaller organization (Island-Care) with a strong religious signature, which – at the start of our research – did not have a medical team and procured these services from Sea-Care. All four organizations were experiencing a severe shortage of medical personnel, especially older person care physicians, and were among the first to act on the policy calls for closer regional collaboration.

In early 2019, the four organizations launched their first pilot, funded by the regional care office, in which the care teams worked with a new triage model meant to reduce the workload of specialist nurses and older person care physicians and to streamline the deployment of medical staff within the organizations. It was also hoped that the pilot would lead the organizations to coordinate a variety of work practices, easing staff exchanges and deployment between them and alleviating temporary staff shortages in one with staff from another. A further hope was that the initial project would inspire other initiatives aimed at closer collaboration between the older person care organizations.

These calls for closer collaboration with neighbouring older person care providers came with a specific project-based financial infrastructure. When the Netherlands' current government entered office, it reserved 50 million euros for projects targeting specific "regional" bottlenecks in the provision of older person care. These funds were distributed by the care offices, which required older person care organizations within their constituency to collaborate in joint projects. As a result, healthcare managers of older person care organizations began to meet regularly from 2018 onwards to discuss possible joint initiatives addressing the shortage of medical staff. However, these projects had funding for only two or three years, and it was uncertain whether they would continue once the funding dried up. Unsurprisingly, managers of the four organizations in Flevoland questioned whether joint initiatives were sustainable in the long run, especially since countervailing forces pushed to disassemble the emerging collaboration.

2. Disassembling the region: the market regime of valuation

Over the course of 2019, relations in the older person care assemblage in Flevoland became increasingly strained. The medical staff shortage was intensified, and instead of investing all their efforts in closer collaboration with neighbouring organizations, numerous participants made strategic decisions that were primarily in the interest of their own organization, even at the risk of jeopardizing the provision of care in partner organizations.

Evaluative principle	Evaluative logic (what is valued?)	Structurally embedded in	Consequences for regionalization
Efficiency	An economical deployment of scarce resources	Project-based financial infrastructure	Assembles regions
Market	Self-interest and competition	Valuation devices, governance and accountability structures	Disassembles regions
Historic	Established partnerships	Policy and practice networks	Assembles and disassembles regions
Organizational identity	Idiosyncratic signature of the organization	Organizational routines	Assembles and disassembles regions

Table 1: Summary of regimes of valuation and the consequences for regionalization

These decisions were informed by a market principle of valuation emphasizing competition and organizational self- interest (Boltanski and Thevenot, 2016). Again, this principle was not

solely ideational; it was enmeshed with the industry's governance and accountability structures and with particular valuation devices that produced the values "self-interest" and "competitiveness".

The smaller organization Island-Care procured medical care from the larger Sea-Care organization but had long been unhappy with this arrangement. Island-Care's general manager was dissatisfied with the quality of care provided by Sea-Care's medical team. This dissatisfaction was exacerbated by the numerous changes in that team and a current arrangement making a physician assistant (PA) responsible for medical care, albeit under an older person care physician's supervision. Island-Care's manager claimed that this arrangement jeopardized the quality of care in his facility. The manager of the larger organization, however, argued that PAs were authorized by law to provide medical care within Island- Care's facilities, and that a shortage of older person care physicians necessitated this arrangement. Since the larger organization was unable to provide an older person care physician, the manager of the smaller organization considered other strategic options, all based on the premise that an older person care physician should be responsible for medical care. One of these was a pan-organizational medical team that would be responsible for medical care in all of the nursing homes of the assemblage in Flevoland. Ultimately, however, he opted for a different route.

> Considering our size, we would like a regional medical team with practitioners and doctors that has our

> preference, but we have not sat still. Tomorrow, we have a meeting with a professional (an older person care specialist) who we might hire. (Island-Care's manager)

Island-Care's manager decided to hire the older person care physician and terminate its current contract with the larger organization, Sea-Care, much to the displeasure of the latter's general manager and medical staff. The main sore point was the competition for older person care physicians in their catchment area. The larger organizations were seeking to recruit older person care physicians themselves and were not amused that the smaller organization, Island-Care, was fishing in the same pond. In the summer of 2019, the three larger organizations decided to exclude the manager of the smaller organization from the management group on regional initiatives for collaboration around the provision of medical care, arguing that his presence hampered the process of regionalization.

This foregrounding of "competitiveness" and "self-interest" did not occur in a vacuum but was underpinned by a governance and accountability structure and by valuation devices through which the aforementioned values were produced. In the Netherlands, nursing homes are required to report annually on the quality of care in their facilities based on certain parameters of "good care", such as the degree of personalized care, the well-being of clients, patient safety and quality improvement efforts. This form of quality reporting is a "valuation device" and has far-reaching consequences for the type of values embedded in policies and managers' strategic choices (Zuiderent-Jerak and van Egmond,

2015), incentivizing decisions that are primarily concerned with upholding the quality of care within individual facilities, even when they might be detrimental to older person care in the organization's wider context. Valuation devices are grounded in a particular governance and accountability structure of older person care. In the Netherlands, the healthcare inspectorate evaluates the quality of care within individual organizations. It actively scouts out organizations that may be providing sub-standard care, and its inspectors may visit and scrutinize individual organizations. If it judges the quality of care in a nursing home to be inadequate, the inspectorate can impose a series of cascading measures intended to improve that quality. This governance and accountability structure takes the individual organization and its locations as the unit of measurement. The structure itself causes managers and medical staff to prioritize the quality of care within the boundaries of their own organization above older person care in the wider catchment area.

Recent attempts in older person care to build an infrastructure around the efficiency regime of valuation spurred the assembling of new socio-spatial formations. Another, highly institutionalized regime of valuation, the market regime provoked a countervailing, disassembling dynamic, while yet another regime of valuation, the historic regime, shaped both the assembling and disassembling of networks.

3. Assembling and disassembling the region: the historic regime

Older person care providers often valued the established

relations within the assemblage to which they belonged. At times, this complicated the assembling of "the region" as propagated by the Ministry of Health and the care offices. Sea-Care, one of the larger organizations in administrative region Flevoland, not only had nursing homes in Flevoland but also in another care office region, Friesland. In recent years, Sea-Care's management board had invested heavily in its partnerships with two older person care organizations, Aquarius and Pisces, both of which had nursing homes in Flevoland but whose core operations were located in Friesland. The four older person care organizations in Flevoland had been discussing preliminary plans for a pan-organizational medical team that would care for all four's clients, but this potential collaboration compromised the strategic plans of Sea-Care's management board.

> Yes, this pan-organizational medical team could be one of the outcomes, but what should we do with all our strategic plans? We are also collaborating with Aquarius and Pisces on rehabilitation and palliative care. (Sea-Care's manager)

Valuing the established partnerships in this way complicated relations between the institutional actors in Flevoland. On the one hand, Sea-Care's general manager was convinced that regionalization and mutual cooperation were needed to address the challenges older person care organizations were facing. On the other hand, he was questioning whether to seek solutions with the three other parties in Flevoland, since he had established partnerships with organizations outside this

administrative area. His hesitation was noted by the managers of the three other organizations in Flevoland, who questioned Sea-Care's allegiance. The valuing of historic relations complicated the emergence of collaborations in the various constituencies of the care offices, with actors often prioritizing relations with organizations from another administrative region.

The valuing of historic relations also benefitted the assembling of healthcare regions, although this seldom involved all the older person care providers in a care office region. The Friesland care office region was one example. In late 2018, one larger older person care provider, About-Care, suggested setting up a pan-organizational medical team composed of older person care physicians, specialist nurses and paramedics. The other Friesland organizations did not support the plan, however, and there was no history of collaboration to fall back on. About- Care then sought closer collaboration with their established partners, including a nearby hospital and a mental health provider. These parties drew up a new plan to create a pan- organizational medical team of older person care physicians, psychiatrists and geriatricians who would provide care in all three organizations. The plan had the support of the care office. Valuing historic relations could thus both spur as well as hamper the formation of care assemblages.

4. Assembling and disassembling the region: the organizational identity regime

Yet another regime of valuation shaped the configuration of the assemblages in older person care. Some actors valued what they

saw as the idiosyncratic signature of care in their organization, and this had consequences for the partnerships they formed. We saw this when studying a stand-alone nursing home in the middle of the Netherlands. Like most stand-alone nursing homes, it could not afford its own medical team and procured medical services from a for- profit older person care provider. The older person care physicians working in the stand-alone facility rotated, much to the dismay of its care workers and management, who took pride in being a small-scale organization offering lifelong employment in which care providers were accessible and in which clients and staff knew one another personally. Valuing these traits meant devaluating the partnership with the for-profit organization. Using the funds available for regional collaboration, the management of the stand-alone facility explored opportunities for a different arrangement of medical care, one that would support their own values of care and allow them to maintain their independence. The solution was to collaborate more closely with a local primary care organization, whose affiliated general practitioners would provide basic medical care in the nursing home with the support of an older person care physician made available by the for-profit organization. The stand-alone facility and the local GPs valued this new collaboration, since it meant continuity of care for their clients, a value that both parties saw as fundamental to the care they provided.

In the previous example, the valuing of the organization's idiosyncratic signature of care resulted in both the disassembling and assembling of care arrangements. This regime of valuation

existed alongside the efficiency, market and historic regimes, with the action spurred by and the interaction between these regimes shaping the assembling and disassembling of socio-spatial formations in older person care.

Conclusion

Our paper challenges the prevailing understanding of (healthcare) regions as clearly bounded topological areas, a view common in policy circles and

healthcare research (Hazen and Anthamatten, 2012). We asked, what is a healthcare region? Drawing on socio-geographical insights, we regard a healthcare region as a complex, dynamic and multi-layered assemblage of heterogeneous – public and private, administrative and professional, national, regional and local – institutional actors (Allen and Cochrane, 2007; Amin, 2004)). We build on recent studies focussing on the spatial dimension of healthcare restructuring (Lorne et al., 2019) and emphasize the multi-layeredness, dynamism and unbounded nature of healthcare regions. The actors in our study participated in a variety of policy and practice networks that were entangled in complex ways and together formed the “regional assemblage” in which regional care initiatives were established. This assemblage was dynamic, with the composition of the constituent networks – even the mandated ones – changing over time and therefore challenging the general understanding of such networks as being rather rigid, with prescribed roles and fixed membership (Waring et al., 2017). Spatially, this healthcare assemblage was boundless and unstable. It comprised a

multitude of networks with a diverse topological reach that changed as institutional actors joined or left. As a consequence, there is no unequivocal reading of what the healthcare region is; instead, it must be conceptualized as an entangled web of networks that is compositionally dynamic.

Regionalization fits in with a larger trend in which governance through networks is seen as a potentially productive approach for addressing "wicked problems" (Ferlie et al., 2013). Recent scholarship emphasizes the discrepancy between the managerial and technocratic view of networks as entities that can be mandated and imposed and a more sociological understanding of networks as emerging from the sustained and meaningful interaction of actors (Waring et al., 2017). We recognize this tension in our research. The policymakers and care offices we studied had a rather technocratic understanding of networks as entities that could be mandated and imposed on the field. As authorities, they set the parameters for regionalization as interorganizational collaborations meant to emerge within a given constituency. At times, this conflicted with the relevant organizations' established networks; some (like Sea-Care) had established partnerships with organizations in a different constituency, and this affected their commitment to the new, mandated networks.

At the same time, these new, mandated networks jeopardized established partnerships when managers started to question which strategic partnerships would be viable in the long run. This echoes other research showing that the establishment of

mandated networks is often complicated by pre-established interorganizational relations (Waring et al., 2017), and that such networks often threaten pre-established practice networks (Addicott et al., 2006). In this light, policymakers would benefit from having a more fluid understanding of what constitutes a region and from acquiring a more sociological perspective on networks. They might wish to refrain from a priori delineation of the geographical area and organizations but instead leave regionalization to the field and allow it to emerge from established relations within a healthcare assemblage.

It has been suggested that governance in networks can overcome the fragmentation brought about by the marketization of healthcare (Ferlie et al., 2013). Networks would foster relations of trust, openness, cooperation, shared decision-making and resource sharing, even if underlying market structures exist (Kickert et al., 1997). Other scholars, however, argue that network relations are often far from harmonious. They are shaped by structural power dissymmetries between groups and relations can be conflictual, for instance due to inconsistencies in health policies that push and pull actors within the network in opposite ways (Waring et al., 2017; Addicott et al., 2006). We asked the following: what mechanisms inform institutional actors' decisions to form, maintain or abandon collaborations with neighbouring organizations within an administrative region? Our paper offers a framework for understanding the conflictual dynamics within policy networks. Rather than seeing strained relations within networks as the product of different sets of values (Klijn and Teisman, 2003), we

argue that tensions may arise from conflictual valuation regimes within the healthcare sector. One practical implication of our analysis is that calls for regionalization in healthcare will be ineffective unless the underlying governance and accountability structures are addressed. Current governance and accountability structures of older person care in the Netherlands are tied to a market evaluative principle, meaning that managers value strategies that are primarily in the interest of their own organization. Without changing these underlying structures, the objectives of regionalization are unlikely to be realized. New modes of accountability that work from a networked perspective must be developed to make regionalization work.

3.

Creativity at the margins: A cross-country case study on how Dutch and Norwegian peripheries address challenges to quality work in care for older persons

Bovenkamp, H., van Pijkeren, N., Ree, E., Aase, I., Johannessen, T., Vollaard, H., Wallenburg, I., Bal, R. & Wiig, S. (2022). Creativity at the margins: A cross-country case study on how Dutch and Norwegian peripheries address challenges to quality work in care for older persons. Health Policy. 127. 10.1016/j.healthpol.2022.12.008.

Introduction

Quality of care for older persons figures high on the policy agendas of many Western countries. Even so, the older persons care sector faces a number of challenges that raise quality concerns, including increased demands on the system due to aging populations, policies aimed at aging in place, and workforce shortages (Wilson, Davies, and Nolan 2009, Kroezen, Van Hoegaerden, and Batenburg 2018a, Drennan et al. 2018, Connell and Walton-Roberts 2016). Compared to other health-care sectors, however, quality work in older persons care remains under-researched, particularly with respect to the impact of different contexts on quality (Coles et al. 2017, Estabrooks et al. 2015, Ree and Wiig 2020, Wiig et al. 2019b). In this paper, we help to fill this gap by researching the role of geographical context, specifically focusing on geographical peripheries.

Geographical contexts differ between and within countries (Ricketts 2000, Sogstad, Hellesø, and Skinner 2020). This paper focuses on geographical differences within countries by exploring differences between center and periphery. While the existing literature on geographical context has traditionally focused on the distinction between urban ('city') and rural areas, with the city often featuring as 'better off' (Wenger 2001, Phillipson and Scharf 2005, Milne, Hatzidimitriadou, and Wiseman 2007, De Smedt and Mehus 2017, Leick and Lang 2017, Kühn 2014, Souza 2018), we take a different route by concentrating on the difference between centers and peripheries (Beetz, Huning, and Plieninger 2008, Nel and Pelc 2020a). Centers can rely on more political attention and more resources because, unlike peripheries, they are positioned

closer to the core of governing and infrastructural networks. This distinction between center and periphery is broader than the classic rural-urban divide; certain cities and non-rural, de-industrialized areas can, for example, also be peripheral (Beetz, Huning, and Plieninger 2008, Malatzky and Bourke 2016, Leick and Lang 2017, Souza 2018). Such areas struggle with challenges similar to those of their rural peripheral counterparts in the organization of care for older persons.

Peripheral areas are often overlooked in health-care research but in fact deserve specific attention (Milne, Hatzidimitriadou, and Wiseman 2007, Malatzky and Bourke 2016) because they struggle to provide good quality and accessible health-care services, for example due to workforce shortages, long travel distances and specialist care being clustered mainly at the centers (Haartsen and Venhorst 2010, Ricketts 2000, Sogstad, Hellesø, and Skinner 2020). At the same time, new interventions or promising innovations can emerge at the fringes; in places where creativity is urgently needed (Ivanova, Wallenburg, and Bal 2016). We conceptualize the strategies emerging in these areas as creativity at the margins (see (Nel and Pelc 2020a, Pelc and Nel 2020)).

In this paper, we use the concept of creativity at the margins to study geographical context in older persons care. While certain areas not only face a concentration of challenges, such as an aging population, workforce shortages, and geographical remoteness, they also pioneer creative solutions for dealing with these challenges. An understanding of how organizations in peripheral areas work on quality and accessibility and handle the challenges

posed by their geographical context is therefore important, not only to draw lessons for other peripheral areas but also for how the quality and accessibility of older persons care is organized in the centers, as these challenges are likely to become more pressing there as well (Haartsen and Venhorst 2010). For policymakers aiming to keep older persons care sustainable, such insights are of crucial importance.

The paper will answer the following research questions: How does geographical context impact challenges regarding quality and accessibility experienced by older persons care organizations in the explorative cases of Norway and the Netherlands, what strategies are used to deal with these challenges, and what are the consequences for quality of care?

We answer these questions by drawing on cases from two large studies on older persons care in Norway and the Netherlands, two countries that harbor a variety of geographical contexts.

The paper proceeds as follows. In the next section, we explain the reasons for our case selection and the methods we used to conduct our study. In the results section, we first provide a short description of how older persons care is organized in Norway and the Netherlands and then discuss how quality and accessibility work is affected by the geographical context in both countries; we then present three strategies we found practitioners to use concerning quality and accessibility issues: scaling up, brightening up and opening up. Finally, we reflect on our main findings and point out our contribution to the literature on the impact of geographical context on quality work.

Methods

Explorative case studies

At this exploratory stage, case studies are an appropriate heuristic instrument for examining how geographical context shapes quality work in older persons care, offering important lessons for future policies and research into organizing quality and accessibility in peripheral areas. For example, findings can be used as input for larger-scale studies that test the specific relationships sifted out from them. Case studies allow for in-depth examination of the relationships at hand, increasing internal validity while taking into account other contextual factors (Halperin and Heath 2020, George and Bennett 2005).

To strengthen the internal validity of our findings, we studied two cases: the large, mountainous, sparsely populated country of Norway and the small, flat, densely populated country of the Netherlands. We acknowledge that these two countries are both relatively wealthy and well-organized, but the geographical differences between them allow us to tease out which patterns recur in quality of care in various types of peripheral areas (Halperin and Heath 2020). The two explorative case studies thus offer a firm basis for further research on the impact of geographical context on quality and accessibility of care, also beyond the two cases. Table 1 sums up the geographical features of Norway and Netherlands. Table 2 and 3 provide the necessary background information about the older persons care systems in both countries.

Geographical context	Population density	Municipalities	Distance to nearest hospital	Landscape characteristics	Developments
Netherlands	513/sq km (ranging from 23 to 6,289 /sq km) Population of 17.2 million on 41,543 sq km	355 municipalities	99.6% of the population can reach the hospital within 45 minutes with the help of ambulance services (Gezondheidsraad 22 september 2020)	Flat country with dense network of highways	Smaller and larger municipalities in the western urban agglomeration ('Randstad") are experiencing strong population growth, whereas 'peripheral' regions are seeing a decline in population and industry
Norway	15/sq km (ranging from 0.3 to	356 municipalities	Driving distances to nearest emergency ward range	Mountainous areas, islands, coastal	Peripheral regions face decline in population and

1,682 /sq km) Population of 5.4 million on 385,207 sq km	from 3 minutes to 7 hours (Sentralbyra)	areas crossed by fjords	employment, in contrast to big cities and their surroundings

Table 2: The older persons care system in the Netherlands

Organization of older persons care: The Dutch health-care system, including older persons care, is a layered system that combines top-down government regulation, market elements, self-regulation by professionals and consultation between different health-care actors (Van de Bovenkamp, De Mul, Quartz, Weggelaar Jansen, et al. 2014). This layered system means that many external actors are involved in quality work with different quality demands (van de Bovenkamp et al. 2020). At the same time, individual organizations have the leeway to decide on their own quality work, and there are efforts to extend this leeway so that organizations can adapt their work to their local context (Zorginstituut Nederland 2017).

Financial system: Older persons care is financed under multiple laws, including the Health Insurance Act (acute and curative care), the Long-term Care Act (including nursing home care and 24-hour

home care) and the Social Support Act (home care). The older person can be subject to all three laws, contributing to the fragmentation of the system and the need for coordination.

Key policy issues: Aging in place (i.e. 'living at home as long as possible') is a key issue on the policy agenda. As a result, nursing home residents and the group of older persons in need of home care have more complex care needs than in the past. In addition, there is a focus on 'sustainable' older persons care, in view of the rising numbers of older persons in need of care and the decline in the young working population. The Dutch government provides funding and quality programs to encourage health organizations to anticipate workforce shortages and the growing demand for care in the near future. Part of the focus on sustainability is the move from competition between care providers towards regional collaboration.

Job market: Nurse aides, nurses, GPs and older persons care physicians are the main professions in Dutch older persons care. Recent decades have seen a growing shortage of both nursing and medical staff in this sector.

Table 3: The older persons care system in Norway
Organization of older persons care: Norwegian municipalities are responsible for primary care, including nursing homes and home-care services. There is no direct line of command and control from central authorities to the municipalities. The municipalities have a great deal of freedom to organize primary health-care services,

resulting in differences in how these services are delivered (Ringard et al. 2013).

Financial system: Primary health care in Norway is financed mainly by the municipalities' 'unrestricted revenues per capita' (tax revenues and government funding) as well as fees and user payments. Municipalities have some autonomy in how they spend their unrestricted revenues per capita, but they are bound to certain service content and quality requirements stipulated in Norwegian law (Sogstad, Hellesø, and Skinner 2020). In 2019, 'bundled payments' were introduced in the Norwegian health-care service as a potential reimbursement model (Mjåset et al. 2020).

Key policy issues: Aging in place is a key issue on the policy agenda (Ministry of Health and Care Services). Patients are now discharged from hospitals to nursing homes and home-care services quicker than in the past. Combined with an aging population with chronic conditions and multi-morbidity, this has increased the demand for long-term care (Sogstad, Hellesø, and Skinner 2020). Patient safety in health care, including older persons care, has figured prominently on the policy agenda from 2010 onward (The Norwegian Directorate of Health 2019).

Job market: Nurses and nursing aides are the main professions in Norwegian nursing homes and home care. In terms of physician staffing, some nursing homes have a regular nursing home physician, while others are serviced by one or several GPs with nursing home duties (Glette 2020).

Data collection

1. Data collection in SAFE-LEAD and REGIOZ project

Two large research projects on quality of older persons care in Norway (SAFE-LEAD) and the Netherlands (RegioZ) served as a starting point for our exploratory study on the impact of geographical context. SAFE-LEAD (for more details, see (Wiig et al. 2018)) is a large mixed-methods study focusing on quality and safety leadership in four nursing homes and four home-care organizations in five different municipalities in Norway (two of which are peripheral) (Ree, Johannessen, and Wiig 2019, Wilson, Davies, and Nolan 2009). Secondary analysis of data collected in these units was used for the purpose of this paper. For this study we used individual (n=3) and focus group interviews (n=5) from the SAFE-LEAD study involving a total of 26 participants. Participants included unit managers, department managers, and professional development nurses who work on quality and are responsible for monitoring and improving quality of care in the organizations. Data collection was based on semi-structured interview guides that included topics related to the Organizing for Quality Framework focusing on different quality challenges including external demands (Johannessen et al. 2020).

The RegioZ project in the Netherlands (for more details, see (Schuurmans, Van Pijkeren, Wallenburg, et al. 2020, Schuurmans, Wallenburg, and Bal 2019)), focuses on the question how to organize sustainable older persons care in a manner that addresses current and future challenges effectively, including an aging population and workforce shortages. We selected three

peripheral regions that participated in the Dutch study, as many of the municipalities in these three regions are experiencing a decline in population and large workforce shortages. For this paper, we analyzed interviews (n=18) with quality managers and leaders (including physicians, senior nurses and medical team managers) working at nursing homes and home-care organizations. These professionals were responsible for the quality of care, or worked on interventions meant to support quality and accessibility work in and among organizations in the region. The interviews focused on the challenges to organizing care in the region and how organizations try to deal with them.

Geographical context was not the initial focus of the two projects but emerged as a potential explanation for why quality work played out differently in various locations. We subsequently discussed this explanation during joint meetings of the two research teams and used secondary analysis to re-examine our data. To explore this issue further we complemented our analysis with additional data collection, so as to gain a more thorough understanding of how geographical context shapes quality work.

2. Additional data collection

To explore the issue of the importance of geographical context for organizing for quality further, we conducted additional data collection through interviews and document analysis.

We interviewed experts on the topic of health care on the periphery in Norway (n=2) and the Netherlands (n=1), selecting the respondents based on their contributions to public and academic debate on this issue. These respondents work on the spatial (re)organization of health care and focus on health

inequalities in and between places. Topics discussed included the challenges experienced on the periphery, concerning workforce, healthcare provision, as well as potential and actual strategies used in response to these problems and attention for healthcare in these specific areas in national and local healthcare policy.

In addition, we conducted document analysis in both countries. We selected national policy documents focusing on the long-term organization of older person care. For the Norwegian case, we analyzed key policy documents dealing with challenges in organizing older person care, especially with regard to quality and patient safety (Ministry of Health and Care Services 2014, Ministry of Health and Care Services , Ministry of Health and Care Services , The Norwegian Directorate of Health 2019, NOU 2019). For the Dutch case, we analyzed national documents focusing on regionalization as a proposed governance strategy to deal with future challenges in the long-term care sector. We also analyzed documents on the spatial organization of health care and welfare in the Netherlands (Schuurmans, Van Pijkeren, Wallenburg, et al. 2020, Planbureau voor de Leefomgeving 2018, Sociaal en Cultureel Planbureau 2013, Ministerie Volksgezondheid Welzijn en Sport 2018b, Capaciteitsorgaan 2019, Ministerie Volksgezondheid Welzijn en Sport 2018a, Ministerie van Binnenlandse Zaken en Koninkrijksrelaties maart 2016, Zorginstituut Nederland 2017). To conclude, we collected and studied empirical research papers focusing on the impact of geographical context on the organization of older persons care in the two countries.

Analysis

This paper is an exploratory study based primarily on secondary analysis. Secondary analysis offers a meaningful approach to new research questions that emerge from qualitative data collected previously (Heaton 2008, Felder et al. 2018). The subject we are addressing emerged from discussions among the researchers involved in the two studies on the impact of context on quality work. We subsequently used the data described above to better understand the impact of geographical context on quality work, with a specific focus on the periphery.

The data used for this paper were coded inductively. We used geographic context, the periphery and creativity at the margins as sensitizing concepts. The thematic analysis comprised the following themes: 1) the impact of geographical context on the challenges facing older persons care and on the organization of quality in older persons care; 2) creativity at the margins in terms of the strategies used to deal with these challenges; and 3) the impact of these strategies on health-care quality work.

The research teams discussed the preliminary analyses multiple times and subsequently refined them by going back and forth between the data and the literature.

Results

In this section, we first focus on the impact of geographical context on the challenges facing older persons care on the periphery, such as remoteness, long distances, workforce shortages, and lack of informal care givers. We then consider the strategies used to deal with these challenges in national policies before moving on to the

strategies used by care organizations themselves. We conceptualize the latter as 'creativity at the margins'.

Impact of geographical context on challenges for older persons care on the periphery

Older persons care organizations in both countries are dealing with challenges that impact their quality work. This is especially the case for organizations working in peripheral areas where populations are aging more rapidly. Certain peripheral areas also struggle with specific geographical problems. For example, in one of the Dutch cases, exploitation of a large natural gas field has caused many earthquakes, resulting in housing issues for older persons care organizations. In Norway, one of the home-care organizations delivers care on two islands that are an hour away from the mainland by ferry, impacting the organization of care.

It is often difficult to persuade young people to return to peripheral areas after they finish up their higher education elsewhere, and even more difficult to attract newcomers, leading to persistent workforce shortages. Geographical distance to the center is therefore a negative factor for these health-care organizations. Even though geographical distances in the Netherlands are much smaller by any objective measure than those in Norway (e.g. it is possible to drive from the southernmost to the northernmost part of the country in under four hours), here too they can be felt subjectively as too large to overcome:

> Zeeland is very far for many people. And if I talk about Zeeuws Vlaanderen it just feels like we're falling off the edge of the earth. (older persons care manager, the

Netherlands)

Despite huge differences in their geographical challenges, then, organizations in both countries experience similar concerns.
Geographical distance also raises other challenges for older persons care organizations working on the periphery. As nurses and doctors must cover wider areas, it is harder to organize 24-hour care and the distance to other health-care services (such as hospitals) can cause problems. This is particularly the case in Norway:

> In rural areas, it could be two hours to the nearest medical center. In one of our districts, I think it takes between 1 and 2 hours to get to the nearest medical center and in our northern area there is one GP on call. If he is busy, there is no one and the next closest medical center is three hours away. (Norwegian expert interview 2)

In addition, rough weather conditions (i.e. snow, ice, storms, and floods are common in some areas) make it difficult to move around, particularly when transport infrastructure is lacking. This was the case in the small peripheral units included in the SAFE-LEAD project; although the two municipalities had few inhabitants, distances could be long and pose challenges in terms of mobile phone and internet access as well as transportation during the winter. This sometimes led to situations in which health-care professionals could not easily consult colleagues when necessary and had to rely on themselves.

Government policies in both countries increasingly expect next of kin to function as informal care givers. In the Dutch case in particular, however, there are few informal care givers who can support older people in aging in place. Although this is a common problem in the Netherlands, it is especially true in peripheral areas, which are experiencing an exodus of young and more highly educated people to the cities. Those who stay behind tend to be older and lower educated.

Both countries face challenges not only in finding enough professional and informal care givers but also in coping with a decline in all kinds of services and facilities in peripheral areas. Hospitals, shops, schools and other places for social gatherings are closing down, and this too is impacting the quality of care. On the one hand, the decline is exacerbating contraction in these areas because they are less able to attract young people to help solve the workforce and informal care shortages. On the other hand, it is making it even harder for the older persons to age in place because they do not have access to places where they can meet others or do their shopping. Social and health problems become heightened in this way, causing one mayor of a shrinking Dutch municipality to worry that local people were ending up as 'second class citizens' because they had less access to good quality services compared to people living in the center .

Based on our results, we therefore found that older persons care organizations on the periphery struggle with a number of pressing difficulties, summarized succinctly by one of our respondents:

> The problems in a region aren't the same. This region is unique for the Netherlands, it is sparsely populated and you have to deal with a low SES [Socio-Economic Status] population. There is a big difference from the city and you have an aging population and a shrinking population and we also have the problems with earthquakes because of the gas production. (...) Every region has its own problems and I think it is important to identify commonalities and find solutions, but sometimes the differences are so large that the city requires another approach than the outlying region. (head of medical team, the Netherlands)

In our analysis of the geographical context, we looked at how organizations deal with geographical distances (between services and to the center), workforce shortages, and landscape characteristics. In the next sections we consider how they tackle these challenges. We first turn to national policies intended to relieve the problems experienced in peripheral areas. We then examine the creative solutions that older persons care organizations seek out and how they impact quality of care.

National health-care policies for the peripheries

National authorities in both countries take an interest in the organization of care in peripheral areas. For example, in Norway health-care providers must have an emergency health preparedness plan in place covering, amongst others, the sort of emergencies that peripheries may experience due to their geographical context, such as landslides, power shortages and so on (Act on Emergency Health Preparedness 2000). Other solutions

set in motion or considered in government policy documents include offering decentralized training in nursing adapted to local competence needs (thus recognizing the connection between place of study and work) (NOU 2019). Historically, nursing training was organized locally for this reason, but the reform of the higher education system, which involved greater centralization of education, cut down on the number of local training programs. Recognizing the downsides of these reforms, government urged universities to provide decentralized nursing training programs again (Aase 2016). The strategy of decentralizing health-care education had proved successful before, with a medical school being established in Tromsø, the capital of northern Norway, that favored students from the region and offered rural rotations in the curriculum. The impact on the region's supply of physicians was highly positive (Straume K and DM. 2010). In addition, a recent white paper (NOU 2019) sets out how technology can reduce the distance between competent personnel and patients in vulnerable districts. Another example of a peripheral focus in national policy is the cancellation of student debt when professionals choose to work in certain parts of the country (Kunnskapsdepartementet 2020). However, as one of the Norwegian experts points out, more integral policies are needed to provide a robust answer to the challenges posed:

> For instance, in a peripheral area, it is also about creating awareness that you can live good lives with steady incomes. You do not necessarily need to move to Oslo but you can have an interesting life here as well. And you need to create [policy] awareness that a lot of different systems

> are linked. For instance, the school structure, people meet their partners when they are enrolled in higher education. So if you want to be a nurse in Finnmark and you have to go to Tromsø or Trondheim to study, then you will meet a life partner there with no ties to your home region. (Norwegian expert 1)

The Netherlands also has a number of national policy initiatives that address the organization of care in peripheral areas. These go back several decades in the case of initiatives focusing on border regions, where cross-border health-care cooperation is organized for acute care (November 2016, Vollaard 2004, Raad voor het Openbaar Bestuur 2010). There is a national action plan for municipalities facing population decline that also addresses health care. It includes some specific measures, such as the possibility of deviating from funding rules for GPs, but the national government emphasizes that its role is largely to coordinate (Ministerie van Binnenlandse Zaken en Koninkrijksrelaties maart 2016). This means that it is mostly up to the peripheral areas themselves to deal with the challenges described earlier. Regional collaboration between older persons care organizations is encouraged as a means of strengthening the provision of older persons care and resolving workforce shortages (Schuurmans and Van der Woerd Forthcoming). Moreover, the national Dignity & Pride program, which supports quality of care initiatives in and between care organizations, can be used by organizations in peripheral areas (and their counterparts in the center) to support interventions tackling the regional problems they are struggling with (Ministerie Volksgezondheid Welzijn en Sport 2018b). In terms of the

workforce issue, the regional care offices (responsible for financing long-term care) bear the primary responsibility. They must cooperate with other parties, such as care providers, local authorities and municipalities, to deliver sufficient quality care.

Creativity at the margins: strategies in the peripheral areas
In this section, we introduce the strategies used in the peripheral areas, summarized as scaling up, brightening up and opening up, and discuss them in turn.

1. Scaling up: forging bonds with other care organizations

The first strategy we identified in both countries is scaling up, which includes cooperating with other care organizations or municipalities. Collaboration across organizations is felt to be necessary to make the most efficient use of the medical expertise available:

> We all fish in the same pond [when attracting new personnel], so we have to make deals with each other. (medical team manager, older persons care organization, the Netherlands)

To foster these efforts in the Netherlands, regional collaboration schemes are set up to find specific solutions to local scarcity and quality challenges. One example is a regional alliance between the hospital, GPs and older persons care organizations intended to integrate care and enable older persons care physicians to work across organizations and make better use of their specialized knowledge. While this makes medical expertise more readily

available, respondents also experienced a downside with regard to the unique identity of the care home:

> If someone [professional caregiver] gets sick, then we have a big problem. Now we have this source [the cooperation scheme] behind us and then someone else can just cover. But the uniqueness of the home, that is what people like. They have ties with a region, they live here. They are connected. But, well, it is a fine art to ensure that uniqueness in an organization when working with a central unit. (manager of an older persons care organization, the Netherlands)

We also encountered examples of cooperation as a strategy in peripheral areas in Norway. The nursing homes and home-care services in the two smallest peripheral Norwegian municipalities collaborated across units. This impacted quality in a positive way, as it helped to provide more integrated care. There was also a high degree of collaboration and learning across departments and organizations (nursing home, home-care organization, research and development department, physiotherapist, occupational therapist, doctors), resulting in collaborative problem-solving. If necessary, the physiotherapist or occupational therapist also visited users at home when home-care services staff were present, for example when users had been at a rehabilitation clinic and needed extra support when returning home, or if home-care staff noticed changes in what older persons could do or manage physically. The organizations also took advantage of the benefits of being a small municipality where people know one another.

Managers of older persons care organizations, for instance, found it easy to collaborate with the municipality because they could contact officials quickly and directly when they encountered problems. One of the experts we interviewed also pointed out the advantage of social proximity:

> [The] advantage of smaller municipalities is that the people know the nurses, so the social gulf between patients and health professionals is smaller, and also between health professionals/managers and municipal staff, which can be an advantage if you want to change certain things. (Norwegian expert 1)

At the same time, cooperation across municipalities is felt to ensure access to services in Norway. One of the peripheral municipalities in the study was planning a merger. Managers of the older persons care organizations thought that this would make specialist health services more accessible and give managers more time to pursue quality work because they would no longer be responsible for virtually all activity in the units (e.g. leasing cars, changing winter tires). One respondent, however, noted that mergers can also increase the geographical distances that nurses have to cover. Another drawback would be that the benefits of social proximity would disappear:

> The downside for us [of the merger is]… Now, the mayor is sitting…we can almost see the door to the mayor's office over there...and the councilor is sitting right over there, so we walk over to the finance manager and say that we are

> struggling a bit. (unit manager, home-care service, Norway)

Scaling up, while having positive effects, thus also has the disadvantage that local ties become looser.

To summarize, we found that the strategy of scaling up is used in different ways. Collaboration across departments, service providers, with the municipality and between municipalities all help to tackle quality challenges such as workforce shortages. These solutions sometimes involve a trade-off in quality. On the one hand, they help to ensure the accessibility of care and more integrated care (depending on the alliances forged); on the other, the personal connection with clients and others involved in quality can be lost along the way.

2. Brightening up: increasing the attractiveness of working in peripheral areas

The second strategy we identified is to brighten up the periphery by making these areas more attractive places to work and live for health-care professionals. Striking examples of the latter in the Dutch case involve offering GPs guest houses in return for spending the summer season working in a peripheral area, or offering physicians' spouses jobs. A nursing training program was also brought to the area in this particular region to attract and train more young people there.

Another important part of this strategy is making the work itself more attractive, for instance through task differentiation and educational opportunities. Alongside national policies in Norway

meant to increase the attractiveness of working on the periphery, there have also been local initiatives. Despite the enormous financial pressures, municipalities in peripheral areas provided strong support for competence-building in organizations, ranging from compulsory courses and training, such as training in new drugs dispensers, to optional courses attuned to employee needs and interests, such as wound care, nutrition, and palliative care. All employees were given the option of attending courses and competence development.

Another example of brightening up is to boost the role of nurse aides and nurses working in peripheral areas. This is the approach taken in one of the Dutch organizations, which trains nurse aides and nurses to detect and communicate deterioration and assigns care tasks to specialized nurses, such as wound nurses, diabetes nurses and nurses specialized in long diseases. Interestingly, these initiatives contribute to more nurse-driven older persons care, with nurses taking over tasks from physicians. This then creates space for new practices in quality of care that focus on person-centeredness and daily living and that make the work more attractive for nurses. It also enhances the quality of care, as there is less turnover among nurses and therefore more stable care teams and fewer staff shortages in the organization and the overall region (Van Pijkeren, Wallenburg, and Bal 2021).

In summary, older persons care organizations try to brighten up regions in several ways to make them more attractive places to work and live. Certain initiatives, for example giving nurses a more

prominent role, can contribute to quality by making care more person-centered.

3. Opening up: bringing society into care for older persons

The focus on person-centered care and wellbeing present in some of the initiatives described above can also be found in the strategy of opening up, which involves initiatives that connect care providers and clients to their broader environments. Examples include arranging for students at a nearby hospitality school to provide catering during celebrations or organizing alternative services aimed at wellbeing in the nursing home:

> And we also have these people here who have four of those [service] dogs who come by, and people [residents] become, well, they become very different, and they pet these animals. So, you also have all kinds of opportunities in that respect, a sort of alternative circuit of activities. (manager of a Dutch older persons care organization)

There are also initiatives focusing on improving the wellbeing of older persons outside the nursing homes by upgrading quality of life in villages, e.g. by converting an abandoned church into day care centre for older persons or by offering services aimed at mental wellbeing. A number of citizen initiatives in one of the Dutch cases are especially worth mentioning; they focus on wellbeing in some cases involve collaboration with a GP. The activities include connecting older persons to one another or to volunteers, and arranging for older persons to have meals together. There are also more formalized initiatives, such as a

citizen care alliance that organizes a more holistic form of care, or improving quality of life in an area by involving older persons in a meaningful way, for example by developing a wheelchair-friendly garden where the older persons teach children how to garden.

We found that organizations are responding to challenges impacting the quality and accessibility of older persons care by opening up to society, and that local citizens are stepping up to arrange older persons care themselves. These solutions can contribute to the accessibility of care and the shift towards making this care more holistic and person-centered, thereby further broadening the concept of quality of care.

Discussion

This exploratory study aimed to shed light on the impact of geographical context on challenges regarding quality and accessibility experienced by older persons care organizations in the periphery, the strategies used to deal with these challenges, and the consequences for quality of care. We used Norway and the Netherlands as explorative case studies. This is an important first step toward allowing policymakers to learn lessons and overcome 'rural blindness' (Milne, Hatzidimitriadou, and Wiseman 2007) or, more broadly, 'peripheral blindness' in policymaking. In policies, peripheries or rural areas are often considered as 'lagging behind' and hardly zoom in on the various ways professionals working in these areas experience challenges. Our study shows that geographical context influences the challenges experienced by older persons care organizations. More specifically, those located in peripheral areas face certain

challenges, such as workforce shortages, ageing populations, lack of support from informal carers, geographical distances to (medical) services, that force them to think differently about organizing for quality.

Another important finding is that much can be learned from the creativity with which peripheral areas deal with their specific challenges. We propose that researchers and policymakers alike look more closely at these efforts. Conceptualizing them as 'creativity at the margins' helps to recognize the potential of these areas to learn and develop new and innovative solutions. This paper shows that actors in older persons care in peripheral areas indeed struggle more with certain challenges posed by their geographical context. However, they also seem to be ahead in dealing creatively with such challenges, for example by focusing on competence-building among staff and by cooperating across organizational boundaries. Moreover, there are also interesting examples of citizen initiatives, some of which are actually contributing to making the long-proposed shift towards person-centeredness and wellbeing (Flesner 2009, van de Bovenkamp et al. 2020, Wilson, Davies, and Nolan 2009). We therefore argue that peripheries in health care should also be perceived in a more positive light as margins where opportunities open up and as places of creativity and innovation (Nel and Pelc 2020a, Pelc and Nel 2020).

Implications

The challenges experienced by older persons care organizations in the diverging cases of the Netherlands and Norway show the

importance to increase attention for peripheral areas in policymaking and moreover recognize the diversity of challenges between areas. In Norway, the organization of care in remote areas is more ingrained in its history (Sogstad, Hellesø, and Skinner 2020), with national policies in place that ensure ongoing attention to workforce challenges in areas for example training and national programs to enhance knowledge for nurses, or initiatives meant to make such areas more attractive places to work and live. In the Netherlands, peripheries are not so much places that are remote in terms of geographical distances, but are areas that often lack political support or attention. Here, the issue of organizing long-term care in peripheral areas only recently gained a more prominent place on the policy agenda, in particular in response to persistent and increasing workforce shortages (Schuurmans, Van Pijkeren, Wallenburg, et al. 2020). Other countries also have national policies on organizing care in peripheral areas, but also there, there are calls for policy that pays greater attention to areas outside the center (Wenger 2001, Straume K and DM. 2010, Rechel et al. 2016). More specifically, policymakers should ~~also~~ turn their attention to the periphery to ensure conditions for creativity at the margins. The fact that there are interesting initiatives at the margins does not mean that actors in these areas should simply be left to fend for themselves. Policies must be put in place establishing the conditions that will allow such initiatives to succeed and continue (Pelc and Nel 2020), for instance, policies that support initiatives and resources to give nurses a more prominent role.

As certain challenges, for example an aging population along with workforce shortages, that are now more acute in peripheral areas will become more pressing at the center as well, it is time for researchers to turn their gaze toward the margins to learn from how they deal with these challenges. Part of this examination involves considering how different responses impact quality and quality work. This study shows that initiatives involving collaboration between organizations may help to ensure accessibility to services but can also impinge upon the personal relationships considered essential to providing good quality care, as becomes clear in the scaling up strategy. We also studied several initiatives (e.g. working together in collaborative centers or opening up the organization to outsiders) that have had a positive impact on person-centeredness, but more research is needed to also identify what may be lost in the process. More in-depth cross-country studies are therefore required to complement the findings of this exploratory study.

Strengths and Limitations

This study has a number of limitations. Our research is based on two large studies on organizing older persons care that vary in focus and set-up. However, combining insights from these two different studies and collecting additional data allowed us to identify and explore the impact of geographical context as an important factor for quality work in older persons care. In this paper we reported on the general themes emerging from our data. This exploratory study thus offers a key initial understanding of this subject, which should be explored further in future research.

The strength of our study is that it revealed a number of common strategies used in response to challenges in older persons care in peripheral areas in two geographically distinct countries. Our broad and generic conceptualization of periphery may be a limitation, however. What is considered peripheral in the Netherlands differs from what is considered peripheral in Norway (Phillipson and Scharf 2005, Rechel et al. 2016). Differences in the geographical context of the two countries are clear. Norway (large geographical area, sparsely populated) and the Netherlands (small geographical area, densely populated) can be considered opposites in this respect. Still, the geographical challenges and the strategies used to deal with them are largely similar in both.

Future research

The results also show that these geographical challenges are to some extent social constructs (think, for example, of the description of one of the Dutch regions as 'falling off the edge of the earth'). Any further statements about similarities and possible differences would, however, require in-depth case studies, as quality work is likely to be affected by the intricacies of country-specific details or internal variations (e.g. the fact that one of the areas in the Dutch case struggles with earthquakes, or that one of the areas in the Norwegian case involves delivering care on islands).

By examining both centers and peripheries in a more variegated set of countries, future research can further determine whether the responses scaling up, brightening up, and opening up can be detected in other cases. Future research can also explain more

specifically how and why health-care actors on the peripheries find creative ways to deal with their challenges. One question is whether this is purely out of necessity or also because they feel less pressure to adhere to organizational templates and standards set in the center.

Conclusions

This paper explores the impact of geographical context on older persons care organizations on the periphery in Norway and the Netherlands and concludes that such organizations are experiencing a concentration of challenges, including staff shortages, trouble ensuring access to care, a lack of informal care givers, and a general decline in services. In response, they are forced to develop new and innovative strategies to maintain the quality of older persons care. We conclude that, despite differences in the geographical contexts of the two countries, older persons care organizations and people living in peripheral areas in both deal with these challenges creatively by scaling up, brightening up and opening up. Initiatives tied to these strategies impact quality, accessibility and person-centeredness in different ways. Our conclusion is that the peripheral blindness of much research and many policies should be combatted by paying more attention (in policy) to the organization of care in peripheral areas and to the creativity at the margins found there.

4.

Caring Peripheries: how care practitioners respond to processes of peripheralization

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Introduction

Peripheral, mostly rural and post-industrial areas, face unique challenges in providing healthcare services due to their lower population densities, geographical distances, and limited availability of healthcare resources. As care is increasingly concentrated in metropolitan areas, peripheral areas are pushed to the margins. Some government organizations and media outlets point to 'medical deserts'[7] to describe areas where inhabitants increasingly lack access to healthcare and remaining care providers have trouble recruiting personnel (Guillaume Chevillard, Veronique Lucas-Gabrielli, and Mousques 2018, Angharad, Rahman, and JiaqingO 2019). So far, research mainly focuses on what concentration of high-end services in metropolitan hospitals means for the quality of care delivered in the urban centre. Less attention is given to the side-effects of concentration: peripheralization, happening in areas 'outside' designated centres where reduction of services and staff is felt (Souza 2018, Keim-Klärner 2021, Milligan and Wiles 2010).

In this research, we start filling this gap by exploring how this trend of concentration of healthcare can contribute to a phenomenon referred to as 'discursive peripheralization' (Willett and Lang 2018, Plüschke-Altof 2016). Discursive peripheralization refers to the process how some geographical areas come to be seen as peripheral depending on its discursive construction and how it is narrated as 'the internal other of the strong core',

[7] European policy defines "medical deserts" as remote rural regions and deprived urban areas that lack an adequate supply of medical personnel and healthcare services (Zerbib 2021).

maintaining and reinforcing existing power differentials (Eriksson 2008). Such processes are not just about language but also about (symbolic) practices of creating differences between areas. Importantly, this discursive production of peripheries shapes the perceptions and practices within specific areas, such as economic activities, the availability of public services and daily routines of local residents (Willett and Lang 2018).

This paper contributes to the literature on discursive peripheralization by focusing on how actors cope with or oppose such processes. It does so by shedding light on the agency of local actors within these processes, which can also counteract dominant discourses about peripheral areas. Souza (2018) for instance, claims that actors in these areas can also spark creativity to deal with harsh conditions. In similar vein, researchers state that attention should be drawn to agency of actors and how new perspectives for future development may arise, supporting an understanding of peripheral regions as 'spaces of possibility' (Görmar and Lang 2019, Willett and Lang 2018). Also in healthcare, actors and local governments in peripheral areas are exploring viable alternatives for the provision of care (Van de Bovenkamp et al. 2021). They are for instance seeking to deliver enhanced care in outpatient clinics, patients' homes, or through collaborative partnerships (Lappegard and Hjortdahl 2013, Magnussen, Hagen, and Kaarboe 2007).

In this paper we aim to shed light on these initiatives and examine how care practitioners actively shape, oppose and

(re)produce peripheralization in healthcare practice and policy in acute care for older persons in the Netherlands and Norway. Both countries face significant challenges in providing general and acute care for a fast-growing group of older persons, who increasingly live at home as a result of ageing-in-place policies. Although the two countries differ in geographical context, they face similar problems and mechanisms regarding the provision of acute care services (Wakerman 2004).

The following question guides our research: *How do care practitioners respond to processes of peripheralization in their (acute) care delivery for older persons?*

In the following, we elaborate on theory on (discursive) peripheralization and the methods used to conduct our empirical case studies. This is followed by the empirical sections in which we analyse how care practitioners engage in local challenges to provide adequate care, and how they, in doing so, co-construct a local practice and understanding of adequate care. We conclude with a discussion in which we outline our theoretical and empirical contribution as well as implications for healthcare delivery and further research.

Theoretical framework

The notion of periphery is rarely used neutrally as it suggests underdevelopment and opposition or dependence on a 'core' or centre (Kühn 2014, Beetz, Huning, and Plieninger 2008, Souza 2018). In this paper we pay attention to the production of peripheries, in line with scholars who advance the concept of

discursive peripheralization. These scholars highlight how peripheries are frequently constructed through narratives and images that portray them in unfavorable ways (Plüschke-Altof 2016, Eriksson 2008), often formed by a counter-narrative of the hegemonic urban. Meyer, Miggelbrink, and Schwarzenberg (2016) for instance, discuss this phenomenon as stigmatization, while Eriksson (2008) explores the construction of rural areas in Northern Sweden as an underdeveloped and traditional rural space in contrast to the "Urban South". Eriksson (2008) shows how specific traits of parts of the region (in this case, Sweden) can become one with the entire region through negative representations of the region in the news – and how finding alternative ways of representing are significant to deconstruct the dichotomy between north and south Sweden. These studies show how the ways in which peripheries are discursively constructed impact processes of peripheralization. Negative internal and external images of 'backwarded' or 'lagging behind' areas can contribute to declining economic activities that create a negative spiral which is difficult to break down (Kühn 2014, Eriksson 2008, Beetz, Huning, and Plieninger 2008). Moreover, the remoteness from decision making at the center can lead to a sense of alienation and powerlessness to influence political decisions. However, dynamics can manifest in diverse ways, as local actors may take proactive measures and attribute new meanings to their area (Görmar and Lang 2019, Willett 2020). Negative images of limited opportunities and constrained access can furthermore coincide with more positive narratives of areas as peaceful and rustic (instead of isolation and remoteness) and tight community-bonds. Žafran and Kaufmann (2022) for

instance show how the tourism industry contributes to the construction of such positive images and narratives to reframe presentations of regions in Croatia and attract tourists and new in-migrants.

Willett (2020) goes one step further in influencing discursive peripheralization by challenging negative peripheral discourses. The author does so by approaching peripheral areas as complex adaptive systems. Peripheral areas as complex adaptive systems can be useful to understand the role of knowledge in processes of peripheralization. Knowledge in 'region-organisms' can flow in narratives and forms of 'truth' about peripheries as well as in more traditional forms of know-how and skills 'produced by the people who live and work within them' (Willett 2020, 87). These traditional forms can play an important role in everyday practices that can contribute to more positive spatial representations. In a similar vein (Görmar and Lang 2019) emphasize studying these practices in their call to approach peripheries as 'spaces of possibility'. They shift attention to practices of actors coping with and opposing the negative (discursive) production of peripheries. With this paper, we respond to this call and focus on care practitioners working in areas where we see discursive peripheralization happening.

In case of healthcare, peripheral areas are often depicted as being less attractive to work or invest in (Bock 2016, Exworthy and Peckham 2006). Another often mentioned challenge in Western peripheral regions is the high percentage of older persons living there. They are encouraged to stay at home as

long as possible. Previous studies on healthcare in rural areas reveal how closing facilities often result in longer travel times and reduced access to public services, leading to feelings of unsafety or neglect (Perucca, Piacenza, and Turati 2018, Prior et al. 2010, Farmer et al. 2012). The re-placement and loss of services is linked in multiple ways to the liveability and quality of places (Prior et al. 2010, Ivanova, Wallenburg, and Bal 2016, Oldenhof, Postma, and Bal 2015, Castleden et al. 2010). Studies have shown that citizens do protest loss of care services and that they are not only worried about losing a facility, but about losing a complex range of assets: an accessible health-preserving service, human, social and economic resources, and a symbol of community resilience (Prior et al. 2010).

We follow authors taking a practice-based approach to peripheralization and empirically study the work that local actors do to (re)organize health care which can contribute to more place-based narratives to ensure equitable development and avoid too much focus on the potential disadvantages faced by these areas compared to their urban counterparts (Görmar and Lang 2019).

Methods

In this paper we focus on acute health care[8] in areas that experience decline in services. With older persons now living at home longer, acute care is increasingly about addressing situations that are "out of balance" or that become urgent,[9] instead of life-threatening situations such as a heart attack (Lappegard and Hjortdahl 2013). This shift in what acute care entails is prompting policy, spatial and medical questions, for example when to intervene, where to treat the patient, and when and how to transport the patient to a healthcare facility. At the beginning of our study, we were particularly interested in the consequences of acute care concentration on older persons care organizations in rural areas. Especially for these organizations, the disappearance of services and shortage of staff can be challenging as the situation of an older person can quickly deteriorate, whilst organizations aim to avoid hospital admission (Schuurmans, van Pijkeren, Bal, et al. 2020).

We focused on two regions, one in Norway and one in the Netherlands, where centralization of services occurred. In these regions, we interviewed care workers and managers in nursing homes and acute care services, such as ambulance services and primary care clinics, who provide acute care for patients in nursing homes and home care. In both regions, the

[8] The term acute care encompasses a wide range of clinical healthcare functions, including emergency medicine, trauma care, prehospital emergency care, acute care surgery, critical care, urgent care and short-term inpatient stabilization[8].
[9] For instance, an older person who is temporarily disoriented by a bladder infection or an overburdened informal caregiver who needs relief from daily care tasks

reorganization of acute care involved shutting down or merging emergency departments from local hospitals and primary care centres, generating frequent local and national media coverage. We acknowledge that these two countries are both relatively wealthy and well-organized, but the geographical differences between them allow us to tease out which patterns recur in assembling acute care in various types of peripheral areas (Marmor, Freeman, and Okma 2005).

In order to anonymize data and locations of our study, we use pseudonyms and refer to the Dutch region as 'Weideblik' and Norwegian region as 'Fjellrike'. In Weideblik, the medical center is in the largest city of the region, and there are several regional hospitals dispersed over the region. Particularly these hospitals undergo closing of emergency posts. In some cases, opening hours of posts are reduced and citizens have to travel to another post in the night, causing longer travel times, from half an hour to approximately 45 minutes to an hour. The financial situation of hospitals, condition of buildings and availability of specialists (nurses and physicians) are reasons to concentrate care (De Smedt and Mehus 2017). In Weideblik, a few villages, located on an island and at the border of the region are harder to reach, and in case of severe emergencies a helicopter is deployed. What is particularly challenging in acute care in this region however are the less severe acute problems, particularly among the older population living on the countryside. Particularly during out-office hours the need for sub-acute care services for older persons is high in this region.

In Fjellrike, the university medical center is also located in the largest city of the region. Also in this region, there are several islands. Residents of these islands are accustomed to longer travel times and used to organize care within the communities. Increasing professionalization of acute care services is taking place in this region. This causes ambulance stations previously run by volunteers, to be disbanded or merged with regional services. Also, an emergency post in a regional hospital closed recently, leading to longer travel times, of approximately 1-1,5 hour for citizens in the (bordering) municipalities. In Norway, municipalities are responsible for ensuring that an emergency care service is always available. Over the past 20 years, an increasing number of neighboring municipalities have established shared emergency posts to ease the burden on local physicians, reduce costs and improve the quality of out-of-hours services. For many patients, this has led to longer travel distances to the nearest emergency clinic in the evening, at night and on weekends (Raknes, Holm Hansen, and Steinar 2013). On the other hand, people living in close proximity to emergency clinics, often people in urbanized areas, have gained access to new well-equipped and well-staffed emergency services (Raknes, Holm Hansen, and Steinar 2013, Nieber T et al. 2007).

Data collection

In Weideblik, our study started in September 2019, as part of a broader research programme on the regionalization of older persons care (Schuurmans, van Pijkeren, Bal, et al. 2020). Our research team tracked four care organizations for older persons as they sought collaboration to alleviate workloads at night and

weekends. We collected data during meetings and interviews with nurses, physicians and managers and selected our data by focusing on (sub-)acute care, transition care or beds, and out-of-hours services. This led to a selection of interviews (N=10) and observations (N=8). We conducted additional interviews (N=8) with physicians and healthcare coordinators and managers working for ambulance and local general practitioners (GP) services in this area in 2020. We interviewed respondents about (future) closures of acute care facilities and (sub)acute care initiatives. Alongside the interviews, the second author attended meetings of regional older persons care organizations (N=5) about collaborating out-of-hours in 2019 and 2020. In Fjellrike, we started in September 2020, by interviewing people working in the regional acute care services, and responsible for the professionalization of care in the region. These respondents (N=3) gave insightful information on future prospects of the organization of care and showed us bottlenecks and good practices. We additionally interviewed healthcare workers and managers (N=16) in four different municipalities, including nurses and GPs operating in primary care centres (covering out-of-hours), ambulance services and first response teams. Alongside the interviews, the first author visited three ambulance stations, a nursing home and a hospital whose emergency department had been closed.

To focus our research, we spoke with care professionals, being nurses, physicians, managers, and how they have an active role in assembling acute care in the region. The position of our respondents in the community was a professional role from

exercising their work as healthcare providers. However, some respondents indicated during the interview that they also felt personal attachment to the community, having lived and worked there for a long time, knowing the patients in the community well. During one of our site visits, at the first response team in Fjellrike, we also spoke with the local council. As they were invited to share with us how they support the initiative, we included this interview in our data analysis.

Data collection was influenced by the Covid-19 pandemic; most interviews were conducted on-line through Zoom, and site visits were limited to a few occasions in accordance with social distancing requirements and other country-specific Covid-19 related rules (Lupton 2021). Verbal consent was asked and obtained from all interviewees. Transcripts were worked put verbatim and pseudomized. Consent was also obtained for observations. Transcripts and observation reports were stored in a protected environment of the Erasmus university. Ethical permission was obtained from the Institutional Review Board of Erasmus University Rotterdam.

Data analysis

The initial focus of our research was the acute care for older persons, in particular the target group for who sub-acute care services (i.e. temporary beds in nursing homes) are important. However, during interviews with respondents' broader issues emerged which included accessibility for residents (young and old) on the islands. Also, some services were initiated for older persons, yet were also used by other patient groups.

In our analysis, we focused on the images and narratives respondents used when talking about the area they worked (and lived) in and the caring and organizing practices they engaged in (Tavory and Timmermans 2014a). In these images and narratives respondents spoke for instance about remoteness, distances, facilities that were closing or replaced and described connectivity between places. We also asked about practices to deliver healthcare and experienced during site visits how they did do so (DeWalt 2002). The first response team for instance demonstrated the cars they converted and the cabinets with emergency material in the nursing homes.

Lastly, we analysed how respondents talked about caring for peripheries in the broad sense; not only in healthcare practices, but also caring for the community and the future and sustainability of the area, or caring for know-how. Our analyses resulted in three overarching themes: representation of peripheralization in acute care / adapting acute care practices / negotiating quality positions. In the following section we present these themes, with selected excerpts and quotes illustrating the themes that emerged from both the theory and data.

Results

We begin this section by analysing respondents' descriptions of their experience with acute care practices in peripheral areas. Second, we analyse how acute care is adapted and aligned by actors in the periphery, touching on how quality standards and guidelines are negotiated. Last, we discuss emerging notions of quality in the organization of acute care in peripheral areas.

1. Acute care and a dynamic representation of peripheralization

In this first section, we describe different notions of periphery through the eyes of healthcare providers. Our findings reveal a variety of narratives and images when respondents talk of the absence or disappearance of care, and portray a dynamic representation of peripheries, surpassing the conventional notion of 'the winners and losers game'. We start with an example from the region Weideblik, where the periphery is seen as disadvantaged by respondents, from thereon we turn to other dynamics.

> There's a problem on the fringes of our region. Care is scaled down here, and that's partly understandable because fewer doctors are available and needed, yet the question is who is left available to provide care...? Particularly on evening-night-weekend shifts it is problematic. (Medical specialist, R26, the Netherlands)

In this interview excerpt, peripheralization is shaped by the re-placement or planned re-placement of care facilities. The loss of care services and physicians, working at the 'fringes' of the region, are considered to be problematic for the continuity of 24/7 healthcare. The region Weideblik has seen emergency departments and several primary care units for out-of-hours acute care being closed in the past few years. The low population density of peripheral areas often makes (specialized) acute care expertise financially unsustainable. Moreover, there are concerns regarding quality of care as medical professionals often do not

perform many procedures, due to a lack of patients with specialized needs. Hospital departments are then replaced to the city, leaving the area with outpatient facilities instead of a 24/7 hospital:

> "Hospitals [in this area] become outpatient clinics where healthcare is available by appointment, five days a week. But what about the other times? I mean, rehabilitation and acute care are needed 24/7… this is particularly true for the outlying areas [due to an ageing population and distances]." (Meeting 2, the Netherlands)

In this meeting the worry is raised that particularly the 'outlying areas' are vulnerable for the decline of services as there are relatively more older persons living there who are less mobile and distances are relatively large (compared to distances in and around the largest city). Peripheralization in 'the fringes or outlying areas' is associated with a lack of continuity of 24/7 care. Also, a lack of connectivity is felt, as respondents mention that patients in these areas are expected to travel longer, while at the same time there are often less infrastructures in place, social (i.e., neighbours and family) and physical (i.e., public transport) to make travelling convenient, particular for older people. This can cause a downward spiral. In Fjellrike, the local council explains how shutting down care facilities is closely linked with the accessibility and availability of other resources. In this municipality facilities are closing down, which might lead to loss of connections and moreover a further deterioration of the livelihood:

> "Yes.. off course we have a countryside and we are a small place. Every shop and every official state office, post office, municipality house is important for the inhabitants in [this village], so also the institution (nursing home). But if we take away [supermarket] this place will die. So off course in smaller places every shop and every gas station and every nursing home is very important. But if you go to [the city] and some shops are closing and new shops are coming up, that doesn't matter..." (councilor municipality, Fjellrike)

This quote, in line with other research, shows how care facilities, such as the nursing homes and ambulance stations, are highly connected with the community, establishing caring relations (Ivanova, Wallenburg, and Bal 2016). The closing down of facilities is also considered as a political choice, and a lack of political attention for people living in these areas.

In our data, however, respondents experience peripheralization in different ways. There are also other narratives. This difference can mainly be seen amongst respondents who live and work in places were facilities are replaced or closed, like in the previous examples, and places were organizing care within the community is more of a historical given, such as on the islands in the region Weideblik:

> "We call it [the island] a sort of mini-society. Care professionals depend on each other more, the GPs, ambulance services, district nurses… you don't want to

> call the helicopter for every incident." (Ambulance service manager, R21, the Netherlands)

Healthcare organizations and professionals have infrastructures in place to organize care on the islands. And this creates a culture as something respondents are proud of. Additionally, the connectivity with the mainland is stressed; "there's a good connection to the mainland by ferry and in a worst-case scenario, there's the helicopter" (R20). Also, in Fjellrike, the uniqueness of the more remote areas creates another narrative on what peripheral in relation to healthcare entails. Peripheralization in this case, relates to being independent, caring for this unique location and having local knowledge of the area to be able to navigate in acute care situations:

> "Well [laughs] it's only recently that the islands of A and B have gotten street names. They didn't before, and there are a lot of people on those islands. When we visited, they would just give us the name of the place and we would ask, "Okay, but where is that exactly?" So you need to know the area to get around. And it's the same thing on the islands, maybe there are people living in the cabins and that is especially a challenge at Easter and in the summer [with all the tourists]. They would just say, you know, "We're in the third grey cabin up from the pier". [laughs] …So far, we've always been able to find them." (Nurse, R8, Norway)

The absence of street names and house numbers means that detailed geographical knowledge of the area and communication between acute care services are crucial. The nurse (R7) explains that help from the community can be important in finding your way:

> "They know the islands best, know where people live and where we should go when we arrive at the pier. People here help out, for instance by offering to come to the pier or asking their neighbour to take them to the pier. And if the patient is too ill, someone on a tractor sometimes takes us to the patient..." (Ambulance boat nurse, R7, Norway)

These examples illuminate knowledge, in terms of skills and local know how, as well as inhabitants who are aware of the skills of care practitioners and even support them in urgent situations. In doing so, inhabitants and practitioners play an active role in keeping healthcare nearby, despite huge distances and challenging landscape. Infrastructures evolve over time, however, and in Norway more and more islands (as well as other remote locations) are now connected by tunnels, roads and digital technologies, such as electronic patient records and electrocardiograms in ambulances. This has shortened response times, connected areas and services and made healthcare 'less remote'.

Following our respondents, peripheralization is not tied to a geographical location or to physical proximity, but rather to

continuity of care or absence thereof, and to changes over time in both care facilities and infrastructures (i.e. social, technological and physical). Care and connectivity are embedded in the experience and materialities of places, such as the presence of a 24/7 healthcare facility or an ambulance service, and the caring relationships rooted in those places. We saw in our data that the continuity of care can still be maintained through strong connectivity between care organizations and communities. However, if that connectivity is not there (yet) and care practitioners, or a local council, do not feel supported (politically or culturally), the continuity of care is at risk and the notion of periphery gets a meaning of 'lagging behind' or being forgotten.

2. Adapting care practices to peripheralization

In this second section, we explore how care practitioners adapt acute care provision with peripheral processes. We start in Fjellrike, in a municipality which counts approximately 2800 inhabitants (4 inh/km^2) and is well known for the mountainous landscape and large lakes. In this municipality is a nursing home which offers home care and residential care for older persons. Due to several severe incidents among older inhabitants in the community, the nursing organization started in 2012 to educate home-care nurses as first responders:

> "The first two or three years we had 30-35 emergency calls, last year we had 83! And the main intervention is [response] time… but also the team's competencies [have increased] and they use [these skills] in their home care services. So, a side effect is that nurses do more systematic

> [clinical] observations…in daily care too." (Municipal healthcare manager, R10, Norway)

Although the initial aim was to deliver first response care to older persons in the community, the first response team is now covering care for all ages, for instance cases of childbirth and traffic or farming accidents. The home care nurses were trained by the regional ambulance service and local general practitioners. As a result, they undertake more medical-specific tasks than nurses working in the city centre or neighbouring municipalities. As the manager explains, the initiative has improved nurses' skills and the quality of nursing home care, and makes their work more challenging and interesting—even attracting other nurses to the area which is a significant development, as it has been "hard to attract staff and turnover in the nursing teams was high" (R10).

Setting up new care constellations does not happen overnight. At first, regional ambulance services were hesitant to assign (sub-)acute care to the first response team because nurses are trained differently than ambulance workers. Another challenge was, and remains, the technical infrastructure enabling the regional hospital, ambulance services and first response team to access and share patient information and coordinate emergency calls. Although these challenges are not easily overcome, the various parties are now flexible about professional standards and working to improve information-sharing, for example by creating a triage system for communicating the first response team's action to the regional services. Besides adapting accreditation and guidelines,

creating awareness of the project among the wider public was significant:

> "If you have an urgent problem, 25 minutes and sometimes more is a long time... so the politicians and the population were as hesitant as the hospital, but they eventually started to appreciate us, and their neighbours heard about it, so now everyone knows that we have an acute team and they feel safer." (Home care nurse, R6, Norway)

Creating awareness of the skills and know-how of the nursing teams, among the wider population, means that these 'knowledges' can be more easily incorporated into positive spatial representations (Willett 2020). This contributes to the liveability for older people, who can age-in-place more safely, as well as developing distinctive skills which makes the work of nurses more interesting. In this case, the support of the local council was significant, financially, to sustain the initiative, as well as in the communication of the initiative in the wider region, by sharing results and creating awareness during regional meetings.

In the region Weideblik, we saw similar initiatives aimed to adjust to processes of peripheralization. For example, how general practitioners are trained to provide emergency care alongside regional ambulance services:

> "They [GPs] are trained in life-saving procedures. You have to train them with some regularity, since

> emergencies [requiring specific procedures] don't occur very often. Also, GP assistants also undergo basic life support training. So, we're developing a team of people with skills who can consult each other, understand each other's methods and can rely on each other."
> (Ambulance service manager, R20, Netherlands)

These examples highlight the crucial importance of mutual trust-building between care professionals and of connections with other institutions, for example local politicians and regional acute care services that can support initiatives financially and a public who accept 'alternative forms' of acute care provision. This seems simple but initiatives can also be seen as a threat to other services. The first response team stresses: "we don't replace the ambulance services. Our cars can't transport patients and we can't spend too much time away from our own clients." (Home care nurse, R3, Norway). Moreover, such initiatives require training facilities and professionals willing and able to take on new tasks. They also require technological adjustments such as information tools, to share patient information, and newly negotiated information standards.

Besides utilizing know how and skills, is the development of multi-use care spaces. In both regions, healthcare facilities are adapted so they have multiple functions and acute care can be performed closer to home. This appears specifically significant for the older generations inhabiting peripheral areas. In Fjellrike, for example, an ambulance boat, previously used mainly for transport, is turning into a place where more acute procedures can be carried

out. During one of our site visits, an acute care nurse mentions that the current boat will be replaced by a catamaran next year. Although the new boat would be slightly slower, it is more stable on the water:

> "The new boat gives us more capacity to move specialist or acute care by local general practitioners on board. The doctor will have more space and equipment and there will be two stretchers instead of one, so they can help more people on the spot or perform more procedures before the patient is taken to the hospital." (Ambulance boat nurse, R7, Norway)

Another municipality invested in "transition beds" in the local nursing home. This means that inhabitants can temporarily stay and be monitored by nurses, when they are not yet ready to go home, for instance after hospital admission. The healthcare manager of this municipality explains that although this is great for older persons in rural areas, who can receive care within their community, it also creates challenges for care organizations, such as having staff available in nursing homes, having general practitioners available for medical consultation, and having enough support (e.g. financially) from the municipality:

> "The municipalities are under more and more pressure from the national systems and the hospitals. People don't stay in hospitals very long anymore. I often say that they're hardly admitted before they're discharged again, so we need good nurses and doctors in the community, because

> this is where most of long-term sick people are now." (Municipal healthcare manager, R10, Norway)

A consequence of the spatial distribution of care, by concentrating high advanced acute care to city-center and sub-acute care to peripheries, can be challenging to organize in peripheries when they don't get the support. Creating new places for care, or adopting existing ones, puts pressure on local administrators, healthcare staff and bed capacity alike. However, scarcity also evokes creativity. In Weideblik, nursing homes have started to collaborate to organize acute care services during out-of-hours. Organizations start sharing shifts so that geriatric specialists and general practitioners can provide care at different nursing homes and in patients' homes (instead of each individual nursing home and primary care unit doing so). This network of physicians during out-of-office hours particular covers a bottleneck in the region:

> "The hospital's emergency department was worried about the number of older people being admitted on evenings and weekends. Often, there were no emergent clinical problems. But children no longer living nearby and on weekends, they visit their parents and notice that they're not doing well. They call the doctor and there's all that hassle. In the end, it often turned out that people were lonely or suffering malnutrition, but don't have acute medical complaints." (GP care coordinator, R24, Netherlands)

In the more rural parts in Weideblik, older persons increasingly lack social networks and their families use acute care services to solve these problems, causing capacity issues at hospitals and nursing homes and stress and anxiety for the older persons themselves. Setting up additional healthcare services – also, transition beds in a nursing home and a network of physicians – creates extra capacity and avoids older persons being taken to the emergency department.

The examples in this second section demonstrate how acute care provision is generated by creating new places of care (e.g. transition beds), transforming existing places (i.e. the ambulance boat), and creating new professional roles (through the development and sharing of skills and know how). It shows that areas, and specifically care practitioners and inhabitants, are not completely at the mercy of facilities elsewhere if care is not (more) or hardly available. Actors set up constructions where local know how is important, e.g. navigating in rough landscapes. Our data moreover shows, in line with previous literature (Willett 2020, Eriksson 2008) that it is significant to utilise (new) knowledge and ideas to make them sustainable and appreciated among a wider public. Organizational and political support is significant to be embedded in local contexts and recognized as valuable local care services. Yet solutions are also contested because they deviate from common practices and defined (quality) standards. This is where we turn to in the next section.

3. Adapting what constitutes good quality care in peripheral areas

In this section we explore how acute care initiatives adapt field standards and shape quality in different ways. First, we show how the further professionalization of acute care, in both Norway and the Netherlands, may be inconsistent with local solutions we presented. Secondly, we argue how care practitioners, by questioning certain standards and dominant ways of working, create new ideas about what constitutes good care in peripheral areas – and in doing so create counter narratives.

Although there are major differences in geographical contexts (i.e. population density, distances, landscapes and infrastructures) between the two regions, the mechanism of concentrating care and what ensues in the surrounding areas are similar. While initiatives such as a first response team, enhance the continuity of care and liveability of places, they also create spatial differentiation and, in the words of some respondents, 'care fragmentation':

> ...Initiatives like that in [municipality], with nurses being trained as first responders, don't align with the general prehospital system… So, they end up being very local initiatives, which is okay for that municipality but doesn't align with other services. …So, you have a lot of different models being generated in municipalities. (Coordinator for prehospital care, R2, Norway)

While regional services support initiatives to provide acute care in municipalities, they also stress that the nurses' competences and skills do not align with principles in the regional acute care system. Problems sometimes arise in communication due to technological differences, a lack of technical resources or differences in equipment (e.g. type of car) and knowledge (e.g. professional skills). Also, adapting quality standards and work routines to existing resources creates problems for the more "central" actors – e.g. those in hospital settings – who have to work with different local arrangements. This ambiguity sometimes leads to tensions between regional care organizations that operate on varying scales (particularly between municipal and regional levels), as the following example from Norway shows:

> "Yes, the hospital wanted to force us into something similar to [municipality X], but we said no we don't want that, we want the ambulance here [in Y]. We need the ambulance here, [otherwise] it isn't safe." (Acute care manager, R9, Norway)

This manager explains that the ambulance station was first run by volunteers but "they [regional services] took over because it was very difficult to recruit the right kind of people and to bring in new competences." While the ambulance was dispatched to the city centre in daytime, the manager wishes the ambulance station to remain in their municipality and use the argument of response times: "[otherwise] it isn't safe".

In both the Dutch and Norwegian healthcare systems, response times are 'field standards' that determine distribution of care and account for quality of care, e.g. how quickly the emergency station answers a phone call, when the physicians arrive, or how long it takes a patient to arrive at an acute care location. But, response times in the Netherlands and Norway differ. In Norway, the population should be reachable within 20 minutes, yet the norm differentiates between urban and rural areas:

> "The response times reflect the circumstances of larger cities. …so if the city is a certain size, the ambulance should reach people in 12 minutes, and if it's a rural area with a certain population density, it's 20 minutes. So you should be able to reach the whole population within 20 minutes, anywhere in Norway. You can imagine that up north it's impossible to reach everyone within 12 or even 15 minutes from an ambulance or helicopter station. So that is kind of what Norwegians accept now." (Regional care service coordinator, R13, Norway)

In the Netherlands response time is not differentiated between rural or urban areas. However, some parts in the Netherlands also cannot always comply with national standards, such as the earlier mentioned 'fringes' of the region Weideblik. In nursing homes in this region, medical specialists often find it impossible to comply with the medical association's 30-minute response time standard. Physicians try to work according to the norm by calling a colleague who lives nearby or a nurse who is providing home care in the area. One of the nursing care directors explicitly renegotiated the

response time with the Dutch Healthcare Inspectorate and reported the following in an email:

> "The inspectorate agreed to a longer response time, as it's well known that physicians are unable to reach patients in this area in half an hour... so it's important to have nurses available as backup. Their suggestion was to have a nurse practicioner perform medical technical procedures (in this case, postmortem examinations) or to hire a healthcare organization that employs nurses." (Nursing home director, R26, Netherlands)

The above example shows that different ideas about quality come into play when shaping care in the periphery. Following the logic of concentration, the placement of care is often treated as a rational economic issue (Pollit, 2011). For actors we spoke to however, the "right or good place for care" might mean providing and receiving care within their own community. In the case of the inspectorate, the response time standard is shifted to enable care in the area and deploy nurses' skills. By questioning the standard, practitioners reverse the narrative and show that they are shaping care, in interaction with community, local councils, or regional partners – and sometimes leading the way, for example when it comes to the deployment of nurses. Quality logics thus appear to shift in peripheral settings where geographical and cultural contexts are more significant than in more central areas.

Discussion

In this paper we focused on practices in response to processes of peripheralization in the provision of acute care, centring the agency of actors in the periphery. We used the concept of discursive peripheralization to understand how actors construct peripheries in narratives and practices of care. This helped us to show that peripheralization is very much tied to the continuity of care, or absence thereof. The continuity of care can be threatened when facilities are closing or are partly closing, such as no longer offering 24/7 care. Care practitioners stress the importance of those services for the care provision, that is very much connected to the liveability of areas. A care place provides a sense of safety and security and maintains caring relations in the community. If that continuity of care can no longer be provided, people not only have to travel further, but also loose a sense of connectivity, which is embedded in feelings of trust and belonging. This is especially visible in the Dutch case, where respondents mention that they are in 'the outer areas' or 'fringes' and feel that these areas lack political attention. In other examples, in particular on the Norwegian islands, we saw that travelling larger distances in itself does not seem to be a problem if the connections, both in the community and between periphery and centre, are in place. This is in line with earlier research that shows that when citizens protest about the closure of facilities, it is not so much about the materialities, but more about the established 'caring relationships' (Ivanova, Wallenburg, and Bal 2016) and quality of places (Prior et al. 2010).

Secondly, our paper shows that care practitioners in the periphery can adapt acute care practices with peripheralizing circumstances, constructing new narratives and practices of care. Earlier insights in media outlets and policies argue that peripheries are seen as weakly innovative because the workforce is less qualified compared to the centers of the economy. This is a well-known deficit of de-industrialized cities and regions. However, the underlying assumption, that in peripheries everything is in decline due to a loss of migration and investments, neglects the possibility of a "de-peripheralization" or "re-centralization". For example, when new (sub)acute care services are set up in small municipalities in response to the closure of acute care facilities, they become new centres for acute care delivery for the wider region, attracting new healthcare professionals while ensuring that older persons can stay in their home region. This is significant, as it means that professionals are boundary crossers, in the sense that they connect communities and health services in order to develop community health (Kilpatrick et al. 2009). However, when peripheries are able to adapt effectively, there needs to be a strong degree of connectivity in order to be able to share knowledge in the region. If stigmatizing and peripheralizing narratives are to be challenged, the general public also needs to be better informed about current developments in the local care landscape.

Thirdly, our study shows that the travelling of knowledge and creation of new connections can evoke a (re)negotiation of what (good) care entails. Care is organized locally in line with

geographies, quality logics and local knowledges (such as skills and know how) (Milligan and Wiles 2010). Situating care involves infrastructural work, both in relation to the materialities needed to provide care (e.g. a modified ambulance facility or transition beds) or enable the flow of information between people and units (e.g. patient records), in relation to professional identities and roles (e.g. training up municipal nurses) and quality criteria (e.g. adapting national norms to local circumstances) (Langstrup 2013). Local solutions can lead to a multitude of care constellations and a wide variety of healthcare professionals working in different constellations across traditional professional boundaries. This again shows the relational aspect of the caring periphery, yet it also raises questions about accountability for the care provided. It further reveals the negotiations between centres and peripheries, and between organizations and professionals working in peripheral areas, about quality norms.

The fragmentation of acute care provision that results creates complex regulatory environments where it is unclear which service provider can be held responsible for quality of care in a certain area. There is a tension between differentiation of services in peripheral areas on the one hand, and the move towards concentration and standardization of healthcare services on the other. We argue that this tension is not necessarily a bad thing. Instead, it challenges healthcare practitioners as well as regulatory bodies to adapt conventional quality standards and norms to local circumstances. Moreover, it pushes both local care workers and government bodies (e.g. an inspectorate) to debate different quality positions. This requires a more reflexive

approach to defining good care (or other public services) within a certain context or region (Loon and Zuiderent-Jerak 2012, Wiig, Aase, and Bal 2020, Castleden et al. 2010). Good care in the periphery might not be the same as in the centre. "Ageing-in-place" and care in the community might be more important to patients in the periphery than care provided according to quality norms set in the centre. Re-valuation of good care is not just about care, then, but also about the re-valuation of place.

This study has some limitations. First, some of the data was collected during the Covid-19 pandemic and social-distancing rules affected direct observation and interviews. Wherever possible, we collected data on-site and conducted additional interviews on Zoom. Second, several researchers contributed to the data collection and analysis. This can be both a strength and a limitation, but we ensured trustworthiness by organizing analysis meetings and researcher discussions. Third, due to the changing circumstances during data collection, the number of observations and interviews in the two countries differ. The results were not used for comparative purposes, however, but to learn about strategies for maintaining and renewing acute care facilities within those areas across both cases. Fourth, the geographical understanding of peripheralization and rural health also differed within each country. Northern regions in Norway, for instance, are very different from southern regions in terms of density and geographical distances, making it difficult to generalize the results. The number of municipalities covered could have been higher and would have perhaps produced different or richer results depending on population size and local

circumstances (sea, mountains, ferries, fjords, distance to hospitals). By considering two case studies, however, we were able to identify mechanisms and problems associated with the provision of acute services that are transferable to other healthcare contexts and rural regions. We suggest conducting further studies to explore healthcare in other rural contexts and to include patient or public perceptions. Such studies could also look more strongly at the connection between care and other services (e.g. education, housing, etc).

Conclusion

Our findings offer important insights for both rural and regional policy. We show how actors in the periphery oppose, shape or produce peripheralization processes in their acute care practices. In doing so, they utilize skills and know-how and produce counter narratives about care in peripheral areas. Zooming in on the work of care practitioners and how they, in relation to care organizations and local authorities, aim to organize care for patients in 'the periphery', contributes to more diverse and alternative narratives of healthcare in these areas. So far, policymakers usually define the value and quality of healthcare provision in terms of population, distances and quality standards. Research, however, suggests that such framings can be problematic for rural and peripheral areas, where geographical distribution and quality norms are likely to differ from more central places (Van de Bovenkamp et al. 2021, Malatzky and Bourke 2016, Castleden et al. 2010). This research has shown that alternative narratives, for instance regarding different perceptions of quality of care, connectivity between care

providers, and innovation should be considered to ensure equitable development and avoid too much focus on the potential disadvantages faced by these areas compared to their urban counterparts.

5.

Triage as an infrastructure of care: the intimate work of redistributing medical care in nursing homes

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Introduction

Healthcare organizations across European countries are facing workforce shortages (Kroezen, Van Hoegaerden, and Batenburg 2018b, Connell and Walton-Roberts 2015), which are most prominent in non-urban, sparsely populated areas and occur against the backdrop of growing care demands due to an ageing population (Kroezen, Van Hoegaerden, and Batenburg 2018b, Kuhlmann, Batenburg, and Dussault 2018). This results in high workloads among existing healthcare personnel, urging policymakers and managers to enhance organizational resilience. Policy measures meant to overcome shortages and sustain organizational workforces include task shifting (Kuhlmann, Batenburg, and Dussault 2018), employing immigrant healthcare practitioners, and "return to practice" courses that allow former nurses to return to the profession (Kroezen et al. 2015). Various countries have introduced policy measures encouraging healthcare organizations to collaborate on workforce capacity-building in specific geographical areas, the Greater Manchester project being a prominent example. There, health and social care services have been rearranged into a regional infrastructure that integrates health and care services and expands regional care capacity (Lorne et al. 2019a). In the Netherlands, a similar movement is made in the health and social care sectors. In this paper, we are interested in how such infrastructures for collaboration are developed for older persons care and what consequences they have for everyday care delivery and for professionals.

A prominent and increasingly common organizational instrument which is central to this study, is triage. The triage system aims to prioritize care demands and builds an infrastructure to make more efficient use of scarce regional medical resources, such as nursing home physicians and beds — as available places for care — for older persons in nursing homes. Triage is also meant to expand the skills and competencies of nurses and nurse aides, as they are encouraged to interpret care demands and reorganize care delivery (Greatbatch et al. 2005a, Johannessen 2017). Triage nurses collect, categorize and prioritize healthcare needs, making healthcare organizations less dependent on the immediate presence of physicians and (re)distributing medical work and responsibilities among other professionals in the organization (e.g. physician assistants, nurse practitioners or specialized nurses). Triage can also facilitate region-based medical care delivery, as it enables the exchange of medical practitioners among healthcare organizations (i.e. nursing home physicians, nurse practitioners), for instance during night and weekend shifts. Triage potentially has far-reaching consequences for the spatial distribution of medical work and for the position and professionalization of medical and non-medical roles in healthcare organizations (de Bont et al. 2016).

The medical and policy literature usually depicts triage as a classification system for structuring and standardizing medical decision-making in acute healthcare settings. Earlier studies in the sociology of health and illness (SHI) have offered in-depth insights into the use of triage in everyday practice (Greatbatch et al. 2005a, Hillman 2014, Johannessen 2017). These studies reveal how

nurses often overrule triage guidelines to meet individual patient needs or to enhance patient-centred services in which they rely on their professional expertise and tacit knowledge rather than on the triage system itself. These studies challenge the managerial logic behind triage systems and reveal that practices are often more complex and "messier" than depicted in the triage system (Johannessen 2017, Greatbatch et al. 2005a). In recent years, the scope of triage has expanded from emergency care facilities to other settings such as general practitioners' offices (Charles-Jones, Latimer, and May 2003) and ambulatory care services (Wilson and Hubert 2002). In this paper, we add to these insights by drawing attention to a triage system in long-term care. We study how triage is used as an organizational instrument to reorganize medical and care work in nursing homes.

For our sociological analyses of triage in long-term care, we draw on the literature of infrastructures and infrastructural work (Bowker and Star 1999, Langstrup 2013). We build on the work of Langstrup (2013) to examine how triage is performed through infrastructural work, examining both the spatial dimensions and built environment of care provision (e.g. Ivanova, Wallenburg, and Bal 2016, Buse, Martin, and Nettleton 2018) as well as social elements (i.e. the social interactions between professionals) in nursing homes. More specifically, we focus on the infrastructural work that goes into the development of protocols, flowcharts, training systems, and the creation of new work routines required to allow physicians to work "remotely" and redistribute medical work between different practitioners. We build on an ongoing, formative evaluation of the regionalization of older persons care

in the Netherlands (2018-2021) in which we act with regional and national actors (i.e. nursing homes, regional healthcare insurers, the Ministry of Health) in developing region-based arrangements and healthcare facilities to foster care for older persons in non-urban areas. This paper focuses on the development and use of a triage system to redistribute medical care, adding to the current debate on the spatial (re)distribution of medical and care work in non-urban, or peripheral areas.

We begin with a discussion on infrastructures in sociological research and conceptualize the introduction and development of triage as infrastructural work. We then explore the research site and methodology of the study. After presenting our analysis of triage practices in long-term care, we show how infrastructural work involves mapping nursing home care, articulating the crucial importance of intimate and "bodily" knowledge in older persons care and the need to recraft and, at least partly, align the medical gaze and the care gaze when reassigning tasks and responsibilities among practitioners. We reflect on how the formative evaluation method we followed enabled us to feed back observations and analyses to the project group developing the triage system and how this helped to adjust both the instrument and its implementation. We conclude with a discussion in which we outline our theoretical and methodological contribution as well as implications for regional care delivery and further research in this area.

Theoretical framework

Infrastructures are often described as technical systems or structures that function in the background of or below our movements (Bowker and Star 1999). In this body of literature, infrastructures go beyond physical structures to include financial systems or knowledge transfer systems, such as patient portals (Aspria et al. 2016). Traditional research into the development of systems has often been based on rationalistic concepts of infrastructures in which all information can be codified, classified and inserted into an infrastructural system. As Bowker and Star (1999) and others have pointed out, however, this explanation ignores the fact that infrastructural systems are human-made and deliver norms and standards with which people interact and negotiate. Instead of prescribing a technological system, infrastructures produce a social order through categorizations, which are then embedded in the infrastructure temporally and questioned and negotiated when the infrastructure changes or breaks (Star and Ruhleder 1996a).

Langstrup (2013) has used the notion of infrastructures to show the work involved in transferring care from the clinic to the home. She describes infrastructures as the mundane arrangements, "made up of various inconspicuous elements (medication, standards, control visits, doses, daily routines, sheets of article for registration and more) that tend to sink into the daily practices of patients and professionals" (2013, p.1010). Although we attend to Langstrup's insight of the mundane work that is involved in aligning existing care practices, we also aim to extend her insights a bit further by showing how triage as an instrument is

reconfiguring an existing infrastructure of medical work and care between nursing homes. We argue that infrastructural work is employed to add new elements to an existing infrastructure, thus changing the organizational practice as well as regional setting of organizing and providing care.

As Bowker and Star (1999) show, an infrastructure requires continuous infrastructural work that is both visible and invisible. Here, invisible work refers to the crucial routine actions and "ways of knowing" that is carried out in hidden or neglected places, often not visible to the outside world. Davina Allen (2014) has highlighted the importance of invisible work in healthcare in her empirical study on nursing work in hospitals. She argues that nursing work is more than direct patient care; much of the work nurses do is bodily work and invisible yet crucial to enabling smooth (hospital) care processes (see also Timmermans, Bowker, and Star (2012)). Additionally, Allen (2014) shows how individual disease trajectories can be unpredictable as patients with co-morbidities and multifarious needs – to which nurses adapt daily care practices – are a poor fit with standardized systems (Allen 2014, 9). This research argues that invisible work is inherent to nursing and should be understood as both articulation work (Allen 2014, Strauss et al. 1985) and intimate work (Timmermans, Bowker, and Star 2012) that is crucial to providing and delivering care to patients. For our analysis, we focus on this significant and hidden work, as "knowing" this work is essential for building and embedding a new triage infrastructure in a healthcare setting.

Earlier work in this journal has revealed that triage standards do not cover the numerous contingencies health professionals come across when dealing with particular patient cases. Standards hamper professionals in delivering patient-centred care because they leave no room for the tacit practices and knowledge that professionals traditionally rely upon, such as nurses' tacit ability to judge a patient's general condition (Greatbatch et al. 2005b{Johannessen, 2017 #3). As a consequence, health professionals often do not follow triage standards or alter them in use by reordering, conflating or supplementing them, depending on the situation. Johannessen (2017), for instance, shows how nurses in an emergency primary care clinic use tacit knowledge and social typification, such as older or mentally unstable patients, to judge the credibility of a patient's signals and symptoms and occasionally decide to upgrade the triage code to speed up medical assistance (Johannessen 2017, 1168). This literature thus emphasises the situational use of triage as a social practice in which professionals and patients constantly negotiate patient categories and approaches.

Langstrup reveals the importance of including mundane and often invisible care work into the building of new chronic care infrastructures. She stresses that the mundane and "real" work often is not taken into account when care is re-placed from the clinic to the home. Langstrup shows the importance of recognizing the "hidden" work because it reveals what is needed to transfer care from one setting to another and enhances our understanding of how infrastructures have place-making effects. First, Langstrup shows, the home itself changes by becoming a place in which

treatment occurs. Second, the home as the preferred site impacts the treatment method(s), as there are other care materials and resources available in the home than in a healthcare setting. According to Langstrup (2013), the negotiations and dilemmas that arise when creating room for treatment and care can come at the expense of others, e.g. family members who may have to provide informal care. Langstrup (2013) stresses that these negotiations and dilemmas are scarcely acknowledged in policy arguments or plans, which assume that "there's no place like home" for chronic disease management.

Likewise, researchers who study the re-placement of care as a means to govern healthcare have revealed the invisible work that goes into re-placing care and reflect on the political-symbolic use of places. This is nicely illustrated by Ivanova, Wallenburg, and Bal (2019), who describe an (illegal) private foundling room for infants that has never been used but offers the possibility of leaving an infant and therefore creates an infrastructure of care for both the mother (and/or father) and (unwanted) baby. This paper highlights the "infrastructural doings" the place engenders, such as a 24/7 helpline. By conceptualizing place and re-placement, researchers have furthermore examined the processes related to the spatial reorganization of care (Oldenhof, Postma, and Bal 2016a). Following this line of research, we recognize that re-placement of care implies more than a geographical movement from one location to another; rather, it involves the infrastructural work of reallocating care between healthcare practitioners, healthcare organizations as well the care materials and resources used in these settings.

In our paper, we use these insights to provide a spatial-relational account of triage practices in a long-term care setting. We study the triage system as an infrastructure and socio-spatial practice of reorganizing medical care provision. In the next section, we elaborate on our research approach and briefly introduce our research sites.

Research sites and methodology

This paper builds on an ongoing, formative evaluation of the regionalization of long-term for older persons in the Netherlands (2018-2021). The research programme encompasses a quality alliance of older persons care organizations (such as nursing homes) operating in 14 regions, the Ministry of Health, a state-financed platform for improving quality of older persons care ("Dignity & Pride"), health insurance agencies, and our university research group. The aim of the programme is to set up regional pilots in which healthcare organizations experiment with new and collective ways of organizing and providing older persons care. We conduct formative evaluations in which we "track" pilots through participatory ethnographic research, sharing findings and insights in three iterative processes. First, we evaluate pilots – in this case the development of a triage system – with professionals in the participating older persons care organizations. Second, we act in regional project groups in which lessons and experiences are shared with other care organizations. Third, we share lessons and experiences on a national level, for example on the Dignity & Pride website and at biennial national network meetings at which all participants to the program can share examples of good practice and discuss the difficulties they face. These meetings aim to

enhance collective learning and to align regional experiments and national rules and regulations. In this paper, we focus on our evaluation of the triage pilot in one particular region, Flevoland. Below, we introduce Flevoland as a care region and then move on to our research design.

Research site: developments in the region

Flevoland, which is located in the middle of the Netherlands, consists of two polders, the result of 20th-century drainage processes. The region became a province in 1986. The landscape is characterized by vast meadowland alternating with fishing and farming villages and one larger (and expanding) urban area. Although the geographical region is relatively young, the population is ageing rapidly. Four nursing care organizations are active in the Eastern part of Flevoland where our study is situated and each one has several care locations scattered across the region. Each has its own unique characteristics, often related to the local fishing tradition, the farming mentality or a more urban outlook. All four organizations are experiencing a growing demand for their healthcare services (including in primary care) along with shortages of medical specialists. This has already led to a freeze on admissions at one of the nursing home organizations, regarded as highly undesirable (and even "illegal", since health insurers are obliged to purchase sufficient healthcare services), as well as illustrative for the worsening of care provision in the region. To complicate things further, in 2018 the local hospital closed down due to severe financial and quality problems, making it even more difficult to attract physicians and nurses with advanced training to this region. The same year, the nursing care organizations decided

to use funding from the regional care office to make more efficient use of the available nursing capacity and remaining medical capacity. This resulted in the development of the triage system, introduced to give nurses a more central role in care so that physicians can work at different locations and deliver more care in the primary care setting, where there is an increasing need for nursing home physician knowledge.

Methodology: following a nurse-led triage system

The triage pilot started in November 2018 at two care locations and was tracked by our research group for over ten months. Data was collected through participatory observations, with researchers spending a couple of hours to a couple of days a week in the nursing home setting, attending project meetings and conducting both formal and informal interviews with care professionals and managers. Dutch nursing homes employ physicians who have completed a two year specialist training program to become a qualified nursing home physician (Hoek et al. 2003). Nursing home physicians bear the medical responsibility for admitted residents and usually have a close relationship with residents and their families. They work closely together with nurses (often nurse aides but nurses and nurse practitioners are involved as well) who are responsible for daily care assistance, and allied practitioners such as physiotherapists and nutritionists. In our research, we accompanied nursing home physicians and nurse practitioners on medical visits in the nursing homes and sat with managers designing the triage flowchart. Triage happened face-to-face or through phone calls in the triage room. We evaluated by providing feedback on our findings and giving presentations on

results in other regions and other relevant issues (e.g. previous research findings on similar issues). We also helped to set up a training course on triage for nurse aides that was informed by our formative evaluation (explained in more detail below). As researchers, then, we contributed actively to the regional care infrastructure by sharing and participating in infrastructural work practices.

We shadowed practitioners (i.e. nursing home physicians, specialized nurses, triage nurses, nurse aides and nurse practitioners) for a total of +120 hours during their shifts, allowing for informal conversations and evaluative reflection on the pilot. Field notes on these interactions were worked up into observational reports within 24 hours. In addition, researchers interviewed 25 respondents, including care team managers, triage nurses, members of the medical team and nursing home directors. Interviews were recorded with permission and transcribed verbatim. All respondents were anonymized. Following Dutch law, ethical approval was deemed exempt.

Data analysis was abductive (Tavory and Timmermans 2014a), allowing us to move back and forth between data and theory and defining overarching themes. Using Atlas.ti software, we systematically compared our field note observations, memos and transcribed interviews. Our analysis focused mainly on the experiences of healthcare professionals and the consequences of triage for their work practices and professional roles. While we discussed the consequences for residents receiving medical care, their perspectives and experiences were not our main line of

enquiry. Throughout the data-analysis process, we member-checked empirical findings with field participants during project team meetings and (informal) conversations with project managers. This iterative and reflexive approach to data collection and sharing enabled us to substantiate our findings. Moreover, it enabled us to share our insights with the project group developing the triage system, and in doing so helped them to adjust the triage instrument.

The following section presents our results. Excerpts and quotes have been selected to illustrate the themes that arose in the overall empirical data: mapping nursing home care, articulating intimate "bodily" knowledge and recrafting the medical gaze.

Mapping nursing home care

> The meeting takes place in a dusky room which is lighted only by a small window. "This is the old mortarium," the project manager explains. "It's not very pleasant but we lack quiet spaces in here." The triage flowchart (figure 1) lies before her. We share some of our observational findings: most of the questions we have encountered concern periodic controls, evaluation of treatment plans and ad hoc questions regarding (small) changes in a resident's behaviour. We suggest that such (ad hoc) questions are specific to the elusive and mundane setting of a nursing home, where all sorts of care issues "pop up" throughout the day. We argue that these small yet important issues are difficult to pinpoint on the flowchart.

> The project manager nevertheless insists on transferring these questions to the flowchart: “In which boxes should we put these types of questions then?” (field notes, 28 February 2019).

This excerpt illustrates how the triage project manager attempts to draft a triage system to prioritize care demands and make more efficient use of scarce medical resources (in this particular case, physicians and a room for medical visits). Drafting the triage system involved describing and categorizing processes of care-giving, allocating these activities on the map and rendering them into neat care delivery practices and processes (figure 2). Besides distinguishing and categorizing medical problems (e.g. urgency of a situation) through the triage system, managers aimed to differentiate care work as well as types of care delivery. Only in an urgent situation is the medical team’s assistance immediately required. In all other cases, care questions are assessed using the flowchart, linking medical issues to the “right” practitioner.

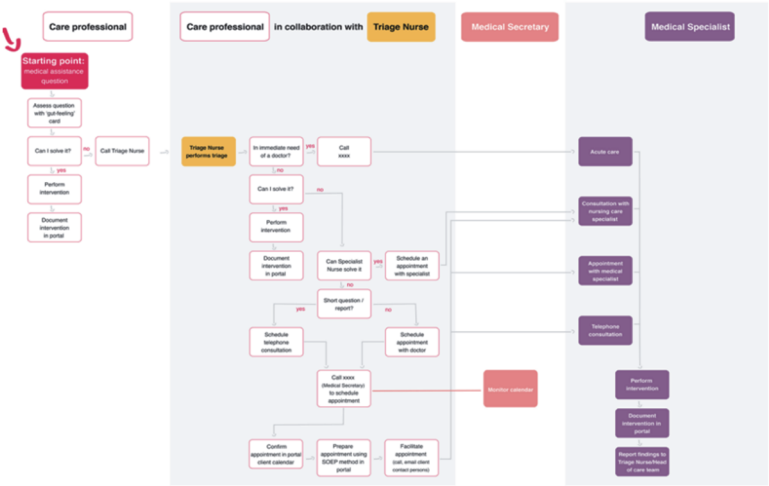

Figure 2: Flowchart

This new infrastructure makes it possible to distinguish between "medical work" and "nursing work". Whereas physicians used to be involved in all sorts of care matters, medical and care issues are now assigned to a variety of (specialized) nurses and physicians. For instance, questions concerning wound care (such as pressure ulcers) are assigned to a wound nurse, while questions regarding psychogeriatric problems or symptoms (such as restlessness or depression) are directed to a behavioural health nurse and questions about pulmonary problems to a COPD nurse.

The triage system also stipulates when and where consultation should take place (i.e. "the same day in the resident's room", or "within three working days at the doctor's office"), depending on the problem categorization and the information obtained. Thus,

besides distributing care activities, the triage system aims to (re)locate care spatially (Langstrup 2013) and temporally. However, because the nursing home lacks adequate meeting rooms and privacy (remember the mortarium where we had to discuss our research findings), professionals tinker with space. Before introducing the new triage system, nursing home physicians frequently visited "their" residents on the nursing wards. They paid regular visits (e.g. once a week) or stopped by during the day in response to an unexpected medical question. The new triage system has changed this routine. Nursing home physicians now only visit a department when the triage nurse request a consultation. Triage nurses act as gatekeepers who guide and schedule the limited availability of medical personnel and available resources (Johannessen 2017). A triage nurse explained: "We not only define the type of injury or problem, but also have to figure out the processes that follow, for instance: when is the wound nurse available and where should the consultation take place?" (triage nurse 7). Tinkering with space and time has led to new care routines. For example, nurses decided to conduct wound care early in the morning, when residents are still in their private rooms and not yet dressed, as this is more convenient than attending to them later in the day when they are fully "dressed and dwelled" in the living room. Triage nurses thus play a central role in developing a new care infrastructure that facilitates smooth care processes. They seek to (re)connect residents, physicians, nurses, daily care routines and residents' lives, reconfiguring established care routines.

Spatial-temporal orderings of triaging

In interviews and during observations, triage nurses pointed out that most of the departments' questions were not about clearly medical issues but more mundane matters or small changes in a resident's behaviour. Triage nurses played an active role in figuring out possible medical issues and distinguishing categories of emergency. A triage nurse explained that urgency is a rather fuzzy concept in older persons care: "…[C]ome on...it is older persons care, right… so there is the top four, it can be lung infections; cystitis; something cardiologic; or neurologic… However, she also pointed out that these situations are rarely acute: "Yet a heart attack is rare, when people come here, they probably already have had one or two [heart attacks] and are already using anticoagulants. The people here live in a therapeutic environment, which means they are constantly being watched…" She continued the list: "CVA [cerebrovascular accident] is also a rare one; TIAs [transient ischaemic attack] however are more common..." (field notes, 12 March 2019).

Rather than an immediate need for medical action, changes happen more slowly. Deterioration of a (medical) situation often spans a longer period of time, from when residents enter the nursing home until they receive palliative care or die. In contrast to the acute healthcare setting (e.g. a hospital emergency department), where patients walk in or call in and are diagnosed based on expressed problems, the spatial-temporal setting of the nursing home is much more about attending to daily issues that happen at a much slower pace (Johannessen 2017, Charles-Jones, Latimer, and May 2003). Most residents suffer from multiple

chronic illnesses (e.g. diabetes and residual effects of cerebral vascular accident, such as difficulty with physical balance and memory) and are unlikely to recover from the disease. Although sometimes they worsen rapidly after admission, residents usually take multiple medicines and have multifarious care needs and problems that arise more gradually and are more diffuse and hence difficult to grasp. The flowchart, however, suggests that medical problems can be assessed remotely. The triage nurse plays an important role in translating care issues into medical problems, joining nurse aides in figuring out the medical issues at hand. At an early stage of the pilot, the triage nurse team decided to move the "triage centre" (a room with computers and a telephone) from an office building to the second floor of the nursing wards. This allowed them to pay a quick visit to a resident who was deteriorating and to collect the information needed to communicate a case to the medical team. Triage nurses thus conducted a great deal of visible ("actual triage work") and invisible work, such as articulation, administration, and creating workarounds to coordinate the different timetables so that triage could be merged into daily care routines. The nursing home setting is therefore more about responding to and adapting with residents' bodily signals, utterances and nurse aides' observations than about a "neat" and orderly reality, requiring a more intimate repertoire of signalling and dealing with medical issues and "doing" triage.

Articulating intimate "bodily" knowledge

We now turn to the nursing wards to examine how physicians and nurse aides gather information on residents and how decision-

making happens collectively. As explained above, medical issues are often not clear-cut but diffuse, emerging gradually. In the recent past, both physicians and nurse aides exchanged information and decisions informally with one another, often over a longer period of time. However, this "mutual doctoring" (e.g. Struhkamp, Mol, and Swierstra (2009) changed when physicians began working more remotely, as they were no longer available to "pop in" when issues or questions arose. Today, nurse aides are expected to notice deterioration and (possible) medical problems and articulate them to a triage nurse. In the following, we describe how nurse aides signal (possible) medical issues, how they make their observations explicit, and how triage nurses and physicians subsequently interpret this information and knowledge – and the difficulties this involves.

Triage practices such as signalling, diagnosing and decision-making are closely interwoven with nurses' bodily work. Earlier research has argued how nurses perform the 'dirty work' in care and how the body is central in this (Meldgaard Hansen 2016, Twigg 1999). Nurse aides are both physically and emotionally close to residents, as they often spend many hours assisting them with daily and intimate activities (getting dressed, visiting the toilet, bathing, taking medicine, eating, going to bed). The body is itself arranged spatially according to what Twigg calls 'graduations of privacy' (Twigg 2002, 427). In their caring practices the nurse aides notice and experience feelings, emotions and bodily experiences, for instance while washing a resident's body, or putting on the compression socks. Physicians, on the other hand, have less of such a hands-on experience of care, which provides them with

different bodily knowledge of their residents than the nurse aides. Nurse aides are constantly in the residents' intimate space – not only their bodies, but also their private rooms filled with their belongings and memories of past times – and thus become acquainted with their habits and care needs (Buse, Martin, and Nettleton 2018). Moreover, residents and healthcare practitioners together build up routines over a longer period of time (Skeide 2019, Meldgaard Hansen 2016). Through this intimate work, nurse aides develop a "bodily knowing" that is crucial for signalling (small) changes. As one of the nurse aides put it, it is often a "gut feeling":

> "In nursing home care it's often 'a feeling', you know the client, you see that he/she is more confused or sleepier than normal; that it's not 'just a bad day'. But it's difficult to make it tangible… this differs from hospital care, for example. In the hospital, medical decisions are based on diagnostic instruments, here it's based more on a feeling." (nurse aid, field notes, 19 February 2019)

Additional to clinical, textbook knowledge, a "gut feeling" is based on the informal and intimate knowledge that healthcare professionals have acquired in numerous interactions with residents over a longer period of time. It is about "knowing the resident" (Meldgaard Hansen 2016). Nurse aides develop this gut feeling through intimate work, and in the past they would call in the nursing home physicians when they noticed changes, engaging with them in a collective process of reasoning and sense-making or "mutual doctoring" (Struhkamp, Mol, and Swierstra 2009) that

involved different ways of (bodily) knowing and acting (Twigg 2002). The triage system reconfigured this process by assigning it to nurse aides and triage nurses. Nurse aides, however, found it difficult to judge when they should consult the triage nurse or wait. A client could feel better in a few minutes or hours, or perhaps after a good night's sleep. Nurse aides had been used to speaking briefly and informally to the nursing home physician – who was also familiar with the residents – about their doubts and signals (their "gut feeling"), but now felt lost and often did not report small changes in the residents' behaviour.

The new triage system also affected the physician's medical gaze. Similar to the bodily knowing of nurse aides, the nursing home physician's medical gaze is closely interwoven with "knowing the resident". They too are used to interacting closely with residents, for instance by posing a quick question or greeting a resident in the hallway, making eye contact, or chatting with the nurse aides about the goings-on on the ward. This is how they conduct their medical observations, comparing them with what they saw, heard or smelled that morning, yesterday or a week ago. The importance of such daily interactions is illustrated in the next excerpt from our field notes:

> A nursing home resident pushes the wheels of his wheelchair firmly with his hands while, unintentionally it seems, blocking forward motion with his feet, which drag over the ground. The nursing home physician stands in front of him, greets him in a soft voice and places the resident's feet on the foot supports. The resident attempts

> to connect in his own way, though dementia has robbed him of speech. The physician turns to the nurse aid and asks, "What is it with his legs? Are they (limp) like this a lot? Is he limited to his chair nowadays? How is he actually doing?" (nursing home physician, field notes, March 2019)

In this particular case, the resident had lost the ability to speak due to progressive dementia. His dragging feet cued the physician to ask questions about his medical situation. The triage system has however altered encounters like these. Physicians now spend less time with residents and nurse aides and visit them less often, hampering the building of intimate relationships with residents in their living space and with care personnel on the wards. This requires a different medical gaze and related work routines.

Moreover, nursing home physicians worried whether nurse aides possessed sufficient medical knowledge and skills to signal medical problems, and whether they would be able to articulate medical issues "clearly" and adequately to the triage nurse and nursing home physicians:

> "I'm worried what will happen if management decouples us from the departments and residents… He [nurse practitioner] explains to me what just happened…: "The nurses had doubts about administrating paracetamol; they pointed out a cold without articulating a clear medical question… and she [nurse aid] overlooked 'the belly problem'… she has trouble telling the 'whole story'

> and doesn't ask the right questions." (nurse practitioner, field notes, 12 March 2019)

This excerpt shows that medical practitioners (in this case, a nurse practitioner who is part of the medical team) have doubts and worries about no longer visiting the wards and residents regularly. In this particular case, information was lacking because the nurse aid had overlooked important medical symptoms (i.e. a swollen belly indicating cystitis) and expressed doubts about administrating painkillers (paracetamol), which the nurse practitioner found irrelevant. If a story is incomplete or "untrusted", the physicians pointed out, they would have to examine a client anyway and she felt uncomfortable about being "decoupled" from the residents.

The excerpts demonstrate that healthcare professionals must build on a shared understanding and language concerning what is and is not a medical issue (or may or may not become one) and how this should be articulated. This requires the invention of new tools and social structures that make up the infrastructure of "doing triage". Nurse aides and the other professionals had to find (new) ways to communicate, to articulate their tacit knowledge and to preserve informal and intimate knowledge. We address this infrastructural work below.

Recrafting the medical gaze through infrastructural work

Our interventions took shape by sharing our insights with health practitioners and managers in the course of the project. One intervention occurred during the project meetings held every two

weeks with nursing home physicians and nurse practitioners, the triage project manager, the medical team manager, and triage nurses. We presented and discussed new versions of the flowchart during these meetings and listened to and evaluated triage-related experiences. In their study on an internet-based application for referring patients between primary and secondary care in a Dutch region, Bal and Mastboom (2007, 258) show that researchers do "repair work" by travelling between all the places relevant to the research project. By showing up and conducting interviews at different locations, researchers are able to transfer experience and knowledge from one place to another. In our project, we travelled between the triage room, the nursing wards, residents' homes and consultation rooms. We soon discovered that nurse aides were unfamiliar with the triage system and felt uncomfortable with the new approach to recognizing and communicating medical issues. We pointed out the importance of nurse aides' embodied knowledge and signalling role, as there appeared to be too much focus on the physicians and triage nurses. The project team subsequently decided to expand its scope to include the nurse aides and the nursing wards by organizing training days regarding the signalling of deterioration and by providing more organizational support (emphasizing scheduled, practical tasks and co-worker support).

All this shifted the project emphasis somewhat as well. Early in the pilot, the S-BAR Method was used to train the "new" triage nurses. The S-BAR method (Situation, Background, Assessment, Recommendation) is commonly used in triage practices to structure communication between professionals (usually nurses

and doctors) (Greatbatch et al. 2005b). There was no such training for the nurse aides on the wards, however, and there were few instances in which the medical team and nurse aides could practise exchanges and deliberation. Besides the S-BAR method for the triage nurses, no common guidelines had been established for how nurse aides should respond to residents' changed conditions. To strengthen the autonomous role of the nurse aides on the wards, as well as their observational competence and organizational skills (i.e. scheduled and practical tasks and co-worker and family support), the nursing home organization developed a training in close collaboration with the triage nurses and nurse aides.

This included a "gut-feeling card" (figure 2 and 3) with details about changing client conditions and how to communicate them. For instance, a triage nurse pointed out during training that nurse aides would no longer call a triage nurse or physician and simply say "the resident is wheezing". Instead, they used the gut-feeling card to clarify the signal "wheezing" in terms of frequency and depth of breathing: is the resident coughing, and what is the medical background? The gut-feeling card offers a list of categories, such as "breathing, circulation, saturation, neurology, mental responses, client indicates that '…'".

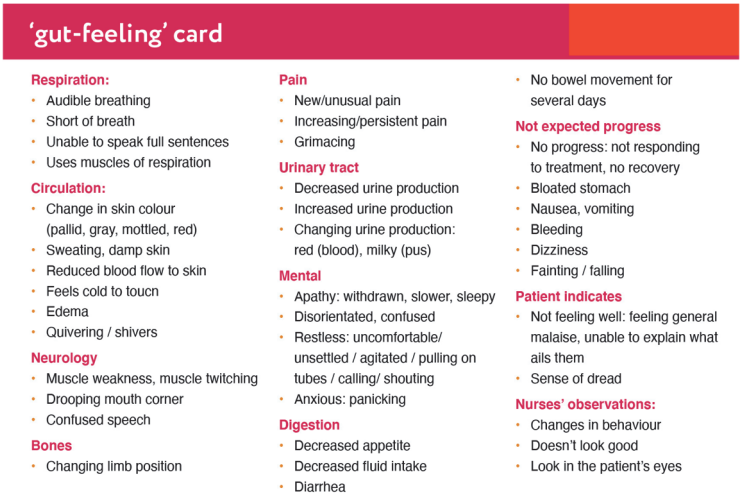

Figure 3: Gut-feeling card front

Using this card should enable nurses to describe in detail what they had observed and what they thought could be the problem at stake. Hence the gut-feeling card supports the articulation work of nurse aides, rather than classifying residents in a particular category. With the card, nurse aides were encouraged to ask residents questions, collect information, and ask for and provide co-worker support. Part of recrafting the medical gaze, then, is to craft the care gaze and strengthen the role of nurses and nurse aides. The gut-feeling card opens the door to conversations, to developing a shared language, and to provide training-on-the-job when the doctors can no longer be nearby. It moreover, made the nurse aides part of the infrastructural work of the triage system.

Reconfiguring the care gaze in this manner involves not only practising care expertise, but also defending and institutionalizing

that expertise in daily practice. For example, a specialized nurse should not merely do what the physician wants but also develop her/his own area of expertise to which the physician should listen in return. Or, as a specialized wound nurse explained:

> "Margot is worried about the wound plan that one of the nursing home physicians has altered. She explained to me that the physician misunderstood her plan and that he can't just make changes without informing her… 'There's a certain philosophy for every wound.' She called the doctor to explain this new way of working to him (once again)." (specialist wound nurse, field notes, 12 April 2019)

It is not just the knowledge flow that changes; the triage system designates several professionals who bear "final" medical responsibility, and the nursing home physician or other medical specialist sometimes has to get used to this. Triage is part of a broader infrastructure; it makes the invisible work of nurses more visible and challenges power relations embedded in the older persons care system. The development of the care gaze in the gut-feeling card makes categories and work visible and negotiable for both physicians and nurses, and connects to the caregiver's perception and meaning-making processes. Based on our findings, we argue that the triage infrastructure, far from excluding moments of interaction, exchange, and personal contact in fact demands new structures into which these moments can be integrated and, in some cases, transferred to different professions (e.g. educating nurse aides to signal deterioration, introducing

specialized nurses as contact person for the family and wound nurses who are accountable for treatment plans). Rather than classifying and structuring, then, triage as infrastructure connects the different professions and locations through a process of "mutual doctoring". Hence triage is not a matter of well-argued individual choices but something that grows out of collaborative and continuous attempts to attune local possibilities and constraints to the daily needs of residents.

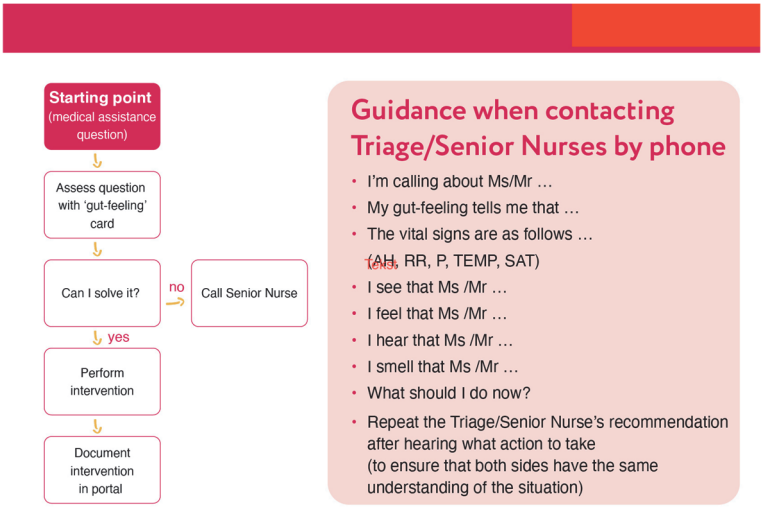

Figure 4: Gut-feeling card back

Discussion

In this paper, we have shown how triage in the long-term care setting has evolved into a new infrastructure that establishes a regional system of older persons care in which nurses and nurse

aides play a significant role. It involves doing the infrastructural work of creating and adjusting the flowchart and rethinking where and how care should be provided as well as introducing new materialities to make triage happen (i.e. the gut feeling card). Mirroring previous studies, we have shown how triage nurses create workarounds and use coordination skills to work with the triage infrastructure in the daily care setting, for example by adjusting guidelines and work schedules to local circumstances (Greatbatch et al. 2005b, Johannessen 2017). Our study has revealed how nursing home physicians, specialized nurses, triage nurses, nurse aides, and other practitioners perform continuous infrastructural work to embed triage within the spatial-temporal order of long-term care. Our findings suggest that, unlike in acute care, triage practices in care for older persons are more diffuse, and that diagnosis and decision-making take place collaboratively and over a longer period of time, with health practitioners acquiring a familiarity and bodily intimacy with residents that appear to be significant for signalling and responding to medical deterioration (Struhkamp, Mol, and Swierstra 2009). Like previous studies, we argue that triage, as an infrastructure, not only structures and simplifies but also opens up new ways of re-placing medical and care work, both professionally and geographically.

Our findings furthermore indicate that crafting a triage system in the long-term care setting means departing from the traditional doctor-client relationship, with medical work being distributed in a larger (regional) care network. This changes and challenges physicians' professional role because they must now take a different approach to diagnosis and depend more on various

information sources and input from other healthcare practitioners, in particular nurse aides. At first sight, our findings suggest that this distance does not necessarily have a negative impact on the quality of care because other professions have taken over the signalling and treatment tasks and must come up with new solutions when the physician is not on location. Defining these new roles is not an intuitive process, however. Instead, infrastructural work is needed to adapt existing roles and tasks, joining "old" and "new" approaches to care. The gut-feeling card is one example; it gives the nurse aides an information tool to strengthen their new, autonomous role by building on their own knowledge and on existing relationships, and materials. This tool facilitates reflection and articulation, and reconfigures the care gaze among nurse aides, rather than functioning as a standard that should be followed. Moreover, by travelling between the different care locations and talking to the various health professionals who shared their stories and experiences, we were able to unpack knowledge, relationships and materials. What we learned and contributed to the pilot project are insights that already existed in the project, but as researchers we transformed them, if only by transferring them to other places (Bal and Mastboom 2007). In this way, we as researchers have also become part of the infrastructural work, enabling different kinds of choices and materializing new ways of doing an information tool.

The crafting of a triage infrastructure thus creates room for (new) ideas on "doing" quality of care. In earlier research, Oldenhof, Postma, and Bal (2016a) show that once care is re-placed, the process of care also changes, producing different ideas on what

good care is. In our case, physicians travelled between the different care locations, contributing and sharing their knowledge and expertise. Every care location has its own ideas about good care and treatment that are embedded in daily routines and practices. These ideas had to be clarified more explicitly among physicians and (medical) practitioners. Furthermore, the notion of good care changed in the process of developing the triage system. For instance, wound nurses got a more central position and can provide specialized wound treatment care while also educating nurse aides on the wards, e.g. which mesh to use and when and how to clean wounds. Medical care for older persons becomes more nurse-driven in this way, and including the nursing professions in the triage decision tree supplements the medical gaze with a care gaze. However, the risk exists that diversifying professionals could lead to more fragmented care and coordination problems. Further research should focus on the development and strengthening of the care gaze within the medical context of older persons care.

Although our findings reveal opportunities to reorganize medical distribution in long-term care, they also present various challenges. Since triage as infrastructure takes shape situationally and gradually, it is more complex to deploy on a regional scale (Lorne et al. 2019a). Reorganizing care on a larger scale, such as in the Greater Manchester project and the regionalization of healthcare in the Netherlands, should accommodate place-appropriate and adaptive solutions. In this paper, we showed that, unlike the instrumental and technical approaches to dealing with decreases and shortages, there is a need for a flexible planning

framework where people are encouraged to meet more often and adapt to place-based solutions (Sennett 2019). Oldenhof, Postma, and Bal (2016a) and Ivanova (2020) argue that re-placing care involves more than moving from one geographical location to another. They show how care and place are linked not only through geography, but also through affective emotions, identity, and imagination. As our results reveal, re-placing physicians has complex effects above and beyond the efficient deployment of the available medical staff. Triage as infrastructure not only changes the location, but also reconfigures the relationships physicians have with residents and nurse aides on the wards. Being where residents live and dwell acquaints physicians with their habits and care needs. The triage system we have studied aimed to make these stories and experiences "travel". Oudshoorn (2012) has pointed out how the place-dependency of the use and meaning of technologies has important consequences for the design and implementation of technologies. In our case, the design of the triage system challenges its regional aim. Although the triage system assumes a certain place-lessness, our research shows that medical decision-making in long-term care is place-dependant and should be embedded in care practices. The formative evaluation method can take this place-dependency and social relationships into account, by revealing such elements and making them part of the infrastructural work.

6.

‘The Night is for Sleeping’: How Nurses Care for Conflicting Temporal Orders in Older Person Care

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Introduction

> The phone rings at the primary care center, it is 8 o'clock on a Thursday evening. The partner of an older woman with Parkinson's disease and dementia is on the line. His wife has just fallen on her back. She is at home, in pain and confused. He seems anxious, not knowing what to do. The GP calls the local hospital's geriatrician, but the geriatrician refers her to the neurologist who is familiar with the patient's health issues. The neurologist however states that the patient can only be brought in when there is a bed available at a nursing home, as she can't stay in the hospital. The local nursing home doesn't have any beds available. The GP contacts the region nurse on call; maybe the region nurse can visit the patient at home?
> (Weekend shift, January 2022, Fieldnotes)

This excerpt comes from our ethnographic study in which we observed region nurses in their work. The regional district nurse (from now on 'region nurse') is a new professional role in the Netherlands, introduced to provide (sub)acute care for older persons during out-of-office hours. Region nurses work in an ambulant team, traveling between nursing home locations, the primary care centre, and private homes, connecting these places of care. This new role aligns with a Dutch policy reform to keep people at home as long as possible and to prevent admission to an acute care hospital or long-term social care institutions (Dungen and Koesveld 2018, VWS 2020). This policy, under the

slogan 'the right care at the right place', has been critiqued by sociologist as an austerity measure to deal with an ageing population, in addition to increasing health workforce shortages (Dungen and Koesveld 2018, Klerk et al. 2019). Whilst the assumption that these policies result in efficiency gains has been questioned elsewhere in the literature (Wittenberg et al. 2018, Schuurmans et al. 2023), in this paper we focus on the consequences of the region nurse for the organisation of care. This policy shift ensures that issues surrounding care shortages, which mainly occur during out-of-office hours, must be solved by the providers and practitioners. As a consequence of these new policies, healthcare organizations have expanded regional collaboration and introduced new professional roles, such as a regional nursing teams to enhance care capacity (Van Pijkeren, Wallenburg, and Bal 2021). We are interested in how this shift is accomplished and its consequences for patient care and professional work.

The promise of the region as a place of appropriate care has become key to policy agendas in various countries in the global North in recent years . In these countries, governments seek to reshape healthcare provision and shift responsibility to patients and their relatives to contain costs and deal with workforce shortages (Lorne et al. 2019b, Evans, Nistrup, and Pfister 2018, Jones, Fraser, and Stewart 2019, Schuurmans, van Pijkeren, Bal, et al. 2020). Sociologists studying this transition have focused on the policy and care infrastructures facilitating the rescaling and replacement in long-term care (Carstensen et al. 2022, Lorne et al. 2019b, Oldenhof, Postma, and Bal 2016c). This literature

draws attention to the work that healthcare professionals, patients and their families do to replace care services and create a caring place at home (Langstrup 2013).

Yet the regional organisation of care not only requires the remaking of policy, professional roles and care infrastructures, it also reconfigures care in time and space. Regional care provision, such as through the region nurse, stiches together various places of care with different 'temporal orders' (Blue 2017). Temporal order are a set of rhythms in time that shape the connections between practices. The timing, routines and sequences of events and practices in a nursing home are different from those in a patient's home, because of ossified organisational rhythms -e.g. the structuring of events in time like consultation rounds and multidisciplinary consultation, versus the more idiosyncratic rhythms of patients living at home to which nurses have to abide. (White 2022, Ward et al. 2022). In this paper we study the ways in which the new temporal order of the region becomes established and the work that region nurses do to sustain this temporal order.

In our analysis, we draw on a growing body of literature which seeks to understand the intersections of temporality, care and care work for older persons (Hirvonen and Husso 2012, Tufte and Dahl 2016, Balkin et al. 2023, Ihlebæk 2021). This literature offers insight into the temporal (re)structuring of healthcare, elucidating how various logics have taken priority over the organisation and production of care for older persons. Much of this work has been concerned with studying the ways in which

neoliberal policies of organising care impact the temporal orderings of healthcare work. They specifically focus on the 'objective' time (quantifiable and manageable) logics of new public management versus the 'experienced' time (embodied) of patients and healthcare professionals (Tufte and Dahl 2016, Balkin et al. 2023, Ward et al. 2022, Hirvonen and Husso 2012). This literature stresses the concern about a rationalisation and dehumanisation of care relationships through objectification and commodification. Such studies for example highlight the unpredictability and invisibility of body work that healthcare workers engage in, making it hard to standardise healthcare practices (Cohen 2011, Davies 2003). Further, these studies reveal the lack of time to perform caring work, as well as the agency of nurses in managing those tensions (Balkin et al. 2023, Kuijper et al. 2022).

In this paper, we aim to go beyond the distinction between 'objective' and 'experienced' time and study how time is constitutive of (nursing) practices (Blue (2017). We will argue that time plays a crucial role in defining and shaping care practices, and in establishing a regional order of care. We determine how, spurred by health workforce shortages, a regional temporal order is constructed that reconfigures how caring practices, and hence care itself, are ordered in time. More specifically, we examine how the region nurse performs temporal work to make the regional temporal order possible. In accomplishing this, we show how region nurses struggle with crafting their professional role in between various care settings and their distinct temporal orders, without getting involved 'too

much', in order to be mobile as 'temporal nurse aides'. The following research question guides our research: How do region nurses engage with different temporal orders in older person care when shaping regional care provision, and what are the consequences for how care is provided?

Theoretical Framework

In this section we elaborate on the concepts of temporal orders, institutionalised rhythms, and temporal work. Time as a term is understood and used differently across disciplines (Blue 2017, Massey 2001, Ringel 2016). In this paper, we draw on a conception of time as "a constitutive effect feature of practice" (Blue 2017, 935). In other words, time is not a neutral background against which caring practices take place, nor something that is experienced within a specific practice, but rather a fundamental element that shapes those practices. In this paper, we analyse how organising care in a regional setting affects the temporal ordering of care and care work.

Temporal orders have been described as a "set of temporal rhythms that shape connections between practices" (Blue 2017, 934). They can be predefined and rationalised, for instance in the work routine and organisational time schedules. Yet temporal orders also exist more distinctly and fluently, such as the rhythm of a person's evening routine (Tufte and Dahl 2016). One of the characteristics of temporal orders is that they influence each other, as practices and routines are connected and open-ended. Blue (2017, 934) gives the example of the working day in a hospital to illustrate how temporal orders can intersect. The

activities during the day, such as consultant rounds, clinic appointments, surgeries, and other tasks, follow a specific sequence and are connected to one another. Such a daily temporal order is further affected by the temporal order of the week, as well as broader temporalities like seasons, or economic cycles. The institutionalisation of a regional temporal order thus includes the coordination of activities over different rhythms. Our focus in this paper is on how regional nurses perform temporal work to mediate between different temporal rhythms.

Temporal orders can be interrupted by events that disrupt routinised, or expected, sequences. These are what Blue (2017) refers to as 'rhythm disruptions', or as 'arrhythmia'. Aligning various temporal orders and accounting for rhythm disruptions in various timespace(s) can be considered an intrinsic part of providing nursing care (Kuijper et al. 2022). Moroşanu and Ringel (2016), for example, coined the concept of 'time tricking' to show how practitioners enact time by, for example, speeding up death in a dying process or, on the contrary, delaying death to give people time to say goodbye to family and friends. Others have argued that time management appears to be easier to realise in a hospital setting than in long term care. These settings often require 24/7 attention with more unpredictable moments of care, for example, an older person wandering around (losing sense of time and place), fall incidents at home, or forgetting or taking the wrong medication (Balkin et al. 2023, Burns et al. 2023). Meldgaard Hansen (2016), for instance, shows how long-term and home care for older persons is mostly about finding and adapting care routines to life rhythms. Nurses, Ihlebaek

(2021) argues, learn to enact a temporal reflexivity in knowing when particular temporal structures are required and how to use them in an ongoing and adaptive response to emerging care needs. These literatures particularly focus on a specific care setting, and not so much on the coordination of temporal rhythms at distinct and multiple places of care provision that must be brought together to create a new temporal order of (regional) care.

In relation to care, research has shown how patients' (bodily) needs, like in cases of sudden illness or emergencies, can disrupt organisational routines and schedules (Cohen 2011, Andersen and Bengtsson 2018, White 2022). In healthcare institutions, increasing emphasis has been put on time-efficiency and task-predictability, stressing a neoliberal or 'managerial logic' of care (Tufte and Dahl 2016). In this logic, tasks are understood as linear actions that can be counted and scheduled, suggesting a work environment that can be planned. This managerial logic has been critiqued by sociologists, who have argued that patient lives and care needs are often messy and unpredictable – for example, an older person becoming restless because of an emerging bladder infection or decreasing blood sugar level may require more continuous care than anticipated within such models (Mol 2008). Performing care work is not linear, but is instead organized through variable and often unpredictable processes; care is infused with temporal orientations of enduring, waiting, prolonging, and hastening (Tufte and Dahl 2016, Lemos Dekker 2020).

Understanding how care practice is temporally managed and enacted requires us to go beyond the dualism of objective and experienced time by focusing on how different practices are temporally connected. According to Blue (2017), these connections may impact the entire nexus of practices, evoking a substantive (institutional) transition as new practices are reproduced and strengthened. We study how such a transition includes both routines and a valuation of what is considered (good) care (Ihlebæk 2021, Schuurmans et al. 2023). Building on this literature, we explore how nurses engage with different temporal rhythms in older person care in the regional setting, how they (seek to) synchronise them and with what consequences for nursing work and care provision.

Ethnography of Regional Nursing Care

Research setting

The ethnographic study was carried out in a long-term care region in the eastern part of the Netherlands between August 2021 and August 2022. Being part of an ongoing, national research program (2018-25) on regional collaboration (Schuurmans, van Pijkeren, Bal, et al. 2020, Van Pijkeren, Wallenburg, and Bal 2021), this paper draws on one specific case study that was marked internally as a promising initiative by both policymakers and organisational actors from other regions, who framed it as 'best practice'.

In January 2020, a team of regional district nurses were introduced by six nursing care organizations. Sixteen nurses who previously worked for these single organizations were selected

for this new role. They received additional training in nurse-technical procedures. The region nurse was introduced to find a solution for pressing workforce shortages in long-term care during out of office hours in the nursing homes, and eventually also home care. Home care was included, as the expertise of the region nurses was considered valuable for older persons living at home by both the management and general practitioners.

Region nurses are consulted in case of acute or urgent (yet not life threatening) situation, like patients with catheter or dripline problems, fall incidents, or restless behaviour. Nurses and nurse assistant working at the nursing home or in home care should consult the region nurse, instead of calling the physician. Region nurses, in turn, can consult a physician to discuss medical issues or to prescribe drugs—as this is legally preserved to medical doctors. The idea (and hope) is that the new role of region nurses will lower the pressure on both older person care physicians and general practitioners, and that the region nurse can support care practitioners at different locations, leading to an outcome where more care can be given with less staff.

Data collection and analyses

Participants from the regional district nurse team were directly invited to participate in the study via one of the nurses, who frequently gave presentations about their work at conferences related to the research program. We shadowed care practitioners (i.e. region nurses, home care nurses, nurses in the technical team) during their shifts, allowing for informal conversations and reflections on their role and work. Additionally, the first author

attended project meetings and conducted both formal and informal interviews with care practitioners and one regional care manager. We joined nurses in their cars, visiting a patient or picking up medication, and shadowed them in the nursing home, the primary care center and at patients' homes, examining patients, talking to care workers and consulting a physician (amongst others). We observed eight region nurses, and two nurses were observed twice. Observation lasted an entire shift, usually eight hours or more (e.g. some shifts were longer because of an urgent call at the end of a shift).

Interviews and observations focused on the temporal work performed by the nurses, the choices they made, their rhythms and pace and the coordination of tasks between settings. In total, 10 shifts and 3 management meetings (60-90 minutes each) were observed, 120 hours of observation in total. Also, we observed the technical nursing team twice. This team operates separately from the region nurse, focusing on technical clinical procedures at home, like adjusting a PICC line (peripherally inserted central catheter), starting sedation or administering chemotherapy at home. We aimed to get a better idea of their tasks and how those differ or overlap with the region nurse (32 hours in total), as this appeared an important discussion in the region. Notes were made during observations and worked up in detailed observation transcripts shortly after. The interviews were recorded and transcribed as well. All participants gave permission for the research. Ethical approval for the research was obtained through the wider project by [BOARD] in the Netherlands.

We used open coding at first with the research team engaging in discussions about the main codes for further analysis. Between coding sessions, we read various literatures related to our analytical focus on temporalities of care practice, which supported our iterative analysis of the data (Tavory and Timmermans 2014b). In our analysis we distinguish between the temporal order of the region, of day and night care, and the temporal order of patients and relatives. We analysed how these orders intersect and what factors disrupt the regional temporal order of care, leading to the following themes: bodily needs and rhythms, (un)predictable technologies, patient and relatives' routines.

The following section presents our results. Excerpts and quotes have been selected to illustrate the themes. The research was conducted in Dutch; quotes have been translated by the authors into English for the purpose of this paper.

Results

Our analysis shows how a 'new' regional temporal order in the evening, night and weekend shifts is enacted through a reorganisation of nursing work and the use of care technologies. However, long-term care is by nature unpredictable and during a shift, various events or 'crises' emerge, jeopardising the new regional temporal order in the making. Region nurses, as a new professional role, stabilise these situations and fosters the new temporal order. In doing so, they act as 'guardians' of the new

regional order and institutionalise its rhythm in and through caring practices.

1. Making a new regional temporal order

With the scaling of care to a regional constellation, various sites and their specific spatial-temporal ordered practices are brought together. In what follows, we show how a temporal order of the region is constructed through various new approaches to care provision (a new professional role; a new care team), the use of specific technologies and the mobilisation of informal networks of care of patients. We argue that the logic behind this new regional temporal order is inspired by a managerial or efficiency logic, aiming to do the most with available scarce resources.

2. The temporal order of day and night care

Our respondents report that workforce problems are most acute in out of office hours shifts. To make care provision more efficient during these irregular hours, the management team aimed to distinguish between planned and unplanned care. Planned care refers to care that 'can be predicted, scheduled, or postponed'. As the regional care manager explained: 'non-acute [care] should be taking place during the day as much as possible and no longer during the night. The night is for sleeping' (March 2022, healthcare manager, interview). To establish this new temporal care order, organizations had to make sure that 'care is provided sufficiently during the day'. This, amongst others, was achieved through good care planning, anticipating and acting on possible swiftly deteriorating conditions of patients during regular hours. Furthermore, a technical team provided planned care at daytime

(e.g. parenteral nutrition, artificial respiration, administering morphine in terminal phase), meeting all the expected daily care needs of care recipients. One of the aims of the technical team was to make sure that no regular care activity had to be done during the evening, night or weekend. During the working day, nurses and physicians of the collaborating organisation took up unplanned care needs of patients. Managers of various collaborating healthcare organizations hoped to reduce the number of full time equivalent staff allocation of nurses and physicians working these shifts by reorganising care and cutting out, as much as possible, planned care from the evening, night or weekend.However, as managers were keenly aware that moments of unplanned care also happened during out of office hours, a new professional role of region nurse was created. The schedules of the region nurse left room for taking up the unexpected care demands of persons in the last life phase. The region nurses had no fixed appointments as they always wanted to be available for a possible urgent (and hence 'unplanned') care demand.

The new regional temporal order was also dependent on the way in which patients' informal care networks could be mobilised by care professionals to perform certain tasks. Informal care givers helped to establish the new regional temporal order through various practices of care. Family members, for instance, were asked to pick up medication at the weekend pharmacy, or to provide a clean and dry environment at home to store or dispose medicine safely. The new temporal orders required patients and

their relatives to be more self-reliant. In one of our conversations, a region manager explained:

> 'For three years we helped Mrs. Jansen to go to the toilet at night,' the region manager explained. 'We no longer do that. We try to prevent toilet visits [by making sure Ms. Jansen stops her routine of drinking tea before going to bed]. The patients really appreciate that they are no longer disturbed during the night.'
> 'Are there situations where planned care is insurmountable?' I [interviewer] ask.
> 'There are cases where it is medically necessary,' the manager explains. "There is a patient, for example, who is bedridden at home and who must be turned over during the night to prevent bed ulcers, and this person has no adequate informal care support. But overall, there are fewer care moments at night and therefore there is less personnel needed.' (Fieldnotes)

This excerpt shows how patients and their families are encouraged to support and hence cocreate the new regional temporal order, one in which the night is for sleeping and professional care is mainly provided during regular working hours.

At the same time, technologies were introduced to help to establish the new regional temporal order. New technologies such as sensors, alarm buttons and fall floors aim to reduce crisis situations and to make care more predictable. We encountered

various examples of technical interventions, for instance monitoring devices that enabled care providers, patients, and their relatives, to better manage care needs. For example, sensor technology was used to monitor patients remotely during the evening, reducing the need to visit patients for check-ups, particularly during evening, night and weekend shifts. These technologies, enabled a region nurse to have less contact moments.

It was the region nurses' primary task to attend to unforeseen care needs, instances that threatened to disrupt the new regional temporal order. In what follows, we tease out the temporal work that region nurses performed as guardians of this new temporal order 'in the making'.

Nurses' role as temporal nurse aides
In our research, we witnessed various moments in which the new regional temporal order was disrupted by sudden bodily needs, malfunctioning technologies and uncooperative patients and their loved ones. At these moments nurses performed temporal work to stabilise these situations and prevent enduring disruptions of the new regional temporal order.

Moving fast, staying short
Bodies of older persons with complex care needs could not always be disciplined into the new regional temporal order. Caring for psychogeriatric patients meant that crisis situations occurred frequently, also during out of office hours. A patient, for instance, could become delirious and not only require instant

attention of care professionals, but also possibly get restless and agitated, waking up other residents. During one of our observations, such a crisis emerged. The region nurse was called upon to assist at a nursing home where an older lady was wandering around, urgently demanding attention from the care staff:

> The patient does not physically resist but is not cooperative either. She moves like a dishcloth that must be unfolded again when putting on the bed. 'What have I done, she asks, I'm not guilty, am I?' The nurse tries to reassure her: 'You are not guilty, but the doctor [region nurse] is here to check on you.' The lady mutters about guilt, photos, her mother… She is obviously confused and anxious. The care worker explains that the patient has been restless all evening. She asks for tranquilisers to have a peaceful night. She states that she cannot keep an eye on this patient the whole night as she also must care for seven other patients: 'Something has to be done now!' she exclaims. (Evening shift, August 2021, fieldnote)

This situation occurred when nurse aides were getting their patients ready for bed. The delirium of the older lady disrupted the care rhythm of the nursing home. The nurse aide asked for immediate action (providing tranquilisers) to bring back quietness and rest on the ward – also for the sake of other patients who were getting increasingly agitated. At the same time, the caring process on the ward had to proceed on as other

patients wanted to go to bed. Yet the region nurse must be available for other possible emergencies and requests in the region, and he could not stay long with the patient. After consulting a physician on call at home, the region nurse decided not to prescribe any tranquilisers:

> 'It is a skinny woman and she doesn't get much medication at all; if we give her something now, she'll drop down in no time,' the region nurse said. Instead, he suggested using a fall mattress and a sensor to monitor movement and respond to this. The care worker expresses her concerns. From 11pm onward, she would be alone with the group. The region nurse, however, stuck to his decision. 'This is more a problem of the care workers than the patient,' he argues back in the car. (Evening shift, August 2021, fieldnote).

During our observations, we regularly encountered similar situations. The preservation of the order in the facility was privileged above the patient state, at least from the perspective of the care worker. This was opposed by the region nurse's, who thought of it primarily as a problem of the care workers rather than of the patient. The temporal work carried out by region nurses focused on stabilising the situation and preventing serious disruptions of the regional temporal order, while also keeping up with quality care.

The temporal work of region nurses to sustain the new regional temporal order had implications for how they related to time, to

care and to patients. Time to sit with patients was generally scarce, and region nurses deliberately did not engage in the care process, including when it was quiet. Instead, they preferred to spend these moments 'backstage', alone or with fellow care professionals behind a computer, at the coffee station or in the car. They explained that their role was to be flexible and to move around, and not to take over care work. Region nurses kept an eye on time and anticipated a (possible) visit to other places. They continuously contemplated how long they could stay in a situation and when to leave for the next visit. In doing so, region nurses made sure not to get involved too closely, for instance by postponing a phone call, delaying a visit, or leaving a care unit when it was obvious that 'more hands' were needed. Yet they deliberately did not consider this part of their work. They made sure not to become part of a local problem and to remain mobile in their role. Their primary concern was to stabilise a precarious situation – restoring the temporal order – so that the problem could be addressed at a later moment (during the next day, or after the weekend). As one of the region nurses explained: 'We solve an issue for the night or weekend.' In doing so, they 'cared for' a situation but kept emotional and social distance and did not take full responsibility for the care process (Milligan and Wiles 2010).

Predictability versus flexibility

Although various technologies were introduced to foster the making of a new temporal order, they did not always play out as intended. Technologies sometimes had unintended effects, jeopardising the new regional temporal order and requiring work

from region nurses to step in. The following excerpt illuminates how a technology to enable 24/7 care had unforeseen implications, requiring more and frequent care:

> We visit a woman who uses a device around her neck to administer a 'bolus' to increase the dose of apomorphine which goes through a drip line in her belly. The medication softens the symptoms of Parkinson's disease. However, her skin is infected due to high doses of the medication. The region nurse visits the patient to clean the wound and instruct the woman how to use the pump. The patient however denies that she gives herself a bolus too frequently. The region nurse suspects addiction to the medication. She concludes that they must visit more often, increasing the moments of care instead of replacing human care through technology. (Evening shift, May 2022, Fieldnotes)

Technologies that should facilitate a regional temporal order might result in new work and an increase of contact moments by region nurses. In this case, the technology of the bolus injection made it possible for the patient to administer medication in case of worsening pain. In theory, this would reduce the number of nursing visits, contributing to the temporal order of reduced and regular care provision. In practice, however, it also gave rise to (new) challenges such as addiction and skin problems that required more frequent care visits and hence time spent with the patient at home. In this case, the region nurse accepted that there was an immediate need for more frequent contact and

hence the expansion of time as a response to bodily needs, and in the hope of preventing an addiction from escalating and potentially posing an even more serious threat to the new regional temporal order.

Beyond the unintended consequences of technologies, other threats to the regional temporal order included families. In some cases, patients as well as families, did not want to settle into the new rhythm of collaborating care organizations. Struggling with a defect bladder catheter in the middle of the night, for instance, can make patients or their informal care givers feel ignored and not cared for. Attending to these care demands helps to ameliorate such feelings. During one of the shifts, a region nurse explained that a lot of phone calls are about bladder problems (something seen as 'daytime care'). Ignoring these requests or finding a quick solution is not always possible. Instead, spending time and listening to the patient is important, it was argued:

> 'The patient must be taken seriously. What are the patterns? When does it bother them? Simply placing a catheter and 'flushing' or replacing it in case of a complaint is usually not the best solution.' (Weekend shift, May 2022, Fieldnotes).

This excerpt depicts a situation in which the 'night is for sleeping' precept is interrupted by patient's immediate needs. Region nurses seek to attend to those needs and in doing so protect the regional temporal order by stepping in. These disruptions also emerge when informal care givers do not want to comply with

the new organisation rhythm and expected actions from them, as is illustrated in the following excerpt:

> We are on our way back to the emergency post at the end of the shift. It is 11PM when the region nurse is phoned by the call centre. This family has called for the third time this night and urges the operator at the call centre to ask the region nurse to visit them. The region nurse has been there earlier today and is aware of the difficult family situation. When we enter the house, the patient is lying on a bed in the living room in front of a big television screen. In the corner of the room, his wife and daughter are sitting in front of another television smoking cigarettes. While checking upon the patient and flushing the catheter, the region nurse tries to speak with the daughter. The nurse explains that her father is doing fine, as was the case during her previous visits. She asks them what they are worried about. The daughter answers that whenever her father complains about pain, she will call. When we leave, the region nurse explains that she finds it hard to deal with situations like these, as it is not so much about the actual pain but more about the living conditions of this patient and how this family copes with the disease and the inconvenience that comes with it. (Evening shift, January 2022, fieldnotes)

This excerpt illustrates how patients and their relatives do not always settle neatly into an established organisational rhythm. In this case, the family insisted that the region nurse visits, while

the condition of their loved one does not require immediate medical attention. However, the temporal work of the region nurse at the patient's home ensures that the patient and family situation is stabilised and does not escalate, not putting any pressure on acute care services.

Discussion

The aim of this paper is to develop an understanding of the spatio-temporal restructuring of older person care in a region with growing capacity problems. In our research, we have built on the notion that time is constituted with practices (Blue, 2017) This has turned our attention to the care provisions, technologies and care work performed by professionals, informal care givers and patients to enact a new regional temporal order. One in which enormous coordination and work is enacted to preserve the idea that night is a time for sleeping. We have particularly focused on the temporal work of region nurses to prevent and repair disruptions of this order, highlighting their role as guardians of the night. We showed how their actions contributed to the institutionalisation of this new temporal order through caring practices.

The regional temporal order was produced through a reconfiguration of caring practices of various actors – care professionals, patients, informal care givers – at various moments. The new regional order for instance required a reconfiguration of caring practices not only during the night, but also during at daytime. Specialised technical nursing teams were positioned to provide planned care during office hours, for

example by using advance care planning to prevent potential care needs in the evening, night and weekends. We have empirically illustrated the dependencies between various temporal orders. For instance, the rhythms of the nighttime and daytime, rhythms of care in facilities vis-à-vis the temporal order of the region. In doing so, the spatial temporal restructuring of work requires a reconfiguration of work routines at various moments throughout the day (Blue 2017).

We also illustrated how nursing work of region nurses and hence care itself were reconfigured. Various scholars have argued that values of good care are both constitutive of practices and produced by acts of care (Oldenhof et al. 2022; Schuurmans et al. 2023). In this research, nurses moved 'in and out of care', anticipating potential emerging crises. Even during a quiet shift, region nurses made sure not to stay long at a patient's bedside, only stabilising a situation to prevent any threats to the regional temporal order. They preferred lingering on the backstage, above hands-on caring for patients and frontline care workers, which was furthered by their urge to always be available for the next possible call. This analysis shows how the enactment of a new regional order required the repetition of certain acts that produces particular values of what good nursing care is. In this case, good care is 'just doing enough' to prevent an emerging crisis from escalating (Harrison, Rhodes, and Lancaster 2023, Waring and Bishop 2020a).

Hence, various spatial-temporal orders intersect and at times resonate and/or disrupt one another. Building on Blue's (2017)

conceptualisation of such disharmonious occurrences, as 'rhythm disruptions' and 'arrhythmia', we have distinguished three types of disruptions of the regional temporal order: interfering bodily rhythms and needs; (un)expected workings of technologies; and disrupting acts of patient and relatives. It was region nurses' prime responsibility to stabilise these interferences and prevent or soften a disruption of the regional order. Interestingly, with the professional role of the region nurse, unpredictability is anticipated as region nurses perform temporal work, dealing with and restoring the disruptions of the temporal order of the region. This differs from what is often described in the literature, where healthcare professionals' experience time clashes with (neoliberal) time regimes imposed on them by healthcare organizations. We showed that disruptions are actually a regular or 'normal' part of the sequencing of events in the regional temporal order (Hirvonen and Husso 2012, Moroşanu and Ringel 2016, Ihlebaek 2021). Region nurses can be seen as guardians of the night, a function inscribed into the temporal order as far as the glitches in the order are already recognised and calculated in.

This research also has some limitations. We only followed a team of a limited number of nurses. More research on scaling up work, in other contexts and countries, is needed to learn more about their changing caring role of nurses in healthcare systems under pressure. In addition, we did not study how patients perceived the quality of care but only gained an insight into possible consequences from interactions during observations. A focused study on patients, their relatives, and how they experience certain practices changing or disappearing is needed.

The configuration of the temporal order does have consequences for both the care and the role of professionals. Research on time and care has shown how efficiency paradigms increasingly are structuring time to care (Ihlebaek 2021) and how the pace of performing care increases, causing time scarcity (Balkin et al. 2023). By focusing on how time is practice, we add to this literature by showing how, even if there is 'objectively' time to stay with a patient (such as in the case of the restless woman), region nurses must act flexibly and therefore distance themselves from situations. We found that certain practices that were previously part of normal routines of caring, such as guiding restless behaviour or not responding well to certain medication, are now seen as disrupting the organisation of care rather than intrinsically part of the process of caring. This can impact on how care is valued as it becomes increasingly debatable what 'essential' or 'good care' means (Felder et al. 2023b, Waring and Bishop 2020b, Harrison, Rhodes, and Lancaster 2023, Felder et al. 2023a). These aspects of time and care should be studied further in future research.

7.

Discussion: reflections on the region as a caring geography

Discussion: reflections on the region as a caring geography

> 'We decided to focus on the 98% of the Earth's surface that is not occupied by cities. At a certain point, the UN declared that half of mankind is now living in cities, since when there has been an avalanche of books and biennales talking only about cities. As a result, there is an enormous deficit in understanding what is happening in the countryside, which is where the truly radical changes are taking place.'
> [Rem Koolhaas in The Guardian about the exhibition 'Countryside, The Future' at the Guggenheim in New York]

In this thesis, I have explored how regions, predominantly rural and peripheral regions, are assembled as caring geographies and, in turn, how the focus on healthcare has generated new interest in the region as a place of creativity and social development. Various scholars and Dutch architects such as Rem Koolhaas (2020) and Floris Alkemade (2016) have pointed out how the countryside and the region as a geographical place serve as experimental sites for innovation and can turn into a model for sustainable caring. Scholars and policymakers are likewise turning to the region as a site for experimentation, echoing what we have called the 'creativity at the margins' (Nel and Pelc 2020b, Van de Bovenkamp et al. 2021).

In the case of healthcare, the central topic of this thesis, such innovation addresses the challenges of workforce and care

integration, enabling the provision of long-term care at home, and assuring the accessibility of care. I have foregrounded peripheral areas and processes – which are often overlooked in healthcare research and policy – and shown that innovation is not just about coping with structural deprivation or representation; rather, it is about the work that actors do and the ways in which they give meaning to the region. In some areas, partnerships between care organizations emerge in response to scarcity. For instance, scaling up evening-night-weekend services in a regional network makes it possible to monitor older persons (using alarm buttons and video screens), and if a crisis arises at home, an ambulatory 'region' nurse can visit a vulnerable or older person. In my research, I investigated what can be learned from such regional initiatives and how they may keep areas 'liveable' by seeing that available resources (both people and technologies) are shared equally between organizations.

Yet it is not all creativity at the margins. This research has shown that there are many different images and stories of rural places and the care provided, and that 'the region' is not just one thing but many. In healthcare, rural areas are generally portrayed as disadvantaged places that receive little in the way of structural investment and are seeing an increasing number of care services close, with consequences for the accessibility of care (Van der Geest 2019, Fogteloo 2019, Lonkhuyzen 2019, Knoop 2022). Above all, this can lead to feelings of 'second-class citizenship' (Koens 2021) and a lack of political recognition (Rodríguez-Pose 2018). Such portrayals extend to a wider economic and political neglect of areas, emphasizing not only the loss of health services

but also of schools, public transport, etc. At the same time, local and regional initiatives are being introduced to compensate for lost services and new ways are being found to deal with geographical distances(Bock 2016, Pot, Koster, and Tillema 2023)

In this thesis, I have shown how 'the region' is often presented simplistically and neutrally as the political answer to the challenges of workforce and care integration in health care, and long-term care specifically. Precisely because it is a 'no man's land', the region is also a 'dreamland', where it is possible for actors to join forces pragmatically around perceived problems and complex social tasks, such as workforce shortages (RVS 2022). In this policy rhetoric and in public discussions, 'the region' and regional collaboration are often presented as a given, something that is clear cut, tangible and agreed. However, what remains unclear in this rhetoric is how regional initiatives take shape, and what they mean for how care is provided, where and by whom. In this thesis, I argue that it is important to take a relational approach to the region as changes in socio-spatial healthcare occur within the context of layered policies, organizational politics, community initiatives, and infrastructural changes (Jones, Fraser, and Stewart 2019, Lorne et al. 2019a, Ivanova 2020). It is therefore important to explore how regional collaboration in healthcare and the construction of the 'caring region' is put into practice.

Looking at both the geography and sociology of regions allowed me to examine how regions are made up of social and technical elements that are made for caring and being cared for in return.

This relational approach helped me to examine not only how care is produced, but also how regions are cared for; in terms of the region and collaborative efforts, it allowed me to go beyond 'caring for a place' and examine the complex network of caring relationships and how these tie in with the symbolic and political meaning of places (Ivanova 2020, Willett 2016, Milligan and Wiles 2010). Drawing on these insights, I explored how infrastructures are built by healthcare professionals in close coordination with organizations, policymakers, patients and informal carers, and how regional geographies of care emerge from this. Specifically, I have focused on rural areas to examine how care is being invented and reinvented to serve a growing population of older persons in a context of declining medical and other capacity. Rather than static, these areas can be seen more as places of transformation, where care unfolds and changes alongside and in close interaction with the assembling of regions.

In this research I have conceptualized the region as a 'caring geography' to highlight the everyday work that people do to take care of one another, as well as the work that is done to care for the region (to keep it functioning, to keep resources available, to maintain its services and the landscape – a future temporality). In particular, I zoomed in on the daily work of health professionals in enacting the region as a caring geography, an area where care is spatially, materially and temporally organized and delivered. I took as my starting point medical specialists in older person care, many of them working in nursing homes, who were in short supply in mainly rural, non-urban areas

(Schuurmans, Wallenburg, and Bal 2019, Daalhuizen, Groot, and Amsterdam 2018).

During my ethnographic fieldwork and research practice, as well as in public discourse, it became clear that, next to physicians, other professionals (such as nurses and nurse aides) play an important role in places experiencing scarcity (of physicians, but also of material resources), precisely because they take over care when new practices are established (WRR 2021, Wieringen et al. 2021). I therefore extended my scope by including nurses and health professionals in general, as well as managers who lead teams of healthcare professionals and take decisions on regional collaboration. I tracked these actors and considered the collective effort involved in doing regional care, of which I became part (cf. Bal and Mastboom 2007).

Part of this collective effort involves an ongoing mobility and change in relationships and regional or other identities. I became part of this mobility, moving between different locations, professional groups and organizational layers that need to create the 'right' conditions for regional care to work. Regional caring, as this research has shown, involves a transition of care from more 'solid' (and traditionally medical) ways of working to a more fluid form of care (Bauman 2000) in which – in regional care for older persons – the boundaries between long-term, acute, and social care become blurred.

My analysis was guided by the following research question: *How are caring regions shaped in the everyday practices of organizing and doing care?*

I studied the region as a caring geography using multi-sited ethnographic research (Marcus 1995). Combining the methods of engagement and an ethnographic research design, I moved in and out of healthcare settings, network meetings and the management offices of healthcare providers, health insurers and patients' homes. The starting point of the research programme, pilot projects within health regions, was already multi-sited, as the projects were taking place in different regions in the Netherlands.

At the start, I was part of various trajectories in which actors (i.e. professionals and administrators in a care region) made regional care plans identifying the main challenges in long-term care in terms of future care needs and possible available medical expertise and the opportunities in their region. From there, care organizations initiated pilots to experiment with regional collaboration in day-to-day practice. Attending meetings and pilots meant that I moved between the life worlds of professionals, administrators, patients and families, and regional care offices (administered by a health insurer), zooming in on their practices (Nicolini 2007). I followed pilot trajectories within several sites of activity, which meant studying the re-placement of care (Oldenhof, Postma, and Bal 2015) and tracking how professionals do so, including the technologies they use and the guidelines, values and habits that connect places. I also

participated in national knowledge meetings at which pilot project results and research findings were exchanged and shared – also referred to as 'quality collaboratives' (Øvretveit et al. 2002, Schuurmans, Wallenburg, and Bal 2019). Attending all those places, not just as a spectator but also as a participant, allowed me to gain an in-depth understanding of how caring regions take shape and the caring practices that make up those regions.

I took a further methodological step in my research by spending four months at the University of Stavanger in Norway, where I conducted collaborative research with peers. This gave me the opportunity to investigate the role of geography in places where health facilities are less present, and how healthcare is organized regionally and locally. One of the ontological questions that I explored concerned the dynamics between centres and peripheries in a regional context and how distances are experienced in long-term care. Including data from this setting gave me another way of looking at different stories in different places in the periphery, leading to a richer analysis. In particular, it allowed me to look at the Dutch situation with a 'stranger's eyes' and examine both differences and similarities between the settings.

In the following, I first provide answers to my research sub-questions and then discuss the theoretical and practical implications of this research.

1) *What organizing and professional work is involved in building or rebuilding a regional care landscape?*

In long-term care, regional collaboration serves to ensure sustainable capacity and delivery of care in the future. In my thesis, I examined how this has major implications for the work professionals do. While my focus was on work and I examined direct patient care activities, I also looked at the social and institutional organization of healthcare, which entails both organizing work (Allen 2014) and professional work (Felder et al. 2024, Felder et al. 2022) . This study showed that healthcare professionals (physicians and nurses, among others) are not just passive witnesses to the transition to the region but instead work to enable the region as 'an evolving entity' (Allen, Massey, and Cochrane 1998). Sometimes they do this by resisting or expressing doubt, for example general practitioners not wanting to join in providing care to patients with highly complex care needs who had been previously admitted to the nursing home. Sometimes they furnish active support, as in the case of the first responders' teams, set up to respond to urgent situations during evening-night-weekend shifts. At the same time, it is precisely these professionals who deploy and enable new forms of care, who dare to experiment and seek collaborations, e.g. in regional partnerships, mobile nursing teams (see Chapters 3 and 5) and knowledge exchanges in the region (for instance on wound care, see Chapter 4).

My analysis shows that three types of work can be distinguished. The first type is infrastructural work. In Chapter 4, I explained

how infrastructures consist of social-technical segments that connect professionals, places, clients and materials and enable the exchange of knowledge and the coordination of action (Langstrup 2013). A prominent example is the triage system in long-term care, introduced to enable older person care physicians to work in, and move between, more care locations. The region nurse, discussed in Chapter 5, can also be seen as a new infrastructure, connecting places of care within the emerging region. Another example is the professionalization of ambulance boat services in Norway. This boat has been extended to include an emergency room that gives local physicians a place to examine patients close to home. These infrastructures should prevent unnecessary hospitalization and provide care 'closer to home' to more people over a larger area – initiatives defined as 'strategies of scaling up' in Chapter 2, where we saw how care organizations and services are forging bonds to make efficient use of the available medical expertise.

The first key finding, which is related to organizing work, is that regional infrastructures are reshaped in each place. Typically, infrastructures are locally embedded and installed on a pre-existing base (Star and Ruhleder 1996b) – they do not come 'from nowhere'. We have seen that socio-technical infrastructures that suggest some kind of 'placelessness' – such as mobile nursing teams (Chapters 3 and 5) or triage systems (Chapter 4) – are in fact closely connected to materials, buildings and physical routes, or occupy a position between the place and decision-making in regional older person care (Ivanova, Wallenburg, and Bal 2019). How clients inhabit and walk in their

home or room, for instance, offers valuable insights into and information about their well-being and looming or actual deterioration – and this 'daily' or mundane and embodied information is used by healthcare professionals in their caring work. When healthcare professionals have to cover larger areas and more patients, this day-to-day knowledge tends to get lost. As a consequence, social relations between doctors, nurses and nurse aides need to be strengthened so that they can rely on one another's knowledge and observations.

A second finding, related to the above, is that professional work itself involves more organizational activities when regional collaboration calls for well-organized infrastructures that connect places. We saw how medical practices stretch out in space and time as new technologies, telecentres and triage models are introduced in the care process (Nicolini 2007). This requires different ways of working for physicians, since they no longer always 'see' or know the patient and get their tacit knowledge elsewhere. Moreover they coordinate more differentiated care (fragments of care), as the relocation of medical practices over time and space requires a redistribution of tasks and work (Oldenhof, Postma, and Bal 2015, Nicolini 2007).

At the same time, the professional work of nurse aides has become more visible and should be more clearly defined and recognized. This research has highlighted their crucial contribution in that they are directly involved in caring for clients. As shown in Chapter 4, they perform the intimate 'bodywork' (Meldgaard Hansen 2016) that provides the tacit knowledge

needed, for instance to notice a patient's deterioration. This professional group of nurse aides – the largest in older person care (Wieringen et al. 2021) – has, however, very little if any representation in nursing care organizations, nor are they involved in regional consultation structures set up to discuss regional collaboration and what the infrastructural work it involves means for them or how they fit into it. In this research, however, these nurse aides were included in the process; they were informed and taught about the triage system. As this research shows, processes of infrastructural inversion such as this (Jensen and Venot 2023) constitute an important vehicle for the work needed to make regions care.

The second type of work is the temporal work healthcare professionals conduct in establishing regional care. This has to do with moving and rescaling care, including adjusting working patterns and rhythms. In regional collaboration, multiple spatial-temporal orders (of households, nursing homes, organizations) converge and must be aligned – as seen in Chapter 5 regarding the region nurse. One of the solutions in regional care is that organizations try to align their tasks and consultations, as well as the timeframes in which clients receive or do not receive care. At first, this seems primarily a process of coordination and planning (adjusting organizational schemes), yet it also requires reviewing and revaluating work and care (which I will tease out in more detail in the next section, which addresses valuation work).

As I have shown, the rescaling of care to a regional level involves making a clear distinction between daytime and night-time care.

In this (ideal) process, night-time care practices are minimized or avoided thanks to technologies (such as remote care, smart floors, alarm buttons) or loved ones who provide support in care. Establishing this regional temporal order involves professionals mobilizing and training patients' informal care networks to perform certain tasks (e.g. how to administer certain medications or how to steady a patient physically), setting up remote call centres (triage or medication monitoring) and good care planning, which includes anticipating and acting on the rapid deterioration of patients during regular hours—and thus also engaging in temporal repair work (Aspria 2023). When all is well, this should minimize night-time care, but it does require older people, their family members and their informal care givers to adjust their rhythms and routines to some extent. This is a layered system; a sole focus on getting professionals to understand the work that needs to be done is too narrow, as the regional pilot concerning evening-night-weekend hours shows. As a professional, the region nurse plays a key role in keeping the (ideal) regional temporal order 'working' by repairing the glitches through her temporal work.

The third type of work is valuation work, which deals with tensions and conflicts between different values situated in the regional organization of care. Analysing valuation practices is crucial, I argue, for understanding how regions are shaped and how care is organized. Assembling regions and the trust relationships, culture and knowledge within them involves valuing regions and their qualities. My research shows how the boundaries of caring regions are fluid and that this requires

administrators, but also care offices and professionals, to constantly align their views of what a region entails. For instance, one common bone of contention is which organizations and places should be included in a region, which again determines where the budget for a pilot may go.

Chapter 1 showed how the process of (dis)assembling regions is partly determined by multiple regimes of valuation. Actors within the networks I analysed continuously assembled and disassembled the socio-spatial formations to which they belong. This work did not occur in a vacuum but emerged from the regimes of valuation embedded in the field of older person care, such as competition between providers but also pre-established relationships between healthcare providers and professionals. This led organizations to partner with other organizations in different echelons, for example, rather than with their direct competitors, or to form alliances that extended administrative regional boundaries. Calls for closer regional collaboration are not necessarily effective when a dominant regime of valuation emphasizes competition over collaboration, this research shows. Moreover, existing professional relationships sometimes extend beyond administrative boundaries, leading to friction in defining what the region is. The research described in Chapter 1 furthermore demonstrated how some actors (especially larger care organizations that have medical capacity that needs to be distributed) are dominant in regional collaborations, with their values consequently prevailing over those of smaller organizations.

Valuation not only plays a role in bounding a region, but also concerns re-evaluating what kind of care can and should be provided. Notably, regional caring is not simply about distributing care capacity, it is also about people (older persons in this case) being able to live in their own home for longer. This means involving older persons, their general practitioners, informal care givers, and the social setting (neighbours, the community). In Chapter 3, I described this as an opening-up strategy, involving care initiatives that connect care providers and clients to their broader environment (and possibly, with a greater emphasis on well-being). Because of this, other values come in, as well as other ideas and norms as to how care should be provided, for example how someone can 'die with dignity', how informal care can be made sustainable, and what kinds of tasks informal care givers should perform. This requires more deliberation as to what constitutes good care and aligning the resulting viewpoints.

I have shown how different valuation regimes exist in different places in long-term care and how these are underpinned by a governance and accountability structure and by valuation devices (e.g. quality reports, care plans, regional plans) in which 'competitiveness', for example, is embedded (cf. Asdal and Huse 2023). The work of discussing and questioning such 'traditional' valuation regimes was undertaken by medical managers, who considered the implications for quality reports if physicians were to work in a regional network. In general, regional collaboration in the Netherlands involves switching from healthcare policy instruments, which place more emphasis on the functioning of individual organizations, to an emphasis on public health, which

is more concerned about the health of the population. In other words, existing valuation regimes and devices need to be recalibrated to encompass a regional population perspective.

2) *How does regional care delivery affect practices of caring?*

The shift to the region, this research has shown, is not a neutral transition. Although policies such as 'the right care in the right place' claim that the quality of care and care itself are improved through regionalization and that better use will be made of existing capacity (Ministerie Volksgezondheid Welzijn en Sport 2018a), this study demonstrates that regionalization does affect practices of care, such as professional work, organizational structures, and care relationships. Choosing to care for a population in a region is a political choice in the sense that it is based on assumptions about who can take care of certain things (and people) and who is in charge of or accountable for what. One example is the evening-night-weekend service set up regionally to monitor people at home and in the nursing home. To care for the region's 'population' in this way requires constant consideration of what to pay attention to and where (Waring and Bishop 2020a).

First, caring for the population in the region entails an ever-larger assembly between different kinds of organizations, professionals, patients and informal carers. Regional collaboration facilitates coordination between services to avoid vulnerable people having to visit hospitals or nursing homes 'unnecessarily' and allowing them to receive more high-level and other care at home. My

research, however, shows how the integration of services also leads to fragmentation, creating a high degree of differentiation. This can be problematic in the sense that local solutions can lead to a multitude of care constellations and a wide variety of healthcare professionals working in these different constellations. Regionalization then creates complex organizational and regulatory environments where it can be unclear which provider can be held responsible for care in a particular area, or for the targeted treatment of a patient. To put it differently, the region as an easy policy solution seems, first and foremost, to be a policy dream. Making it reality requires hard work, and a lot of repair work.

Second, my research shows that regionalization does affect elements that are related to quality of care, such as care relations, time for care and timing of care, and the places where care is given. Regional infrastructures ensure that care can be provided over a wider area, for example by a doctor working remotely (increasingly as a back-up), and that it can also be provided by someone else. Because of this, professional work is becoming more stratified and digitally relocated (Noordergraaf 2016, 796) in regional collaborations. An older person care physician is no longer 'tied' to a nursing home but might offer consultations in a home-care setting, together with a general practitioner. Clients might be treated by physicians or nurses located elsewhere, working through a central teleservice, or even in another region, affecting professional-patient relationships. This creates other forms of involvement (with patients, with their situation, with their medical records) and intimate care (no

longer the same face all the time), as we have seen in Chapters 4 and 5.

Third, regional cooperation is working towards standardisation and uniformity of patient data and information in regional infrastructures, such as defining what is 'acute' and how to respond to it in a flow chart. By including the notion of place, this research showed how the places where care is provided guide what is understood by 'good care'; for example, while the best care may be available in the central hospital, it may be more important for an older person to receive care close by (in a regional hospital in a nearby municipality). In regional care, ideas about quality and who is responsible for it may vary (compared to other scales, such as the individual or national level). The question for policymakers (and others) is: to what extent is variety allowed, who is responsible for it, and how can it be acted on reflectively. In other words, re-placement also brings with it the need to question quality standards – and these questions are currently not being adequately addressed.

Fourth, regional care is about different aspects that inhabit a certain opposition, but that are also closely related: cure vs. care, acute vs. long-term care, nurses vs. doctors. In this research, I found that in regional care practices the focus is shifting more towards 'care' and nursing work, initially in places where there is a shortage of physicians. But this is a broader development; rethinking the concept of 'acute' within long-term care is about recognizing situations that are not necessarily life-threatening, but rather characterized by a sense of imbalance and loss of

control (Stromme, Aase, and Tjoflat 2020, Tjora 2000). As a result, the nature of the (care) demand shifts from what I conceptualised as a 'medical gaze' to a 'caring gaze'. However, national policy on acute care still emphasizes 'high-end' care far too much instead of day-to-day acute situations (Postma and Zuiderent-Jerak 2019). This research shows that important organizational and accountability structures have not yet been adapted to the shift towards a caring gaze (such as a nurse being allowed to do a medical check-up in a region where there is a shortage of doctors), and how adapting those structures often provokes resistance, especially from medical associations, hampering the transition to caring regions.

3) *How does regional care delivery contribute to the reconfiguring of regions?*

Care not only involves organizing and caring for older persons on a daily basis but also organizing and caring for the region as a place to live. Caring for the region entails a 'web of caring', referring to the interplay between how people, nature, objects, and the relationships between them are cared for (Ivanova 2020, Puig de la Bellacasa 2017). This also means defining what a region is: its scale, borders, population, and care demands. This research shows that for some, the region is defined by the administrative boundaries of long-term care offices, while for others, it is a network of care organizations, or a place where people share the same language or landscape features (such as living on clay or peat, or on an island). Sometimes scales and borders match and a care region appears to be coherent, but more often, such as in the context of Dutch long-term care, this is

not the case. Caring for the region then becomes, in the first place, caring for the multiplicity of regions in long-term care. A geographical region, for example the Achterhoek, often has several sub-regions and not all organizations (and professionals) falling within that geographical region are necessarily automatically involved in regionalization.

The many regional constellations that have been set up to organize care lead to many regional linkages and overlapping boundaries. In long-term care, the region is thus an emergent concept that takes shape in practice and involves assembling or disassembling multiple regions (see Chapter 1). This multiplicity offers opportunities for new collaborations and pilots, but also difficulties, e.g. in identifying the region to which one belongs. We saw how new care providers are emerging to deal with scarcity issues, for example the arrival of private equity, or consulting firms, joining regional collaborations and responding to shortages and concerns in a geographical area. Yet these new actors do not always have ties to shared customs or cultures. The multiplicity of the region thus requires ongoing infrastructural, valuation and repair work and leaves the caring region itself as something that must be accomplished over and over again.

To understand long-term care practices in rural areas, and places dealing with scarcity, I have focused both theoretically and empirically on the dynamics between peripheries and centres. The notion of centre-periphery is politically contested. Empirically, it is also an actor term, with respondents referring to ‘living on the outskirts’ or ‘working in the periphery’. Moreover,

as I have shown, the relationship between centre and periphery is layered, with the centralization of certain services within 'marginalized' regions sparking a counter-reaction of peripheralization in other places (Kühn 2014). What constitutes the centre and what constitutes the periphery is thus constantly shifting. Furthermore, actor terms do matter. I used the notion of discursive peripheralization to study how peripheries are constructed in relation to healthcare and how this works out in relation to regionalization (Willett 2020). In this study I saw that peripheralization, in terms of healthcare, is not only about deprivation but also about valuing an area and the work that is done to care for older persons and the liveability of specific places. In places where professionals are accustomed to working more remotely, there are often infrastructures and networks in place that ensure that healthcare can be provided – and it is generally accepted that care will be provided by other means, for instance, with longer response times. This is also ingrained in the culture and habits of people and communities, as we saw in the vignette about farmers in Norway in the introductory chapter: people never 'just' call a doctor; calling (or not calling) a doctor is part of the way in which people live their lives.

On the one hand, by examining peripheralization in different geographical contexts (comparing regions within and between countries), this research reveals a variety of narratives and images in respondents' references to the absence or disappearance of care and in their portrayal of peripheries as dynamic places. In some of the Dutch cases, respondents mention that they feel these areas are being ignored by

politicians and policymakers. If continuity of care can no longer be provided, people not only have to travel farther but also lose a sense of connectivity, which is embedded in feelings of trust and belonging. Although regional collaboration can produce new connections enabling continuity of care, it may rouse opposition at the same time because people feel that care is being 'taken away' instead of equally distributed.

On the other hand, we see creativity emerging in areas where care is disappearing or moving. Healthcare professionals do infrastructural work and oppose or cope with peripheralization processes (sometimes in the form of pilot projects). For example, new acute and sub-acute care services set up in small municipalities in response to the closure of acute care facilities then become new centres for acute care delivery. Regional infrastructures also have place-making effects (Langstrup 2013). On the municipal level, the acute care team in Norway (Chapters 2 and 3) not only created another care infrastructure alongside the existing ambulance services but also changed the care provided in the nursing home and the skills of the nurses working there while making the area an attractive place to work and live (again). In the Netherlands, the introduction of the 'region nurse' created a new professional role for nurses that may be more appealing to them. In this thesis, I have argued that it is important to focus on building these regional infrastructures for two reasons. First, because they contribute to liveability in areas and preserve care and knowledge in those areas, by making nursing work more attractive in rural communities, reducing turnover, facilitating knowledge-sharing, and providing

training. Second, they change the narrative about an area and care in a way that contributes to a sense of belonging and being taken seriously.

This thesis has shown that there are different stories about regions and care; stories about shrinkage, about deprivation, about community-driven care, and about creativity. My aim in writing this thesis was not to take a position on which framings and narratives are true or false; differing perceptions also emerge in the data. Instead, I want to show how important it is to understand these perceptions and discourses in the regionalization of care. Healthcare policies often focus on one story rather than another, but we do not have to choose; we can bring them together. By studying the multiplicity of 'the region' in healthcare, I show that the region has more than one face and I analyse it in different ways, with different consequences for how care is done and how regions are made.

Overall conclusions and theoretical implications

Previous research has shown how long-term and chronic care often involve a lot of 'bodily work' and intimate relationships (Struhkamp, Mol, and Swierstra 2009, Twigg 1999). This entails that care relationships are built over a longer period, and diagnoses and decisions are often made based on a lengthier acquaintance with a specific patient. In this thesis, we have seen that this is changing due to regionalization. Although this does not necessarily mean that bodily work and intimacy will disappear altogether, it does suggest that intimate work and bodily knowledge are being shaped differently and becoming

more stratified, for example with more layers of professionals, places and technologies emerging. Consequently, a physician may no longer know every patient (and their bodies) and not notice, for instance, that a patient is limping more than before (indicating deterioration), making the physician more dependent on others to alert him or her to this information. This 'stratified' or 'distanced' care provision creates opportunities but also has disadvantages.

Let's start with the opportunities. The shift from clinician-oriented to more collective processes of care provision also includes a shift from what I have called the medical gaze to the caring gaze. I have shown how in most regions, nurses and other care workers have come to occupy a more central role in organizing and providing care. This is partly due to shortages in the pool of available physicians (who have been replaced in part by nurses through task substitution), but also because care and social problems are increasingly being recognized as central issues in long-term care. This caring gaze then enables a more person-centered form of care.

Now the disadvantages. This study has shown that the focus on collective professional work and efficient care delivery is not a neutral transition. In most places, it goes hand in hand with less accessible, fragmented or less available care. Moreover, this transition tends to legitimize impoverishment of care, partly because of the increasing level of mobility (professionals must move between places of care), but also because of ambiguous constellations of responsibilities. This became clear in Chapter 5,

when I showed that nurses could not 'stay' with clients and were specifically there to solve problems temporarily, over the weekend and at night.

Turning to rural and 'peripheral' areas specifically, I have argued that care practices in these areas deserve a richer description. Scholarly debate pays scant attention to care in these areas, and especially not to older persons in need of medical support. When it is discussed, the dominant discourse is on hospital care (Postma and Zuiderent-Jerak 2019) or centralization of services (Gakeer 2019). It is valuable to study changes in long-term care in relation to other areas, centres or semi-peripheries so as to understand the dynamics between these different geographies – and their mutual dependencies. In this thesis, I approached the periphery as an empirical site. I also approached 'caring peripheries' conceptually, through the notion of discursive peripheralization. I have argued that processes of peripheralization are not merely discursive, in terms of language, but also about (symbolic) practices. My analysis showed how care remains feasible in areas where facilities disappear or there is a shortage of physicians through the work done by other professionals (amongst others), e.g. setting up alternative forms of care such as a first responders' team. At the same time, caring for peripheries involves a lot of repair work that also comes with a certain temporality and vulnerability. For instance, we have seen that certain caring practices (moments) disappear when care is made more sustainable; that structural funding is not always available (for temporary pilots that are set up to deal innovatively with a local challenge); and that local solutions

sometimes create fragmentation that cannot be incorporated into the accountability structures of regional assemblages, or that are not recognized. While the forms of discursive peripheralization I have described –the 'creativity at the margins' – may thus lead to accessible and good or 'good enough' quality care, such accomplishments are always temporal and vulnerable to further change. A retiring doctor, or a new policy measure leading to further centralization, will necessitate a new round of creativity. This also shows that such creativity may have its limits and that more structural changes are needed to guarantee accessible care.

Lastly, my findings reveal that a variety of narratives, practices and images emerge whenever respondents talk about the absence or disappearance of care and portray peripheries as dynamic places; these range from 'remote alternatives' to 'it is not so different here'. It is precisely this diversity that is important to understand and see – both in research and policy (which I will elaborate on in the next section), as this may help planners, politicians and care parties to be more closely attuned to diversity. Going back to Sennett, who I highlighted in the introduction, this plurality of caring peripheries may be difficult to include in a regional 'sustainable' model, but it is a necessary concept to incorporate if we are to avoid ending up with homogenous and hegemonic planning of areas, and care in areas. We should not study the 'peripheral' region solely in relation to care centres and centralization (as the place where volume standards cannot be met, for instance), but instead investigate it as a place with its own needs and ways of caring. I

argue that the concept of care in particular can provide an important lens through which to examine these changes and see how local knowledge and know-how and practices are part of the caring geography, and passed on (or not) when facilities change or move (Willett and Lang 2018, Ivanova 2020). This approach can help us move beyond normativities and standards set at the centre (e.g. there is a shortage of older person care physicians in nursing homes and that implies scarcity, or: only serious incidents should be taken to Emergency) by questioning and exploring what works in a specific place – for the professionals and older persons living there. These should then also be dynamic, adjusting to new situations, and embedded in an inclusive, democratic process.

Methodological reflections

Multi-sited ethnographic research serves to unravel situated practices and to capture locally embedded knowledge. By shadowing healthcare professionals, I familiarized myself with their daily practices and routines, for example how they move from one place to another, interact with other professionals and managers, and do day-to-day care tasks such as washing, lifting and dressing patients or administering medication. Ethnographic research makes it possible to observe such everyday practices and to understand, for instance, why the number of calls made to an older person care specialist decreases or increases. This provides insight into both the built structures and infrastructures and how they are experienced and performed, and what this means for care. Using multi-sited ethnography moreover gave me the opportunity to compare different regions and countries;

whilst this is not a 'comparative' study in the traditional sense, these wanderings between regions allowed me to distance myself from developments and practices in the regions I studied, making it possible to look for specificities as well as commonalities.

Although initially, I focused on 'shrinking and rural regions' in the Netherlands, it became clear during the course of my research that it was not only nursing homes in rural areas that are facing staff shortages but also those in growth areas, for various reasons (e.g. few training places and no university town nearby). Much more than population density, it turned out, staff shortages are related to questions about liveability, about how professionals work together to continue to provide care in an area, and about how this affects accessibility and quality of care in certain places. I focused on liveability and care; by doing so through ethnographic research, I was able to explore discursive practices that give shape to the liveability of regions (or do not). I therefore focused on how geographical context impacts quality work and used data taken from studies in Norway on nursing home care as well as data from our research programme in the Netherlands. This was productive, since Covid-19 restrictions temporarily prevented me from observing pilot projects on site in nursing homes.

Another methodological contribution of the multi-sited ethnographic approach is that it reveals the multiplicity of regions – and how they are 'lived' and 'done' in different settings. I have shown that the region has more than 'one face'

and analysed it in different ways: as a physical place, as a governance construct and as regional infrastructure. At times I struggled with the 'regional object' I had to analyse (and its boundaries and scale). Studying an object that is constant on the move provides for challenges, until I came to recognize that this dynamic itself was important to follow. In the end this made the approach richer because it demonstrated how difficult it is to pinpoint the right 'health region', something that also holds for policymakers, managers, professionals and others. Multi-sited ethnographic research simultaneously allows for theoretical generalizations that go beyond the long-term care context and capture the transition to 'a regionalization of healthcare'. I would argue that concepts such as infrastructural work and caring peripheries are not only applicable for long-term care but have heuristic power for other settings and phenomena in broader social policies, for example on housing, education, child protective services or acute care, in which 'the region' is also referred to as an organizing entity.

The multi-ethnographic approach also contributes to spatial-temporal research in healthcare that involves the accessibility of services and care environments for older persons. Housing older persons across the region requires significant travel and organizing work and raises new methodological questions about how to study such spatial-temporal movements. While research on these topics is conducted in neighbourhoods and towns (Meijering 2023), they also merit attention on the regional level, especially given the ever-closer connection between social and medical services at the regional scale. Studying the region as a

well-defined spatial-temporal place is not easy, however, as my research has shown. It is an area where services are both clustered and dispersed. In tracing the geographies of regions, I have 'staged a geography that is ours alone, connecting some places and actors while leaving others out'(Asdal and Huse 2023, 9). I have explored many different places, practices and professionals, but I have not covered them all. I have by no means been able to talk to all the regional actors or visit all the places. Even so, the multi-sited approach allowed me to move with a significant number of actors in order to study the relocations and reveal the work involved in this process.

Practical implications

This research has implications for both policy and healthcare practices involved in regional care.

First, there is an outright belief in the current policy discourse on regionalization that the shift to regional care provision and the associated re-scaling of long-term care will not affect and may even improve the quality and accessibility of care. The political promise appears to be that we can do 'more with less' (Dungen and Koesveld 2018, WRR 2021). This thesis shows, however, that the regional organization of care delivery does affect care relationships and accessibility of care. It impacts how often a patient is seen by a physician or nurse, where a patient receives care (more often at home, and preferably during working hours), who provides that care (increasingly, new care professionals and/or remotely through a triage centre), and the amount of time available for it. More reflection on this is needed.

Another observation concerning regional collaboration in medical care for older persons is that it focuses on how organizational and governance interventions should be organized almost to the exclusion of the patient's perspective or patient representation. During my research, I encountered almost no patients or patient representatives; the shift towards caring regions appears, first and foremost, to involve organizational and political reform. However, regional collaboration requires a re-valuation of care from the perspective not only of professionals but also of patients. This research shows that regionalization touches on social issues concerning the availability and accessibility of care, and on issues of 'proximity' and the involvement of informal care, directly affecting patients and their relatives. To date, however, patients have little if any representation in the regionalization debate. This is partly because client councils have yet to be organized at the regional level (van de Bovenkamp et al. 2023). Municipalities could take a leading role in patient involvement, but this is something that they should then do as a group, since regions usually transcend municipal boundaries. Another option, which aligns with current governance structures, is to have patients and their representatives participate in the regional care offices or in the acute care regional structures.

This research has shown how the focus on regional care provision makes it possible to reorganize traditional ways of working in healthcare. It facilitates the redistribution of tasks and responsibilities, both between professional groups and between formal and informal care. Whereas task substitution and task

reallocation have been problematic policy aims in recent decades, not least due to resistance from the medical profession against the reallocation of power and responsibilities (van Schothorst et al. 2020), the focus on the region appears to have opened up opportunities for various professional groups to take a leading role in care provision. The emphasis on single professional groups has shifted to a more collaborative network approach in which nurses, carers and paramedics work alongside general practitioners, specialists in older person care and other medical specialists, leading to more diffuse and redistributed responsibilities. As a consequence, organizational leaders and individual professionals are uncertain about the legality and possible consequences of task substitution and the reallocation of professional work. It is crucial that healthcare professionals feel supported and trusted by their peers, professional associations (especially medical associations), and public and private agencies and authorities (e.g. the healthcare inspectorate, health insurers) in this transition.

Turning to the topic of centres and peripheries, I explored how places (and people) are connected in the provision of regional care. The clustering of some services in more central areas creates opportunities in peripheral places to organize care in their own way and to look for creative solutions that have a certain uniqueness that serves a place – yet does not always fit into the uniform norms also desired in healthcare provision. This raises questions such as: who decides what is a (regional) norm, who is committed to shaping caring places, and how are those people supported (by municipalities, healthcare inspectorate or a

network of care providers)? In the Dutch case, current frameworks hinder rather than help regionalization. First of all, they are developed for individual organizations and professionals and not for collaboration covering 'regional populations'. An example is the joint evening-night-weekend structures set up in various regions in which accountability is very fragmented. Second, current norms are quite rigid. The Dutch inspectorate does try to experiment with 'regional networks of accountability', or adapt 'response times' for a specific place. Actors in regions need to learn from one another, however, and use the data to explore what works best in a specific context. We saw how in Norway, a distinction is made between rural and urban areas but that in practice it remains difficult to define what is rural (or not). Even so, the distinction does make care providers aware of differences between areas and that one region requires different focal points than another. Such flexibilities and differentiations provide spaces for regional actors to experiment with different caring infrastructures.

Third, the liveability of a region is a key and often overlooked element in the shift to the caring region, as researchers and advisory councils tend to focus mainly on the loss of health services in particular areas. Recent and prominent examples are the hospital closures in Delfzijl and Lelystad, or the care homes that are being replaced by 'modern nursing homes' in Groningen (reserved exclusively for people with complex care needs). In their report 'Every Region Counts', Dutch government advisory councils argued that disparities between regions are increasing due to disappearing facilities – and that this is mainly happening

in places already experiencing health inequalities (RLI, ROB, and RVS 2023). These debates about the closing of healthcare facilities are primarily waged with a view to their funding. They virtually ignore the issue of liveability and therefore frame the notion of quality in very narrow terms. As previous research has shown, and a Norwegian municipal council pointed out, nursing homes, ambulance stations and other care facilities may be closely connected with the community and maintain caring relationships that encompass an intimate knowledge of areas and clients (Ivanova, Wallenburg, and Bal 2016, Prior et al. 2010). Here too, some form of democratic legitimization would be an important addition to other understandings of quality, for example where older persons meet, how they experience contact with healthcare professionals, or how regionalization affects older persons in terms of mobility. In long-term care and in areas where a significant share of the population consists of older persons, what constitutes high-quality care may sometimes be interpreted differently, in a way better suited to the area or the patient. This suggests that in the regionalization debate, concentration and clustering of care should be examined and discussed in all its breadth rather than formulated narrowly (e.g. in terms of volume norms) (Postma and Zuiderent-Jerak 2019). This broad approach offers more opportunities to look differently at care and the delivery of care in peripheries.

This thesis has shown that in the context of care, the periphery is not a static given, but changes continuously. Notably, when individuals in these regions actively collaborate and take an active role in shaping care, new centers emerge. These processes

give rise to new ideas about care delivery and fosters new knowledge and connections between people, cities and villages. However, the establishment of care initiatives and the ongoing adaption of infrastructures should not lead to the assumption that 'things will get organized anyway'. The latter approach would hide all the work necessary to keep care organized and infrastructures up and running; yes, things do get organized, but there is additional work involved and infrastructures can be fragile and exclusionary (i.e. not available to everyone). Addressing disadvantages requires long-term attention, while government support programmes tend to be short-term, incidental, and limited in scope (RLI, ROB, and RVS 2023, 6). By focusing on the work done to create caring regions, this thesis has developed insights that are necessary to change the current polarized debate about 'the region', as well as the policy and knowledge practices that underpin day-to-day dealings with issues of scarcity. This knowledge is also valuable for centers or larger cities that must collaborate with peripheral areas in regionalization processes. Turning to the caring region involves patience (in policymaking), creativity and organizational work from all of the actors involved – qualities that are mainly grounded in the mundane practices of regional care.

8.

References
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Summary

Caring geographies: the region as a place of care

The region as a place of care is gaining increasing attention, not only in healthcare but also in other sectors such as education and housing. Regions are viewed on the one hand, as appropriate settings for decentralizing policies and public services. On the other hand, they are being rediscovered as opportunities to scale up and cluster services. Working at the regional level allows for a focus on local needs – adapting to the specific characteristics of a place, culture or area – while also facilitating the efficient use of resources across a geographic area. For example, regional collaboration can address challenges like ensuring access to care in areas facing depopulation. This dissertation examines how regional collaboration in long-term care for older people is unfolding and what this means for the design and transformation of both regions and care.

In policy and literature on the 'regionalization' of care, the region is often taken for granted. This work does not consider that individuals, including health professionals and health providers, deliver regional care and that regions are being constructed as (caring) places that are constantly changing. As a result, the effects of regionalization for a place or landscape and the people living there remains implicit, as do the changes that regional care delivery brings to everyday care practices. This study examines how healthcare providers and medical and care professionals - together with administrators, older people and their relatives - shape everyday regional care provision. It describes how regional

initiatives and agreements are institutionalized; what decisions are made and what values are weighed. So far, literature has primarily focused on the governance of regionalization and the physical structures of regions, while the work involved in providing regional care has received less attention. This gap in the literature, is what this thesis will address.

The research is being conducted in care organizations, including health professionals working in rural and peripheral areas. These organizations are being encouraged, with government funding, to collaborate regionally to address place-based challenges, such as staff shortages and home care accessibility. The study initially focused on the role of older person care physicians (often working in Dutch nursing homes) who are particularly scarce in rural areas. However, during ethnographic fieldwork and in public discussions, it became clear that other health professionals, such as nurses and nurse aides, play a vital role in addressing care scarcity. These care professionals often take over care tasks and support innovative ways of working. I therefore broadened my focus to include nurses and nurse aides, as well as managers who lead care teams and make decisions about regional collaboration.

Ethnographic research took place in care organizations developing initiatives to overcome, for example, the shortage of older person care physicians, or rearranging evening-night-weekend shifts to reduce staffing pressures. The study focuses on three themes: the meaning of regions in long-term care; the social and technological infrastructures that replace and connect care; and how regional care affects notions of time, distance and

proximity. The empirical analysis then provides insights to 1) the everyday work of providing (regional) care, 2) how this changes caring practices 3) how the region is shaped as a place of care. In doing so, this study answers the following research question: How are 'caring regions' shaped in the everyday practices of organizing and doing care?

Chapter two explores the meaning of regions in long-term care for older persons. The findings show that a (healthcare)region has different meanings to different people and is therefore multiple. For some, (healthcare)regions are the administrative boundaries of care offices, for others a network of care providers, or areas with a common language or landscape features (such as living on clay, peat, or an island). Sometimes boundaries and scales coincide, making a region seem logical, yet in Dutch (long-term) care this is usually not the case. This means that there are different regions to which providers, professionals and clients must relate. This diversity also offers opportunities for new collaborations and ways of working. For instance, with commercial care providers that are trying to meet regional shortages and demands for care. At the same time, this creates frictions, as these new players often have little affinity with local customs and care cultures. Regional working is moreover hampered by existing governance and accountability structures, which are often dominant and position healthcare organizations as competitors.

In the third and fourth chapters, I explore the meaning of rural and peripheral in relation to care and examine solutions to deal

with place-based challenges (such as distance between services and the disappearance of facilities). Chapter three explores creativity in care provision in rural home care in the Netherlands and Norway. It shows that care organizations in these areas have limited access to quality care (e.g. medically staff, 24-hour care) because of their geographical context. Yet, it is precisely in such places that interventions or new ways of working emerge. The findings identify three strategies for dealing with place-based challenges: scaling up, brightening up and opening up. Opening up includes, for example, initiatives that improve the well-being of older people outside of care homes, such as converting a church into a day care centre or offering services focused on mental well-being. Strategies affect both the quality and accessibility of care: scaling up care to a regional network, for example, can change the personal connection with clients. The chapter argues for a policy focus that looks beyond deprivation or scarcity, zooming in on how professionals experience challenges and initiate strategies to sustain care.

In the fourth chapter, I examine examples of such regional pilots and initiatives where care providers want or need to organize (acute) care for older people differently. I do this in places in the Netherlands and Norway where (acute) care facilities are (partly) being relocated or disappearing. I talked to care providers and asked how they experience the disappearance of or distance to facilities, what solutions they find and how these relate to regional (infra)structures and regulations. The findings show that different narratives and practices of peripheralisation coexist and are closely intertwined with care provision. The findings also

show that the diversity of practices is sometimes in tension with the trend towards concentration and standardization in regional care provision. However, this tension need not be negative: it encourages healthcare providers and regulators to better adapt norms and standards (such as a standard for arrival times) to local and regional needs, and to reflect on different notions of quality.

In the fifth chapter, I explore how infrastructures for regional collaboration are developed in the workplace and how this affect day-to-day care provision. More specifically, I examine how the use of triage in nursing home care enables a larger area (with more clients and older people) to be served by fewer doctors. The results show that triage, as an infrastructure, changes not only the places where care is provided but also the relationships between doctors, clients and nurse aides, thereby shaping notions of distance and proximity. By being present where residents live and dwell, medical and nursing professionals become familiar with residents' habits and can identify changes. The triage system I studied aimed to transfer these habits and experiences. Special attention should be given to the work of nurse aides and nurses; work that is often undervalued. This chapter shows that their work is very important for triage in making triage workable in older person care and maintaining proximity.

Chapter six demonstrates how different rhythms and perceptions of time are brought together and 'intertwined' in the provision of regional care. Based on ethnographic research in a region in the

east of the Netherlands, I shadowed so-called regional nurses during their shifts and examined how they coordinate (sub-)acute care across various locations during evening, night and weekend shifts. Using the concept of ‘temporary regional order’, I analyzed how care is organized in 'time and space' by nurses, management, clients and informal carers. In structuring regional care within a regional order ‘interruptions’ occur, which I distinguish into three types: patients' physical needs, (unexpected) technological problems, and actions of patients and family. Regional nurses are employed to repair interruptions and to create a steady and predictable regional temporal order. At first glance, this may appear to be primarily a matter of coordination and planning (e.g. adjusting rosters and triage schedules). Yet, the chapter reveals that it also requires a revaluation and reappraisal of what constitutes 'good (enough) care'.

In the discussion, I combine the findings from the chapters and draw three conclusions. First, I explain that ‘caring regions’ are assembled in everyday practice of care. This perspective highlights how the shift towards regional care is a political decision full of assumptions about where people should receive care (at home, in a nursing home or in a clinic), who receives what care (and who does not) and who is or becomes responsible for each aspect of care. Second, health professionals, including nurse aides, nurses and doctors, are not passive witnesses to the regional care transition; rather, they play an active role in enabling it. In my analysis, I identify three types of work that help illustrate this process: infrastructural work,

temporal work and valuation work. A practical implication of this research is that regional work affects proximity and 'bodily work'. While proximity and 'bodily work' are not disappearing entirely, it is being reconfigured in more layered ways, involving different professionals, locations, and technologies. This requires a rethinking on who delivers certain care and makes decisions (e.g. a physician remotely, a nursing aid at the bedside), and what opportunities this opens for professional groups such as welfare workers, leading to a less medicalized approach of older person care. The study also shows that the impoverishment of care can occur, especially when revaluation of care is not adequately discussed, by professionals among themselves and/or with patients and loved ones. At present, clients and loved ones are hardly involved, if at all, in issues of regional care. Another point is that regional services are not always aligned well, responsibilities shift and older people 'fall through the cracks' between providers or financial systems. This often happens when professionals are uncertain about the legitimacy of the redistribution of their work. It is therefore crucial that care professionals (both medical and social) are supported by colleagues, professional associations and authorities such as the Health Care inspectorate, care offices and health insurers.

Finally, my analysis shows how care in peripheral and rural areas remains feasible through the commitment of professionals and their work on technological and social infrastructures, such as the establishment of first response teams. However, care in and for these areas is often fragile, as initiatives depend on project funding, making them temporary or focus too narrowly on

certain types of care. I argue that it is important to map infrastructures to get a clearer view on what initiatives are there, who is working on them and what support they need. Moreover, this also may help to get a better understanding of the diversity of rural and peripheral places. These insights can help to break down the current polarized debate about 'wrecked or lacking-behind regions'. This knowledge is also valuable for larger cities or regional and national centers working with rural areas. For example, knowledge exchange on addressing scarcity, balancing uniformity and diversity, and trade-offs in care quality. One key policy recommendation is to explore alternative measures of quality beyond numerical indicators. This can involve examining where older persons and carers interact, how care is perceived and how regional service clustering affects mobility. This allows for a more situated approach on scarcity, and on citizens and health care professionals and organizations to collaboratively shape regional care.

Samenvatting

Zorgende geografieën: de regio als plek van zorg

De regio als zorggebied is steeds vaker onderwerp van discussie. Niet alleen in de gezondheidszorg, maar ook in andere sectoren zoals onderwijs en huisvesting. Regio's worden enerzijds beschouwd als een geschikte plek voor het decentraliseren van beleid en publieke diensten en anderzijds herontdekt als schaalniveau voor het opschalen en clusteren daarvan. Regionaal werken biedt zodoende de mogelijkheid om zowel oog te hebben voor het lokale - passend bij een plek, cultuur, gebied - als voor het opschalen en efficiënt inzetten van de beschikbare middelen in een gebied. Dit kan bijvoorbeeld door samen te werken aan specifieke gebiedsopgaven zoals de toegankelijkheid van zorg in krimpregio's. Dit proefschrift onderzoekt hoe de langdurige zorg voor ouderen steeds meer regionaal wordt georganiseerd en wat dit betekent voor de gezamenlijke vormgeving en herinrichting van regio's en zorg.

In beleid en literatuur over het 'regionaliseren' van zorg wordt de regio vaak beschouwd als een gegeven. Daarbij wordt niet in acht genomen dat individuen, waaronder artsen en zorgverleners, werken aan regionale zorgverlening. Regio's zijn geen statische entiteiten, maar worden als (zorg)plek opgebouwd en veranderen in de loop van de tijd. Het vertrekpunt dat de regio een gegeven is, maakt dat de gevolgen van regionalisering voor een specifieke plek of landschap impliciet blijven. Evenals de veranderingen die regionale zorgverlening teweegbrengt op de werkvloer. Het onderzoek in dit proefschrift laat zien hoe

zorgverleners, medisch specialisten en bestuurders, met ouderen en naasten zorg regionaal vormgeven in de dagelijkse praktijk van zorg en ondersteuning. Het beschrijft hoe regionale initiatieven en afspraken worden geïnstitutionaliseerd, welke keuzes daarbij worden gemaakt en welke waarden worden afgewogen. Tot nu toe heeft de literatuur zich vooral gericht op de bestuurlijke context van regionalisering en de fysieke structuren van regio's. De zorgpraktijk en het werk dat nodig is om regionale zorg te verlenen, zijn daarentegen onderbelicht gebleven. Dit proefschrift richt zich juist op die aspecten.

Het onderzoek vindt plaats bij zorgorganisaties en zorgpersoneel in niet-stedelijke gebieden, ook wel landelijke en perifere gebieden genoemd. Zorgorganisaties in deze gebieden worden met overheidsgelden gestimuleerd om regionaal samen te werken om zo met plaatsgebonden uitdagingen om te gaan, zoals personeelskrapte en de toegankelijkheid van langdurige zorg aan huis. Het onderzoek begon bij de rol van specialist ouderengeneeskunde in de langdurige ouderenzorg. Deze specialisten, vaak werkzaam in verpleeghuizen, zijn vooral in landelijke gebieden schaars. Tijdens het etnografische veldwerk en in publieke discussies bleek echter dat ook andere professionals, waaronder verzorgenden en verpleegkundigen, een cruciale rol spelen in het omgaan met zorgtekorten. Zij nemen zorgtaken over en ondersteunen de ontwikkeling van nieuwe werkwijzen. Met dit inzicht breidde ik mijn focus uit naar verpleegkundigen en verzorgenden en midden managers die zorgteams aansturen en besluiten nemen over regionale samenwerking.

Etnografisch onderzoek vond plaats bij zorgorganisaties die initiatieven opzetten om bijvoorbeeld een tekort aan specialist ouderengeneeskunde te ondervangen, of avond-nacht-weekend diensten efficiënter inrichten. In het onderzoek staan drie thema's centraal: de betekenis van regio's in de langdurige zorg; de sociale en technologische infrastructuren die zorg verplaatsen en verbinden; en hoe regionale zorgverlening noties van tijd, afstand en nabijheid beïnvloedt. De empirische analyse geeft vervolgens inzicht in 1) het dagelijkse werk om (regionale) zorg te verlenen, 2) hoe dat praktijken van zorg verandert en 3) hoe de regio als plek van zorg vorm krijgt. Daarbij geeft dit onderzoek antwoord op de volgende onderzoeksvraag: Hoe worden zorgregio's vormgegeven in de dagelijkse praktijk van zorgorganisatie en -verlening?

Hoofdstuk twee onderzoekt de betekenis van regio's in de langdurige ouderenzorg. De bevindingen laten zien dat de regio voor verschillende mensen iets anders betekent en daarmee meervoudig is. Voor sommigen zijn regio's de administratieve grenzen van de zorgkantoren, voor anderen een netwerk van zorgorganisaties, of gebieden met gedeelde taal of landschap (zoals wonen op klei, veen of eilanden). Soms vallen grenzen en schalen samen, waardoor een regio logisch lijkt, maar in de Nederlandse (langdurige) zorg is dat meestal niet het geval. Dit betekent dat er verschillende regio's zijn waar aanbieders, beroepsgroepen en cliënten zich toe moeten verhouden. Deze diversiteit biedt kansen voor nieuwe samenwerkingen en werkvormen. Bijvoorbeeld met commerciële zorgorganisaties en

adviesbureaus die regionale tekorten of zorgvragen proberen op te vangen. Dat levert tegelijkertijd ook fricties op, omdat deze nieuwe spelers vaak weinig affiniteit hebben met lokale gewoonten, of zorgculturen. Daarnaast wordt regionaal werken bemoeilijkt door bestaande bestuurs-en verantwoordingstructuren die vaak dominant zijn en zorgorganisaties als concurrenten positioneren

In het derde en vierde hoofdstuk verken ik de betekenis van ruraal en perifeer in relatie tot (ouderen)zorg en onderzoek ik oplossingen voor plaatsgebonden uitdagingen, zoals afstand tot diensten en het verdwijnen van voorzieningen. Hoofdstuk drie richt zich op creativiteit in zorgverlening in de verpleeghuiszorg in landelijke gebieden in Nederland en Noorwegen. Het toont aan dat zorgorganisaties in deze context beperkte toegang hebben tot zorg van hoge kwaliteit (zoals medisch personeel, 24-uurs zorg), maar dat juist op zulke plekken interventies of nieuwe werkwijzen ontstaan. De bevindingen onderscheiden drie strategieën om met plaatsgebonden uitdagingen om te gaan: opschalen, verlevendigen en openstellen (scaling up, brightening up and opening up). Openstellen omvat bijvoorbeeld initiatieven die het welzijn van ouderen buiten de verpleeghuizen verbeteren, zoals het ombouwen van een kerk tot dagbesteding of door diensten aan te bieden gericht op geestelijk welzijn. Strategieën beïnvloeden zowel de kwaliteit als toegankelijkheid van zorg: opschalen naar een regionaal netwerk kan bijvoorbeeld de persoonlijke band met cliënten veranderen. Het hoofdstuk pleit voor een beleidsfocus die verder kijkt dan achterstand of schaarste, door in te zoomen op hoe professionals uitdagingen

ervaren en strategieën initiëren om de zorg draaiende te houden.

In het vierde hoofdstuk onderzoek ik voorbeelden van regionale pilots en initiatieven waarin zorgverleners de (acute) zorg voor ouderen anders willen of moeten organiseren. Dit doe ik op plekken in Nederland en Noorwegen waar (acute) zorgvoorzieningen (deels) verplaatst worden of verdwijnen. Ik heb gesproken met zorgverleners en bevraagd hoe zij het ervaren dat voorzieningen verdwijnen of verder weg zijn, welke oplossingen zij daarvoor vinden en hoe die zich verhouden tot regionale (infra)structuren en regelgeving. De bevindingen laten zien dat verschillende narratieven en praktijken van periferalisering naast elkaar bestaan en dat deze nauw verweven zijn met de zorg die beschikbaar is. De bevindingen tonen daarnaast aan dat de diversiteit aan praktijken soms op spanning staat met de trend naar concentratie en standaardisatie in regionale zorgverlening. Deze spanning hoeft echter niet negatief te zijn: het stimuleert zorgverleners en regelgevers om normen en standaarden (zoals een norm over aanrijdtijden) beter af te stemmen op lokale en regionale behoeften en zet aan tot reflectie op verschillende ideeën van kwaliteit.

In hoofdstuk vijf verken ik hoe infrastructuren voor regionale samenwerking op de werkvloer worden ontwikkeld en de gevolgen voor dagelijkse zorgverlening. Meer specifiek onderzoek ik hoe door de inzet van triage in verpleeghuiszorg, met minder artsen een groter gebied (met meer cliënten en ouderen) bediend kan worden. De bevindingen laten zien dat

triage als infrastructuur niet alleen de plekken waar zorg gegeven wordt veranderen, maar ook de relaties tussen artsen, cliënten en zorgverleners - en daarmee ideeën over afstand en nabijheid. Door daar te zijn waar bewoners wonen en leven, raken medisch en verpleegkundig specialisten vertrouwd met de gewoonten en zorgbehoeften van bewoners en kunnen ze veranderingen signaleren. Het triagesysteem dat ik heb bestudeerd, was erop gericht om deze gewoonten en ervaringen over te dragen. Specifieke aandacht dient daarbij uit te gaan naar het werk van verzorgenden en verpleegkundigen. Werk dat vaak onderbelicht blijft. Dit hoofdstuk laat zien dat hun werk van groot belang is om triage werkbaar te maken en nabijheid te behouden.

Hoofdstuk zes laat zien hoe verschillende ritmes en belevingen van tijd worden samengebracht en 'verknoopt' in het verlenen van regionale zorg. In een regio in Oost-Nederland heb ik regioverpleegkundige gevolgd tijdens hun dienst en onderzocht hoe zij (sub)acute zorg coördineren over verschillende locaties tijdens avond-nacht-weekenddiensten. Met het concept tijdelijke regionale orde heb ik geanalyseerd hoe zorg wordt georganiseerd in 'tijd en ruimte' door verpleegkundigen, management, patiënten en mantelzorgers. Bij het structureren van zorg naar een regionale orde doen zich 'interrupties' voor, die ik onderscheid in: lichamelijke behoeften van patiënten, (onverwachte) technologische problemen en acties van patiënten en familie. Regioverpleegkundigen worden ingezet om deze interrupties te stabiliseren en zo een voorspelbare regionale temporele orde te creëren. Op het eerste gezicht lijkt dit vooral

een kwestie van coördinatie en planning (zoals het aanpassen van roosters en triageschema's), maar het hoofdstuk laat zien dat het eveneens een herziening en herwaardering vereist van wat 'goede (of voldoende) zorg' is.

In de discussie bespreek ik de inzichten uit de hoofdstukken en trek ik drie overkoepelende conclusies. Ten eerste zet ik uiteen dat (zorg)regio's geassembleerd worden in de dagelijkse praktijk van zorg. Deze benadering maakt inzichtelijk dat het streven naar regionale zorgverlening een politieke keuze is, met aannames over waar voor welke mensen gezorgd moet worden (thuis, in het verpleeghuis, of in een kliniek), welke mensen welke zorg krijgen (en wie niet) en wie waarvoor verantwoordelijk is of wordt gemaakt. Ten tweede zijn professionals in de zorg, waaronder verzorgenden, verpleegkundigen en artsen, geen passieve getuigen van de verandering naar regionale zorgverlening, maar zetten zij zich in om regionale zorgverlening mogelijk te maken. In mijn analyse heb ik drie soorten werk genoemd om dit inzichtelijk te maken: infrastructureel werk, temporeel werk, en waarderingswerk. Dit soort werk verandert de nabijheid tussen professionals en cliënten. Hoewel nabijheid niet volledig verdwijnt, wordt dit anders ingericht en meer gelaagd, met verschillende professionals, locaties en technologieën. Dit vraagt om heroverweging wie bepaalde zorg uitvoert en beslissingen neemt (een arts op afstand, een verzorgende aan het bed) en welke kansen dit biedt voor beroepsgroepen zoals welzijnswerkers, wat leidt tot een minder medische benadering van ouderenzorg.

Het onderzoek toont ook dat verschraling van zorg kan optreden, met name wanneer herwaardering van de zorg niet voldoende besproken wordt, door professionals onderling of met cliënten en naasten. Een ander punt is dat regionale diensten niet op elkaar afgestemd zijn, verantwoordelijkheden verschuiven en ouderen tussen wal en schip vallen, ‘tussen’ aanbieders en financiële systemen. Dit gebeurt onder andere wanneer professionals onzeker zijn over de rechtmatigheid en gevolgen van de herverdeling van werk. Daarom is het essentieel dat zorgprofessionals (medisch en welzijn) gesteund worden door collega's, beroepsverenigingen en autoriteiten zoals de Inspectie voor de Gezondheidszorg, zorgkantoren en zorgverzekeraars.

Tenslotte toont de analyse hoe zorg in perifere en landelijke gebieden mogelijk blijft dankzij zorgprofessionals die werken aan technologische en sociale infrastructuren, zoals eerste hulpteams. Toch is zorg in en voor deze gebieden vaak kwetsbaar, omdat initiatieven afhankelijk zijn van projectfinanciering, daarom tijdelijk zijn of (te) beperkt gericht op bepaalde typen zorg. Het is essentieel om deze infrastructuren structureel te ondersteunen en de diversiteit van landelijke gebieden beter te begrijpen. Deze inzichten kunnen helpen om het huidige gepolariseerde debat over 'de regio' te doorbreken. Dit soort kennis is bovendien waardevol voor grotere steden of regionale en landelijke centra die samenwerken met landelijke gebieden. Zo kan kennis en praktijkervaring gedeeld worden over de aanpak van schaarste, de balans tussen uniformiteit en diversiteit en afwegingen in zorgkwaliteit. Ook kan worden gezocht naar andere vormen van

verantwoording over kwaliteit. Waar in de huidige discussie vaak de nadruk ligt op numerieke vormen van verantwoording zoals volumenormen of aanrijdtijden. Dit kan bijvoorbeeld door onderzoek te doen waar ouderen en zorgverleners elkaar ontmoeten, hoe ouderen het contact met zorgverleners ervaren, of hoe regionaal clusteren van diensten ouderen beïnvloedt in termen van mobiliteit. Op deze manier wordt enerzijds ruimte geboden aan gesitueerde manieren om met schaarste om te gaan maar worden anderzijds zorgaanbieders en burgers ook meer gestimuleerd om samen vorm te geven aan de zorg in en voor de regio.

Curriculum Vitae
PhD portfolio

Courses
2019 WTMC Workshop, Postcolonial
2019 Risbo Didactics
2019 Risbo Group Dynamics
2019 EGSH Photovoice
2019 WTMC Summer School 'Experimenting'
2020 WTMC Workshop 'Care'
2020 EGSH Academic Writing
2020 EGSH Atlas-ti
2020 EGSH English Presenting and Teaching C1
2020 UvA Course Medical Anthropology and Sociology
2021 WTMC Winter School 'Political Sociology'
2021 WTMC Workshop 'Innovation Systems'
2021 EGSH Storytelling
2022 WTMC Workshop 'Truth and Trust'
2022 PhD Workshop, Birmingham

Presentations
2019 Care Workshop, WTMC meeting, Ravenstein
2019 Paper review, EHPG Annual Meeting, London
2019 4S, Society for Social Study of Science, New Orleans

2020 Monthly Meeting, Centre for Health Resilience, Stavanger

2021 Chronic Living Conference, Copenhagen, Virtual Conference

2021 Nordic STS Conference, Copenhagen, Virtual Conference

2021 Interpretative Policy Analysis Conference, Virtual Conference

2022 The Politics of Technoscientific Futures, EASST, Madrid

2022 ESA RN19, Interim Conference, USBO, Utrecht

2022 Caring Geographies Symposium, EUR, Rotterdam

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Bovenkamp, H., van Pijkeren, N., Ree, E., Aase, I., Johannessen, T., Vollaard, H., Wallenburg, I., Bal, R. & Wiig, S. (2022). Creativity at the margins: A cross-country case study on how Dutch and Norwegian peripheries address challenges to quality work in care for older persons. Journal of Health Policy.

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Teaching activities
Bachelor Health sciences, Erasmus University
2018-2020 Workgroups (Kennis), Zorg en Welzijn
2019-2020 Workgroups (AVV), Zorg en Welzijn
2020-2021 Thesis supervision
2021-2022 Essays Advanced Research Methods

Master Health Care management
2021-2022 Workgroups Quality and Safety
2020 -2021 Workgroups Choices and Dilemmas
2022-2024 Thesis Supervision

Guest Lecture
2022 Guest Lecturer, Governing the Healthy City

Additional activities

Sep 2020/ Nov 2020	Visiting Researcher at Centre for Resilience in Healthcare (SHARE), University of Stavanger,Norway
Jan 2022/ July 2022	Researcher at National Council for Health and Society (Raad voor Volksgezondheid en Samenleving), The Hague
Nov 2022	Co-organizer symposium 'Caring geographies', Erasmus University

About the author

Nienke van Pijkeren (1987) studied Cultural Anthropology at Utrecht University, with a minor in Human Geography and Regional Studies. She continued with a master in Culture, Organization and Management at VU Amsterdam, where she learned about ethnography in organizations. During her studies Nienke did an internship, at Stichting Mainline in Amsterdam. She then worked in various roles, including as a research assistant at the Robert Bosch Stiftung and in educational program development at Museum GeoFort.

In November 2018, Nienke began her PhD research in Healthcare Governance, at the Erasmus School of Health Policy and Management. She worked together with a diverse set of (long term) care organizations, participated in the RegioZ research program and co-organized the Caring Geographies symposium which brought together scholars to explore the intersections of care and geography. As part of her research, she was a visiting researcher at the University of Stavanger at the Centre for Resilience in Healthcare. In addition, she taught in various courses for bachelor and master students. Next to her academic work, Nienke temporary worked at the National Council for Public Health and Society, where she contributed to a policy report 'the promise of the region'. In the last year of finalizing her PhD, she participated in the project 'proactive care planning in the end of life' as a postdoctoral researcher.

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Dankwoord

Hoewel mijn proefschrift zich grotendeels afspeelt in landelijke regionen, liggen mijn wortels in Nieuwegein. Een groeikern die in de jaren tachtig transformeerde van weilanden tot levendige nieuwbouwwijken. Inmiddels woon ik in het dorp Grou, in Friesland. Dit promotieonderzoek betekende veel reizen, tussen dorpjes, steden, met de trein, bus of auto. En natuurlijk pendelen tussen Friesland en mijn werk in Rotterdam. Gelukkig ligt Nieuwegein 'lekker centraal' en kon ik daar altijd terecht, maar ook bij vrienden in Utrecht, Rotterdam, of in andere windstreken. Dit proefschrift is dan ook tot stand gekomen dankzij een infrastructuur van mensen, bureau's, slaapplekken en technologische hulpmiddelen. Graag wil ik de mensen in dit dankwoord centraal stellen.

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[10] Voor familie en vrienden: STS staat voor Science and Technology Studies, in het Nederlands Wetenschap- en Technologie onderzoek.
[11] HCG staat voor Health Care Governance en dat is de vakgroep waar ik mijn promotieonderzoek heb gedaan.

vragen over regionaal bestuur én tips voor mooie reisbestemmingen. Hanna, dank voor je creatieve inbreng en attente berichtjes. Hugo, we deelden naast inzichten over veldwerk vooral ook een hoop lol. Laura en Estella, jullie brachten frisse energie in de regionale vraagstukken en ik kijk uit naar jullie promoties (straks)!

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