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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

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ABSTRACT

Background: Peripheral areas are often overlooked in health-care research but they in fact deserve specific attention. Such areas struggle to maintain access to good quality health-care services due to their geographical context. At the same time, new interventions or promising innovations often emerge in places where creativity is urgently needed. In this paper, we explore this *creativity at the margins* in older persons care organizations in peripheral areas, which other healthcare providers and policymakers can learn from.

Methods: This exploratory study is based on two large research projects on the quality of care for older persons in Norway and the Netherlands. We performed secondary analysis of interviews with quality managers and other quality workers and used additional document analysis and expert interviews to deepen our analysis.

Results: The results show that older persons care organizations working in peripheral areas must deal with a number of challenges caused by their geographical context, e.g. geographical distances (between services and to the geographical center), workforce shortages, and landscape characteristics. We found that organizations use different strategies to tackle these challenges, such as scaling up, brightening up and opening up. These strategies, conceptualized as creativity at the margins, impact quality work in different ways, for example by enabling more person-centered care.

Conclusion: We conclude that both policymakers and research should overcome their peripheral blindness by learning from and supporting creativity at the margins in future policies and research.

1. 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 [1–4]. 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 [5–8]. 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 [9,10]. 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' [11–17], we take a different route by concentrating on the difference between centers and peripheries [18,19]. 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

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[15,17,18,20]. 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 [13,20] 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 [9,10,21]. At the same time, new interventions or promising innovations can emerge at the fringes; in places where creativity is urgently needed [22]. We conceptualize the strategies emerging in these areas as *creativity at the margins* (see [19,23]).

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 [21]. 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.

2. Methods

2.1. 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 [24,25].

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 [24]. 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.

Tables 2 and 3 provide the necessary background information about the older persons care systems in both countries.

2.2. Data collection

2.2.1. 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 [37]) is a large mixed-methods study focusing on quality and safety leadership in four nursing homes

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 [29]. This layered system means that many external actors are involved in quality work with different quality demands [30]. 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 [31].
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 1
Geographical features.

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* [26]	99.6% of the population can reach the hospital within 45 minutes with the help of ambulance services [27]	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 1,682 /sq km) Population of 5.4 million on 385,207 sq km	*356 municipalities* [26]	Driving distances to nearest emergency ward range from 3 minutes to 7 hours [28].	Mountainous areas, islands, coastal areas crossed by fjords	Peripheral regions face decline in population and employment, in contrast to big cities and their surroundings

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 [32].
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 [10]. In 2019, 'bundled payments' were introduced in the Norwegian health-care service as a potential reimbursement model [33].
Key policy issues: Aging in place is a key issue on the policy agenda [34]. 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 [10]. Patient safety in health care, including older persons care, has figured prominently on the policy agenda from 2010 onward [35].
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 [36].

and four home-care organizations in five different municipalities in Norway (two of which are peripheral) [1,38]. 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 [39].

The RegioZ project in the Netherlands (for more details, see [40,41]), 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.

2.2.1.1. 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 [26,34,35,42,43]. 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 [40,31,44–49]. 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.

2.3. 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 [50,51]. 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 healthcare 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.

3. 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 caregivers. 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'.

3.1. 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 caregivers. In the Dutch case in particular, however, there are few informal caregivers 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 caregivers 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 [52].

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.

3.2. 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 [53]. 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) [26]. 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 [54]. 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 [55]. In addition, a recent white paper [26] 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 [56]. 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 [57–59]. 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 [49]. 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 [60]. 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 [46]. 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.

3.3. 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.

3.3.1. 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.

3.3.2. 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 healthcare 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 aids and nurses working in peripheral areas. This is the approach taken in one of the Dutch organizations, which trains nurse aids 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 [61].

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.

3.3.3. 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 apartments 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.

4. 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' [13] 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, in a more prominent way than their counterparts in the center, 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 [1,62,30]. 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 [19,23].

4.1. 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 [10], with national policies in place that ensure ongoing attention to workforce challenges in peripheral 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 [40]. 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 [11,55,63]. 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 [23], 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.

4.2. 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 [12,63]. 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.

4.3. 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.

5. 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 caregivers, 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.

Declaration of Competing Interest

We have no conflict of interest to declare.

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