The Netherlands is home to an ageing population of guest workers, post-colonial migrants, and former refugees. Older migrants have worse health yet use less aged care services than native-born older people. This book describes what policymakers and care practitioners do to address these inequities in Dutch cities.

The findings are drawn from qualitative case studies in Nijmegen and The Hague (2017-2020). Using relational health geography and social practice theory, the author analyses how post multiculturalism and localism influence the scope for local responsiveness to migration-related diversity in aged care practices. Topics discussed include neighbourhood-focused care, diversity-mainstreaming, minority-specific services, and how social, historical, and demographic dynamics in cities shape older migrants' pathways to care.

This book will be useful to scholars, practitioners and policymakers interested in understanding and addressing inequities in access to care faced by minority groups.

CARING FOR OLDER MIGRANTS IN DUTCH CITIES

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HANNA CARLSSON

A Study of Responsiveness to Diversity in Aged Care Practices in Times of Post-Multiculturalism and Localism

Caring for Older Migrants in Dutch Cities

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Hanna Carlsson

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in Times of Post-Multiculturalism and Localism

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This thesis is dedicated to my parents Björn and Marita Carlsson.

Er tro på mig har gett mig kraft att breda ut mina vingar och utforska världen.
Er kärlek gör att jag alltid hittar hem.

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CHAPTER 1
INTRODUCTION

Introduction

1.1 A persistent societal problem in need of a new scientific approach

Older migrants have higher levels of ill-health than their majority population counterparts (Kristiansen et al. 2016; Reus-Pons et al. 2017). Despite this, research repeatedly shows that older migrants access aged care[1] to a lesser extent than older people from the majority population (Greenwood et al. 2015; Hazeleger et al. 2016; Koehn et al. 2013; Suurmond et al. 2016). This is the case not only in the Netherlands but also in other European countries, and in North America and Australia (Bolzman et al. 2004; Warnes et al. 2004; Reus-Pons et al. 2016; Markides and Rote 2018; Radermacher and Feldman, 2017; Reus-Pons et al. 2018; Steinbach 2018; van Gaans and Dent 2018). The barriers minority-groups experience to access aged care services include limited knowledge about healthcare systems, limited proficiency in the local language, low health literacy, experiences of racism, and a lack of culturally, linguistically or religiously appropriate services (Ahaddour, van den Branden and Broeckaert 2016; Arora et al. 2018; Brotman 2003; Greenwood et al. 2015). Older migrants are a "super-diverse"[2] group (Vertovec 2007), and not all individuals experience similar barriers to access aged care (Ciobanu, Fokkema and Nedelcu 2017; Kristiansen et al. 2016; Warnes et al. 2004). Nevertheless, on a population level, there is a problem of inequity in access to and use of aged care services.

Much is known about the reasons why older migrants make low use of aged care despite their relatively high levels of illnesses at the population level. However, judging from the persistence of inequities in access and use of aged care when comparing migrant and non-migrant groups, this knowledge has not been mobilised sufficiently by neither care providers nor policymakers. As pointed out by the Dutch-Turkish family carer and intercultural adviser Fatos Ipek-Demir in an interview with ZonMW, the Dutch Council for Healthcare Research[3]:

> "We can fill entire football fields with reports on older migrants. But my Dutch-Turkish father, who has Alzheimer's disease and sits in a residential care home has no use for all those papers..."

1 In this thesis UK English is used, with the exception of the term 'Aged Care' – in UK English the full term would be Old-age Aged Care but for brevity I use the Aged Care.

2 The term super-diversity is used to describe populations that are diverse not only in terms of ethnicity, but also in terms of countries of origin, language, religion, migration channels, sex, age, and immigration status. As shown by Warnes et al. (2004) and Ciobanu et al. (2017), the term super-diversity accurately describes older migrant and minority populations in many countries.

3 Interview published online June 2020, retrieved from https://publicaties.zonmw.nl/participatienieuwsbrief/ervaringsdeskundigen-programmacommissie landurige-zorg-en-ondersteuning-participatie-vraagt-wat-van-ons-allemaal/ June 30 2021

Based on a scoping review of the field of aged care and older migrants, Torres argues that researchers need to take a new approach to investigate the inequities regarding access to aged care:

> The key to being able to remedy the injustices that some of these older people experience lies in moving beyond stating the obvious (i.e. that 'belonging' to a minority group increases a person's chances of experiencing inequalities of different kinds) to exploring how inequalities are created and maintained in spite of us knowing that they lead to injustices. A social-justice-informed agenda for ethno-gerontology needs namely to shift this scholarship's focus from who these older ethnic minorities are, and what they need, to what practitioners and policymakers can do to address these older people's needs"
> Torres (2019: 177)

This thesis is a response to Torres' call for more research on what practitioners and policymakers can do to increase older migrants' access to and use of aged care provisions such as day care, home care, home aid and social care. More specifically, this thesis[4] investigates the responsiveness of policymakers and practitioners to the care needs of older migrants that reside in cities. Not limited to specific care forms, the term 'responsiveness' refers to the attention given to the care needs of older migrants in all policy-making and caregiving practices. See section 1.3.1 for further discussion of this definition.

Most older migrants in Europe live in cities (Kotzeva and Brandmüller 2016). Also, because of the policy trend of localism[5] the provision of aged care has increasingly become the responsibility of local authorities in many European countries (Arlotti and Aguilar-Hendrickson 2018; Bannink, Bosselaar and Trommel, 2013; Longo and Notarnicola, 2018). Despite this, researchers studying older migrants have paid little attention to the city as a place for care provision. 'Place' tends to figure merely in terms of national context; for example what the barriers are for ethnic groups in a specific country to access care, see for example recent studies by Czapka and Sagbakken (2020) and Chaouni Berdai, Smetcoren, and De Donder (2020) on access to dementia care in Norway and Belgium. Although there is some literature on the living conditions of older migrants in cities (Buffel, Phillipson and Scharf 2013; van der Greft et al. 2016; Wanka et al. 2019), none of these studies investigates the scope and limitations urban policy makers and practitioners face when seeking to address inequities in older migrants' access to and use of aged care. In spite of this lack,

4 This thesis is a subproject in the research project 'Caring for Diversity' which investigated responsiveness to sexual and migration related diversity in Dutch municipalities after the decentralisation of aged care from the state to municipalities in 2015. The principal investigator (PI) of this project was Dr. Roos Pijpers, the primary supervisor of this doctoral thesis.

5 For a definition of localism see section 1.3.1.

research shows that the historical, demographical, organisational and social makeup of cities influence how (national) policies on migration and care are implemented (Ambrosini and Boccagni 2015; Durose 2009; Schiller 2015). In this thesis I[6] therefore draw on insights from relational Health Geography in combination with insights from social practice theory to provide an answer to the following question:

What are the scope and limitations for responsiveness to older migrants' needs in aged care practices in local landscapes of care in times of post-multiculturalism and localism?

This overarching research question has guided a three year, practice-oriented[7] qualitative study of the local care landscapes of the cities of Nijmegen and The Hague, the Netherlands. This thesis is based on four papers, three of which are co-authored and one which is single-authored, which have been published in scientific journals. To provide a full overview of the research design of the study, the methodology is discussed in the second chapter. In the remainder of this introduction, I will begin by discussing the significance of the research gap. Thereafter, the theoretical framework of 'local care landscapes' is unpacked. Firstly, it is explained why in this thesis the original framework from relational Health Geography has been extended with insights from social practice theory. Secondly, the overarching research question and the subquestions guiding the individual chapters are discussed with reference to this conceptual model. To further contextualise the research questions guiding the study, I then critically discuss the national trends of post-multiculturalism and localism, as well as the terms older migrants/ethnic minority elders and culturally specific/ethno-specific/minority-specific care. An understanding of the former terms is important to comprehend the context of the study, while a description of how the latter terms are used is needed to reconcile inconsistencies between the empirical chapters. The introductory chapter concludes with an outline of the thesis.

1.2 Knowledge gap and the scientific and societal relevance of the thesis

As aforementioned, limited attention has been paid to how the place of cities influence how older migrants' needs are responded to in the literature on aged care. Drawing on the literature on relational Health Geography and the literature on Urban Studies and Public Administration respectively, I argue that this gap is significant for two reasons. Firstly, because current research does not appreciate how the complex and locally-networked nature of aged care provision influences the scope and limitations of the actual response

6 Chapters 1, 2, 6 and 7 are single authored. I therefore use the pronoun I in these chapters.

7 For a discussion of how social practice theory informed the methodology, see Chapter 2.

to the needs of older migrants. Secondly, because national policies on migration and 'diversity' and neighbourhood governance are known to be implemented differently in different cities (Cianetti 2020; Dobusch 2017; Durose 2009), which in turn is likely to affect aged care provision for older migrants.

1.2.1 Drawing attention to the complex and locally networked nature of aged care provision

Aged care is provided by a variety of formal care organisations, as well as by informal carers. These organisations and actors – whether providing home care, day care, primary care or informal care – cooperate with each other and are locally networked. However, studies on aged care provision for migrants tend to focus on specific care forms, such as care provided by community health workers (Verhagen et al. 2014), or palliative care (Torensma et al. 2019), or ethno-specific residential care homes (Heikkilä, Sarvimäki and Ekman 2007). Although these studies have generated valuable insights into these specific care forms, they do not answer the question whether these 'minority-specific'[8] services might influence sensitivity to diversity in the wider urban 'landscape of care' (Ammann, Rauber and Salis Gross, 2019; Radicioni and Weicht, 2018). Furthermore, by overlooking the interactions between care providers and communities, researchers have not investigated how access to care can be facilitated through cooperation between different types of services and service providers and local minority communities, despite calls for more research on such partnership models (Radermacher et al. 2009). Investigating cities as a place for care provision, therefore, can provide insights that may be used to identify possibilities to increase access to aged care locally through inter-organisational collaboration and learning.

1.2.2 Investigating the local implementation of national care and migration policies

The literature of Public Administration and Urban Studies has shown that national policies on issues such as care, diversity, integration and migration are interpreted and implemented differently by local authorities and public organisations (Ambrosini and Boccagni 2015; Dobusch 2017) and by individual practitioners (Durose 2009; Schiller 2017). For example, Cianetti (2020) shows that the agency of local actors and local particularities meant that similar austerity and mainstreaming policies are interpreted and implemented differently across European cities. Durose (2007) found that social care workers use local knowledge to adapt local and national public health policies, for example by focusing on the alleviation of financial exclusion in poor neighbourhoods as a means to improve health. Such findings suggest that to understand the influence of national policies on existing inequities in access to care, it is necessary to consider what occurs in cities. However, when it comes

8 In this thesis, both the term 'minority-specific', 'culturally specific' and 'ethno-specific' are used to refer to care services tailored to the needs and preferences of older migrants. For more information regarding the use of these terms, see section 1.3.4.

to aged care for older migrants, the literature on national health and migration policy (e.g. Brandhorst, Baldassar and Wilding, 2021; Karl and Torres 2015; Warnes et al. 2004) has developed largely separately from research on care provision. Therefore, little is known how national care and migration policies affect aged care provision for older migrants locally.

To summarise, researchers studying care for older migrants have paid limited attention to cities as a place of care provision. This gap is significant because of i) the complex and locally networked nature of aged care provision, and ii) because the interpretation of national policies on integration and care depends on local authorities and practitioners. By not taking these aspects of urban care provision into account, the literature has not only focused too little on what practitioners and policymakers do, but it has also omitted to investigate the scope and limitations of the responses of policymakers and practitioners to older migrants' care needs where most of this population lives, namely, in cities.

Understanding how to improve urban aged care provision for older migrants is societally relevant because the older Dutch population with a migration background is set to rise from 14% to 25% of the total population aged 65 years and over by 2050. Most of these older people will live, or are already living, in cities (Schellingerhout 2004; van der Greft et al. 2016). This population trend is similar to that in other countries in Europe (de Valk and Fokkema 2017; Kotzeva and Brandmüller 2016; Rallu 2017; Wanka et al. 2019), particularly in those countries which have had a high influx of labour migrants in the 20th century (van Mol and de Valk 2016). Because it is known that the current population of older migrants faces inequities in access to and use of aged care, the question of how to address these inequities in the face of a growing population of older migrants is a pressing societal issue.

1.3 Conceptual model and research questions

To investigate the scope and limitations of responses to older migrants' care needs in cities, I have chosen to apply a practice-oriented interpretation of the relational health geographical framework of 'landscapes of care' (Milligan 2009; Milligan and Wiles 2010; Power 2016). Before I outline the conceptual model of landscapes of care, I will discuss why I chose to focus on 'responsiveness' in aged care practices.

1.3.1 Investigating 'responsiveness'

In this thesis, I approach aged care from the theoretical perspective of an ethics of care (Beausoleil 2016; McEwan and Goodman 2010; Tronto 1993). From this perspective, there can be no single definition of what constitutes good care. Rather, what good care is, must be decided through the interaction between those giving and those receiving care (Tronto 1993). Therefore, good care has an inherent quality of responsiveness: The caregiver must be attentive to the needs of the other in the specific situation at hand (ibid).

When it comes to how to care for diverse populations, the notion of responsiveness is particularly valuable. That is because research shows that practitioners often assume that the care needs of older migrants can be deduced from the ethnic group that they belong to (Berdai Chaouni, Smetcoren and De Donder 2020; Yu 2009). However, research also shows that often the care needs and preferences of older migrants cannot be reduced to assumed ethnic characteristics. Rather, migrants from a similar ethnic group may have diverse cultural backgrounds, which in addition to their "individual characteristics and life experiences" (Giuntoli and Cattan 2012: 143) shape their care needs and preferences. Because responsiveness is an open-ended concept, it does not essentialise what older migrants' care needs are, which is in contrast to past models for delivering good care to older migrants, such as, for instance, the cultural competency model (Beagan 2018).

Tronto originally thought of responsiveness as a quality of hands-on care. In this thesis, however, I have chosen to broaden the notion of responsiveness and define it as a quality that can be part of a range of care related practices, from policymaking to management of services and the delivery of specific forms of care. Drawing on Beausoleil (2016), I further understand responsiveness as a situational ethic emerging in encounters. This means that the question of what constitutes responsiveness in aged care depends on the local situation, and needs to be determined through deliberation between local actors. Such a relational and situational approach resonates with the tradition in relational Health Geography, namely that of searching for possibilities for greater justice within the local context (Hall and McGarrol 2013; Jupp 2013; Smith et al. 2016; Williams 2020).

1.3.2 Local landscapes of care

Within health geography, relational approaches to place have become more common in recent years (Cummins et al. 2007; Duff 2011; Milligan 2009; Milligan and Wiles 2010). One concept which captures this turn is the concept of 'landscapes of care'. The concept was originally coined by Milligan (2009) to capture the networked and spatially dispersed nature of aged care. Later the concept was broadened to include more forms of care, at different spatial scales, and was defined as "the complex social, embodied and organisational spatialities that emerge from and through relationships of care" (Milligan and Wiles 2010: 736). As this definition suggests, from the perspective of a care landscape, places are conceived as configurations of formal and informal relationships of care between different actors, including social groups, individuals and organisations (Milligan and Wiles 2010).

To operationalise the concept of a care landscape, I have chosen to narrow down the original definition, drawing on inspiration from the wider literature on relational approaches to place (Cummins et al. 2007; Duff 2011; Massey 1995) and the literature on social practice theory (Hui, Schatzki and Shove 2017; Nicolini 2009; Nicolini 2011; Schatzki 2019). Drawing on these authors, in addition to Milligan (2009), and Milligan and Wiles (2010), I define 'local landscapes of care' as *local configurations of formal and informal relationships of care, manifested in social practices, which are spatially concentrated but not confined to cities, and which are embedded within the regional, national and global institutional and political nexus*[9]. In the following sections, I will unpack this definition in more detail.

'Local configurations of formal and informal relationships of care' refers to the fact that local landscapes of care involve relationships between local authorities, care and welfare organisations, the practitioners working in them, informal carers and local communities, and the older people receiving care. Care receivers can be conceived as the central node in a network of caring relationships (see Figure 1.1). Care receivers are connected to informal carers living close by, such as neighbours, family and friends, as well as to organisations providing social and medical care. The closeness of their relationship to formal care providers determines the ease with which services are accessed. From a relational perspective, accessibility is not only a question of physical proximity and regulations, e.g. whether a referral is needed and whether the service is provided daily or less frequently. Distance is also understood as having a social dimension. Services may be experienced as close or distant depending on an individual's level of trust in and knowledge of the service and on the individual's ability to access it, for instance, in terms of their language proficiency and/or their access to navigational support[10] (Cummins et al. 2007; Green et al. 2014). As shown by van Herk, Smith and Tedford Gold (2012) relational distance to services can be bridged by making places where formal care is provided more attuned to the life world of potential service users. This can be done by, for example, adapting the style of furniture, speaking the language of the service user, and adopting appropriate customs of greeting.

Although the investigation centres on aged care provision in cities, which means that I am primarily concerned with *'local configurations of caring relationships'*, it is important to acknowledge that caring relationships are *'spatially concentrated but not confined to cities'*. This entails that older people's individual relationships of care with family and friends may stretch not merely across urban borders, but also across national borders (Baldassar 2007). Similarly, local authorities and care organisations may be connected to additional political and institutional actors through national politics, and policies and regulations. As such, local landscapes of care are embedded within the *regional, national and global institutional and political nexus*. Figure 1.1 contains a visualisation of the relationships of care that constitute the urban landscape of aged care.

Figure 1.1 The local landscape of care (see next page)

9 The term nexus is drawn from Hui, Schatzki and Shove (2017) and refers to large constellations of connected 'practice arrangement bundles', in this case the welfare state.

10 "Navigational support" refers to assistance with finding one's way in a health care system (Green et al. 2014) which can come from sources like family, formal care professionals, religious organisations, charities focused on migrants, internet resources and members from the same minority group who are more familiar with the national care system.

https://www.vilans.nl/producten/infographic-wie-is-wie-in-de-wijk

The original concept of 'landscapes of care' can be used to analyse the complex and locally networked nature of aged care provision, as well as the connections between the city where aged care is provided and the national institutions and politics in which aged care is embedded. However, in itself, this relational approach does not explain *how* national political trends like localism and post-multiculturalism shape the practices of urban policymakers and practitioners. I, therefore, understand relationships of care to be '*manifested in social practices*'. The reason I use social practice theory is that this body of theory articulates how practices transform, for example in response to changes in policy, the place where a practice is performed, and/or because of the improvisation and creativity of the practitioners (Blue et al. 2016; Nicolini 2011; Schatzki 2019).

From a social practice theory perspective, all social phenomena are made up of social practices, here defined as entities with shared elements of meanings, materials and competencies (Shove, Pantzar and Watson 2012) anchored in places, i.e., 'spatial and material arrangements' (Schatzki 2019). A practice changes when the meanings, materials and/or competencies of the practice are altered and/or when the spatial and material arrangements in which the practice is anchored changes. An example of how practices can change is when public policies prohibited smoking in public places. One of the meanings of smoking for many practitioners of smoking was socializing whilst engaging in other practices, such as drinking beer at the pub. When the new policy altered the spatial arrangements of the practice, that is, where smoking could take place, many people stopped smoking since smoking in other places, like the home, did not fulfil the same purpose (Blue et al. 2016).

A second, more incremental way in which practices can change, is through the 'bounded creativity' of practitioners (Nicolini 2012: 225). The term bounded creativity refers to the fact that even though practitioners rely on shared meanings, materials and competencies to perform a certain practice, their performances are not necessarily identical. Rather, the performance of practices are acts "of poiesis, creation, intervention, and improvisation (...) Practices are literally re-produced on each novel occasion" (Nicolini 2012: 226). Because practices are always performed anew, in a specific situation, and therefore leave room for improvisation, there is space for practitioners to alter the practice by varying how it is performed.

Figure 1.2 is a graphical representation of this practice-oriented (re)conceptualisation of the care landscape framework. The upper line represents the care landscape as a spatially concentrated figuration of care practices, which is the "practice arrangement bundle" (Schatzki 2011: 4) of urban aged care provision. Schatzki defines "practice arrangement bundle" as "interwoven timespaces: interwoven teleologies and motivations that govern, and place-path contexts in which, the activities composing bundles and social phenomena take place"(Schatzki 2011: 4, see also Schatzki 2010). I use the term "practice arrangement bundle" to highlight that care landscapes consist of interconnected practices

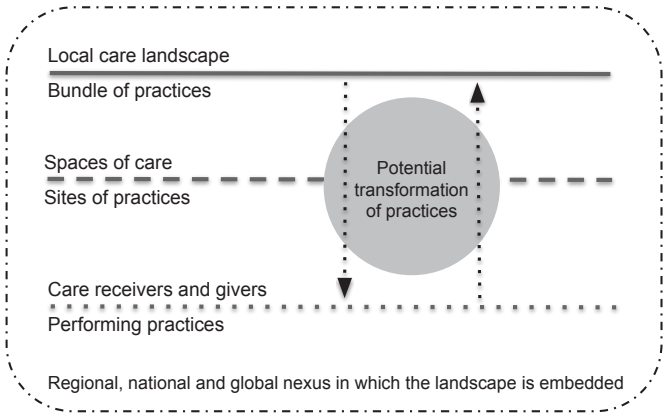
that are anchored in and, therefore, influenced by the materiality, history and people in the place where the practices are performed.

The middle line represents spaces of care; the sites within the care landscape where practices are performed, such as day care centres. The lower line represents the individuals who perform practices of giving and receiving care in the city. The porous line that encircles the care landscape symbolises the wider political and institutional nexus in which the landscape is embedded. This highlights that while the bundle of care practices constituting the local care landscape is spatially anchored in the city, it is not spatially confined, but stretches across space through relationships of care and interconnections with practices elsewhere (Massey 1995; Milligan 2009; Hui et al. 2017)

The vertical lines indicate how practices may transform to be more or less responsive to older migrants' care needs. As described earlier, this can occur when individual practitioners use the bounded creativity of a practice to improvise in situations where they care for older migrants. Practices can also transform towards more responsiveness through the introduction of new sites of practice that facilitate encounters between older migrants and care practitioners. Lastly, the local care landscape can become more responsive to older migrants' needs through the interactions between more and less responsive actors and sites involved in practices relate to aged care.

While the vertical lines highlight the potential for local responsiveness, the porous lines around the landscape highlight how responsiveness is bounded by the nexus in which the care landscape is embedded. The nexus can delimit the bounded creativity of practitioners locally through required adherence to, for example, national regulations pertaining to care and policy directives.

Figure 1.2 The local care landscape[11]



11 Figure 1.2 is an adapted version of a conceptual model in a research proposal by Pijpers (2015). The proposal is available upon request.

1.3.3 Research question and sub-questions

To answer the overarching question of **what the scope and limitations are for responsiveness to older migrants' care needs in local landscapes of care in times of post-multiculturalism and localism**, the fieldwork was guided by four sub-questions. These questions allowed me to look at how responsiveness takes shape in the care landscapes from different vantage points: the situatedness of the landscape in a political and institutional nexus; sites/spaces of care; care workers; the perspective of individual older migrants receiving care. The questions, which are answered in each of the empirical chapters, are as follows[12]:

1) **How does the implementation of diversity-mainstreaming policies in aged care provision affect the scope for local stakeholders to address the care needs of ethnic minority elders? (Chapter 3)**

2) **How does neighbourhood governance of social care affect the scope for frontline workers to address the health inequities experienced by ethnic minority elders in their daily work? (Chapter 4)**

3) **i) To what extent does the space of the day care centre allow staff to shape a care practice that is responsive to cultural diversity, and ii) How do these culturally specific care spaces interact with the wider care landscape in Nijmegen? (Chapter 5)**

4) **Which relationships of care in the two cities facilitated older migrants' access to aged care? (Chapter 6)**

To investigate the scope and limits for local responsiveness to older migrants' needs, I set out to study two policy trends related to post-multiculturalism and localism: diversity-mainstreaming (sub-question 1) and neighbourhood governance (sub-question 2). In the following section, these policy trends are defined and contextualised. Furthermore, it is explained why different terms are used to refer to older migrants and the care forms tailored to their needs.

1.4 Study context and definition of terms

While the study underpinning this thesis is primarily concerned with aged care in specific cities in the Netherlands, many of the findings are applicable to other regional and national

12 Each of the sub-questions was formulated for the purposes of the individual articles; hence the inconsistency in the terms used (see also Section 1.4)

contexts because the Netherlands finds itself at the intersection of two political trends, which can be observed in Australia (Brandhorst, Baldassar and Wilding et al. 2021) and in a number of European countries, namely, post-multiculturalism and localism. Here I make the argument that these two trends should be seen as connected.

1.4.1 Post-multiculturalism

Post-multiculturalism is a political trend that is shaping both aged care and migration policies. Post-multiculturalism refers to a disaffection with multiculturalism and its associated policies in countries where such policies were previously common, such as Sweden, the Netherlands, Australia and the United Kingdom (Vertovec 2010). In care policies, multiculturalism was expressed through the supply of information in minority languages, training in intercultural competence, and the provision of ethno-specific services to lower the thresholds for minorities to use services.

One reason why multicultural care policies have lost support is that they were thought to hamper the integration of minority groups (Helberg-Proctor et al. 2017). Multiculturalist care policies have also been criticised for overly emphasizing the role of cultural differences in care, whereby professionals came to 'culturalise' (health) problems which in fact had causes that were not because of cultural or ethnic differences (Rugkåsa & Ylvisaker 2019).

Diversity-mainstreaming is the postmulticultural alternative to policies targeting ethnic minority groups. Diversity-mainstreaming refers to efforts to pay attention to 'diversity' across all policy domains and within all public services (van Breugel and Scholten 2017). This approach to policy has gained ground in countries like the Netherlands, United Kingdom, Belgium, France and Australia (Brandhorst, Baldassar and Wilding 2021; Vertovec 2010). An intended outcome of diversity-mainstreaming in the care domain is for all services to become responsive to migration-related diversity since this would widen minorities' access to services. Another advantage of diversity-mainstreaming is that by focusing on diversity more broadly, rather than on ethnicity, it helps care providers avoid stereotyping and essentialising of ethnic difference. Lastly, considering the increase in aspects of migration-related diversity, such as a range of religions, cultures and languages, a diversity-mainstreamed approach might be the most feasible approach to provide care and welfare services to today's 'super-diverse' populations (Boccagni 2015; Phillimore 2011).

Critics of diversity-mainstreaming argue that 'diversity' is a vague term and therefore lacks clear directives on how inclusion of disadvantaged minorities should be achieved (Ahmed 2007). Furthermore, it is argued that the 'diversity discourse' individualises problems and thereby obscures the structural disadvantages experienced by specific minority groups. Lastly, research indicates that the shift to diversity-mainstreaming has undermined investment in ethno-specific and multicultural aged care services and bi-cultural aged care workers in Australia that are trained to work in multicultural settings (Brandhorst, Baldassar and Wilding 2021). Since studies on barriers of access to care

faced by older migrants often call for more of such services, the turn to diversity-mainstreaming policies in aged care might result in an increase in inequities in access to aged care services. However, thus far there has been no research into the interpretation of diversity-mainstreaming policies in local aged care provision, which is why subquestion 1 addresses this issue.

1.4.2 Localism

The term localism has been popular in policy discourse for several decades, and as such, it has been interpreted and implemented over time in various ways in different countries (Evans, Marsh and Stoker 2013). For the purpose of this thesis, I rely on the following definition:

> "Localism is an umbrella term which refers to the devolution of power and/or functions and/or resources away from central control and towards front-line managers, local democratic structures, local institutions and local communities, within an agreed framework of minimum standards'" (Evan, Marsh and Stoker: 405).

The underlying belief of localism is that local actors, such as municipal politicians, care organisations and, notably, local citizens, are best suited to make choices about care provision (Featherstone et al. 2012; de Boer and van der Lans 2013; Oldenhof et al. 2016). In the Netherlands, a common expression of localism in the care and welfare sector is neighbourhood governance of aged care. Neighbourhood governance assumes that neighbourhoods are "viable, recognisable units of identity and action, and are therefore the appropriate locus for the planning and delivering of a range of services and activities" (Chaskin 1998: 11, see also Lowndes and Sullivan 2008; Engelmann and Halkow 2008).

Proponents of neighbourhood governance argue that giving local actors freedom to experiment and innovate improves access to, and the quality of, public services. However, neighbourhood governance can, similar to other policy expressions of localism, be critiqued for misunderstanding the relationship between people, place and health (Cummins et al. 2007, Oldenhof, Postma and Bal 2016). Localism relies on what Cummins et al. (2007) have characterised as a "conventional understanding of place". From this view, it is assumed that people residing in a neighbourhood constitute a homogenous population and that residents not only have similar characteristics, but also have a sense of being part of a common, local community. Furthermore, it is assumed that spatial proximity automatically increases the accessibility of services. Following this reasoning, it is logical to expect that services will be more accessible if they are provided in the neighbourhood, tailored to the needs of neighbourhood residents, and in places dedicated to the local community such as neighbourhood centres. While this reasoning is attractive, there is evidence that these assumptions rely on an overly simplistic understanding of place.

Firstly, research shows that neighbourhood residents in most European cities do not constitute a homogenous group (van Gent, Musterd and Ostendorf 2009). While some scholars find evidence that practitioners tailor services to local needs (Durose 2009; Bartels 2017), the idea of tailoring services to local needs is not as straightforward as many policymakers may have assumed. Secondly, as shown by geographers taking a relational approach to place, spatial proximity is not a guarantee that care services are accessible to all residents (Conradson 2003; Cummins et al. 2007)). In addition, localism might be particularly detrimental to minorities because interventions that target the general population tend to increase access for groups that already enjoy certain advantages at the expense of more vulnerable groups like minorities (Blacksher 2012). It is therefore questionable whether neighbourhood governance can improve access to aged care services for older migrants. Sub-question 2 addresses this issue.

While neighbourhood governance of care and diversity-mainstreaming might be seen as disparate developments, I argue that they should be seen as connected because both policies target individuals, conceived as neighbourhood residents or as individual migrants, rather than groups. As such, both approaches frame solutions to inequities in access to care as an issue that should be resolved at the level of individuals. Considering the structural inequalities that older migrants face at the population level, I take a critical perspective on this individualised approach. That is because the responsibilisation of individuals and local authorities eschews giving attention to local inequities in access to care that are caused by structural inequalities, which arguably cannot be resolved at the local level (Andreotti, Mingione and Polizzi 2012; Levitas 2012)

The critique of these approaches as described above is also reflected in my choice of terminology to describe the study population and the forms of care provision in the different chapters. As pointed out by authors writing on race, structures of inequity are adaptive. When norms regarding what is acceptable to say, change, so will the language of oppression (Ansell 2006; Bonilla-Silva 2015). Finding the right language to describe the phenomenon of inequity in such a way that underlying power relations become visible is therefore challenging. The following section describes how I tackled this challenge in the context of this thesis.

1.4.3 Older migrants/ethnic minority elders

In this thesis, I refer both to the terms'older migrants' and 'ethnic minority elders' to describe the same population group. The reason I chose to use the term older migrants, rather than the term ethnic minority elders, is that many of the 'barriers of access' that older migrants face to access aged care services are not causally related to their ethnic background, or to their country of birth, such as barriers like limited knowledge about healthcare systems, limited proficiency in the local language and low health literacy (Greenwood et al. 2015). Furthermore, the term older migrants is useful because it draws

attention to the heterogeneity that exists within and between older people from different migrant groups. It also leads researchers to question reliance on ethnic categorisation, which is a common way to identify people, highlight needs and assign services. For this reason, I refer to 'older migrants' in the introduction and the conclusion, and in chapters five and six of the thesis.

However, in chapter three and four, I have chosen to use the term 'ethnic minority elders' because the term migrant in itself does not highlight that being a migrant, particularly in the case of older people of colour, often means that one belongs to a minority group and that being part of a minority can influence the extent to which one's care needs and preferences are seen as legitimate. A minority lens is therefore useful when seeking to explain responses, or the lack thereof, of care providers and policymakers to inequities in access to and use of aged care services by people from minorities, for example, when people deviate from the mainstream societal norms in respect of their race, religion, culture and/or ethnicity.

1.4.4 Culturally specific/Ethno-specific/Minority-specific services

Multiple terms are used in this thesis to describe services tailored to older migrants. I have both chosen to use *a priori* categories from the field, categories common in European policy debates on care and welfare, and categories that reflect my engagement with the Critical Diversity literature e.g. (Ahmed 2007; Dobusch 2017; Zanoni et al. 2009) and Urban Studies literature concerned with migration and integration (Ambrosini and Boccagni, 2015; Uitermark, Rossi and Van Houtum, 2005). Here I will describe each of these categories and expand on the reasons for their use in the empirical chapters.

In the context of the Netherlands, aged care services which target older migrants are referred to as 'cultuur-specifiek'[13], which can be translated as culturally specific. This term refers to organisations and services which specifically target older migrants. In Chapter 5, I use this *a priori* category. In Chapter 3, which focuses on the interplay between local and national policies, I use, instead, the term ethno-specific care. The reference to ethnicity is not fully accurate, since not all services described as ethno-specific in the chapter service clients from the same ethnic groups. Nevertheless, the term ethno-specific care is chosen to enhance clarity with regard to the European policy debates of which Chapter 3 speaks.

In the sixth empirical chapter, the term minority-specific care is used. The reason I introduce this term in Chapter 6 is that the aim of this chapter is to highlight that the

13 This term is used in an overview of services and facilities for older migrants published in February 2021 by NOOM (Netwerk van Organisaties voor Oudere migranten), the Dutch network of organisations for older migrants, see https://netwerknoom.nl/wp-content/uploads/2021/02/01_02_21-Lijst-CulrSpecZorg-en-welzijn-initiatieven-.pdf . Culturally-specific care is also the term used by the Dutch Ministry of Public Health, Welfare and Sport for a committee tasked with the creation of guidelines for care organisations to improve care for older migrants (leiddraad cultuurspecifieke zorg).

migration-related identities that bring older migrants to a particular care service and/or together as a group depends on the local context. So-called culturally- or ethno-specific services often serve a heterogeneous clientele that cannot be narrowed down as belonging to a specific culture or ethnicity. The term minority-specific is useful because it highlights that the aforementioned care forms in fact cater to individuals with shared migration-related diversities. Another reason to use the term minority-specific is to highlight that other, mainstream care organisations cater to the needs and preferences of the majority population. As shown in the critical diversity literature, references to culture and 'diversity' tend to disguise the fact that there is a majority (Ahmed 2007; Dobusch 2017; Zanoni et al. 2009) and, thus, a minority. By using the term minority-specific I seek to draw attention to this fact.

1.5 Outline of the thesis

This thesis consists of seven Chapters: The introduction, the methodology, four empirical chapters and a conclusion. **Chapter 2** details the research design of the thesis. In this chapter, the practice-oriented research strategy of 'zooming in and out' is outlined. Furthermore, I explain how the cases of Nijmegen and The Hague were chosen and why day care centres were chosen as the central example of care spaces. It is also discussed how the data were collected, stored, and analysed. The chapter ends with a summary of the methodological approach. This methodological chapter is followed by empirical chapters in which I look at the care landscape from different perspectives.

Chapter 3 looks at the influence of the political and institutional nexus, in which the care landscapes are embedded, regarding the responsiveness to migrants care needs. It does so by answering the question: **How does the implementation of diversity-mainstreaming policies in aged care provision affect the scope for local stakeholders to address the care needs of ethnic minority elders***?* Drawing on the literature of Public Administration, local governance of care is theorised as 'crafting practices' involving policymakers, care managers and professionals. Applying this lens, the chapter discusses how diversity-mainstreaming is plagued by implementation paradoxes when it comes to providing inclusive care for older migrants. It highlights how the current framing of older migrants' care needs in diversity-mainstreaming policies might delimit the capacity for responsiveness in the future. This chapter has been published in the *Journal of Ethnic and Migration Studies* as an article titled: "Diversity-mainstreaming in times of ageing and migration: implementation paradoxes in municipal aged care provision".

The third chapter, which zooms out on the landscapes, is followed by two chapters that zoom in on how care professionals and care organisations negotiate and tinker with existing care practices to better meet older migrants' care needs while dealing with the resistance that these transformations of practices encounter in the respective care

landscapes. **Chapter 4** zooms in on how individuals respond to diversity in the older population through the performance of practices of care. Specifically it answers the question **'How does neighbourhood governance of social care affect the scope for frontline workers to address the health inequities experienced by ethnic minority elders in their daily work?'**. Theoretically, the chapter applies a relational approach to place. This approach emphasises social and cultural distances to social care as the reason why older migrants may not access services, even though these are physically close. It applies this perspective to investigate how professionals across different types of health and social care organisations have sought to facilitate older migrants' access to care within the framework of neighbourhood governance. Based on the findings, the chapter critically discusses how a neighbourhood-focused, generic approach to service provision both limits and enables care workers responsiveness to older migrants' needs. This chapter has been published in the *Journal of Health Organisation and Management* in the special issue 'Boundary organising in health care' as an article titled: 'Working towards health equity for ethnic minority elders: spanning the boundaries of neighbourhood governance'

Chapter 5 considers the role of spaces of care in transforming the local care landscape. In doing so, it answers the research questions i) **To what extent does the space of the day care centre allow staff to shape a care practice that is responsive to cultural diversity?** and ii) **How do these culturally specific care spaces interact with the wider care landscape in Nijmegen?** Theoretically the chapter combines insights from social practice theory on the role of place and affect, and the literature on spaces of care. These insights are used to understand how the space of culturally specific care allows staff to interpret and translate the practice of day care in a way that invites older migrants to make use of this service. Furthermore, I use social practice theory to reflect on the tensions that occurred between culturally specific care spaces and the wider care landscape, caused by national regulations on the quality of care and the policy of neighbourhood care. While Chapter 5 focuses on a specific type of care space, namely day care centres, the emphasis is on how these spaces are embedded within the local care landscape, and how the performance of care practices in these spaces might increase responsiveness to diversity in related practices of care. This chapter has been published in the *Journal of Social and Cultural Geography* under the title: "Day care centres for older migrants: Spaces to translate practices in the care landscape".

Chapter 6 builds on chapter 3, 4 and 5, in that it uses insights regarding the structure and dynamics of the two landscapes of care as described in the papers mentioned above. However, in exploring the care landscape, this chapter does so from the perspective of individual older migrants. Drawing on interviews with 32 older migrants who had accessed home care, day care or home aid and participant observations in day care centres, the chapter **identifies which local relationships of care facilitate access to aged care for older migrants** by combining relational approaches to place with the lens of super-

diversity. This chapter has been published in the *Journal of Ageing & Society* as an article titled "Migrants' pathways to aged care: the role of local relationships of care in facilitating access for super-diverse older populations".

In **Chapter 7** the conclusions of the thesis are presented. First, an answer to the overarching research question is provided by discussing how the landscapes' embeddedness in localism and post-multiculturalism delimits the scope for responsiveness to older migrants' needs. Thereafter, I outline the implications for practice that were generated by applying an relational place approach to the study of aged care provision. This is followed by a discussion of the theoretical contributions of the study to debates at the intersection of older migrants and aged care services and the literature of Health Geography. The chapter concludes with suggestions for future research that investigates the scope for greater responsiveness to migration-related diversity, not only in the current but also in future local landscapes of care.

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CHAPTER 2
METHODOLOGY

Previous versions of Section 2.5 of this Chapter have been presented at the 2019 Emerging and New Researchers in the Geographies of Health & Impairment Conference and at the 2021 Midterm conference of the Research Network on Ageing in Europe (RN01) European Sociological Association (ESA) (online).

2.1 A practice-oriented methodology

This chapter outlines the practice-oriented qualitative methodology that was used to investigate responsiveness to older migrants' care needs in the local landscapes of care in the cities Nijmegen and The Hague. The chapter has two aims, firstly, to show that the research design used was appropriate to collect the data needed to answer the overarching research question; and secondly, to provide evidence that the data has been properly analyzed and stored. Because this thesis is based on published articles, a detailed outline of the methods of data collection and analysis that were used to answer each of the subquestions is provided in the methods section of each empirical chapter. In this chapter, however, data collection and data analysis are discussed in general terms with the aim to highlight the fit between the research questions and the research design.

The chapter proceeds as follows: First, I will discuss the empirical boundaries of the local care landscapes (see Section 1.3.2 in the previous chapter for a definition) in Section 2.2. Thereafter, the research design is outlined in Section 2.3 where I introduce the strategy of 'zooming in and out'. This is followed by a description of how I applied this strategy to collect data, why I 'zoomed in' on day care centres, and why Nijmegen and The Hague were chosen as case studies. Thereafter, an overview is provided of the data collected. Lastly, it is discussed how the data were analysed and how it was determined that data saturation had been reached. Section 2.4 includes a reflection on positionality and ethics and a description of how the data were stored. In Section 2.5 I discuss how the practice-oriented methodological approach influenced the way knowledge was disseminated and valorised in the context of the study. The chapter concludes with a summary of the methodological approach in Section 2.6.

2.2 Researching care landscapes

As discussed in Section 1.1, the overarching research question guiding the study was what the scope and limitations for responsiveness to older migrants' care needs were in local landscapes of care in times of post-multiculturalism and localism. Care landscapes were defined as *local configurations of formal and informal relationships of care, manifested in care practices, which are spatially concentrated but not confined to cities, and which are embedded within the regional, national and global institutional and political nexus* (see Section 1.3.2). To methodologically operationalise this relational concept, it was necessary to construct its empirical boundaries (Desmond 2014; Jarzabkowski et al. 2015; Marcus 1995).

The first of these boundaries that I chose to focus on was aged care services that support older people living independently at home. In the Dutch context, these services include, but are not limited to, day care, home care, home aid and social care. They do not include residential care homes or advanced and/or in-patient medical care. In the

Netherlands, there is an institutional division between health and social care that is enforced through organisational boundaries and different funding streams. In this study, I have included services that are seen as either medical or social care, as well as ones that bridge both categories. This is because individual care organisations – whether providing homecare, day care or primary care – cooperate and are locally networked to various degrees. Because care practices existing within different organisational and institutional boundaries overlap in daily life, it, therefore, made sense to investigate these connections rather than rely on artificial institutional or professional boundaries.

While the choice to include a wide range of services was made at the onset of the study, the spatial boundaries of the care landscape changed during the fieldwork phase. I had planned to study multicultural neighbourhoods because both cities, Nijmegen and The Hague, had a policy of neighbourhood governance of aged care. However, during the fieldwork, it became apparent that many minority-specific services operated in a city-wide frame, an issue which is further explored in Chapter 4. I, therefore, chose to widen the spatial boundaries of my study to include the entire city.

I defined older migrants as people over the age of fifty-five born in a country other than the Netherlands. In the Netherlands, older people are defined as individuals over the age of sixty-five by the Central Bureau of Statistics. However, older migrants are known to have an earlier onset of age-related diseases and chronic illnesses compared to older people from the majority population (Conkova and Lindenberg 2018). I, therefore, chose to widen my age bracket when recruiting interviewees to include people over the age of fifty-five.

As discussed in Section 1.3.1, I defined responsiveness as attentiveness to the needs of the other in the specific situation at hand. I further understood this to be a quality that could be part of a range of care related practices, from policymaking to the management of services and the delivery of specific forms of care. A certain practice would be responsive if it facilitated care workers to adapt care practices in their direct encounter with older migrants, or if the practice itself responded to older migrants' needs as evidenced by their participation in the practice as care receivers.

To capture responsiveness to older migrants' care needs in the local care landscape from different viewpoints, the study was guided by four sub-questions. As discussed in section 1.3.3, the subquestions were:

1) **How does the implementation of diversity-mainstreaming policies in aged care provision affect the scope for local stakeholders to address the care needs of ethnic minority elders? (Chapter 3)**

2) **How does neighbourhood governance of social care affect the scope for frontline workers to address the health inequities experienced by ethnic minority elders in their daily work? (Chapter 4)**

3) **i) To what extent does the space of the day care centre allow staff to shape a care practice that is responsive to cultural diversity?, and ii) How do these culturally specific care spaces interact with the wider care landscape in Nijmegen? (Chapter 5)**

4) **Which relationships of care in the two cities facilitated older migrants' access to aged care? (Chapter 6)**

While each of these sub-questions are answered in separate empirical chapters, they should not be seen as having led to separate sub-projects. Rather, each chapter highlights the same phenomena from different viewpoints, so as to provide a comprehensive overview of responsiveness to older migrants' care needs in Dutch cities. In the following section, I describe the strategy of zooming in and out and discuss how I applied this strategy to generate the data necessary to answer each of the sub-questions.

2.3 Research design

2.3.1 Zooming in and out as a research strategy

To structure my fieldwork, I applied a research strategy called 'zooming in and out' devised by social practice theorist Nicolini (2009; 2012). Zooming in is done by observing the performance of practices at a particular site. This can be done using participant observation and/or semi-structured interviews. The aim of zooming in is to study what the elements of a particular practice are and how the practice unfolds. In doing so, it becomes possible to detect variations in how a practice is performed, and what the possibilities for 'bounded creativity' are (Nicolini 2012: 225). An example of such bounded creativity is how healthcare professionals 'tinker' with rehabilitation exercises and so meet the emotional needs of a specific patient, yet also meet the goal of the practice, that is, to train the patient (Gibson et al. 2020).

The aim of zooming out is to understand how local activity, like the performance of rehabilitation exercises, is affected by other practices (Nicolini 2012: 229). For instance, such practices might be part of the bundle of care practices aimed at treating and supporting the recovery of people with a stroke, which is guided by meanings about person-centred care that are circulating in the nexus of the national healthcare system (Gibson et al. 2020). Thus, to zoom out, one traces connections between practices by following "intermediaries (people, artefacts and inscriptions)" to/from the sites on which one first has 'zoomed in' (Nicolini 2009:1048). Once one has established the relevant people, artefacts and inscriptions to follow, these can be studied using document analysis, semi-structured interviews and participant observation. Analysis of these data makes it possible to appreciate to what extent the performance of a practice at a specific site is influenced, constrained and/or enabled by other, connected practices.

Overall, the strategy of 'zooming in and out' was devised to "understand both the conditions of the local accomplishment of practice and the ways in which practices are associated into broad textures to form the landscape of our daily (organisational) life" (Nicolini 2009: 1392). I wished to investigate the scope for local actors to negotiate and adapt practices in the local landscape of care (sub-question 2 and 3), appreciate how the landscapes' embeddedness in a wider institutional and political nexus limited such responsiveness (sub-question 1 and 2) and grasp which relationships of care, manifested in care practices, facilitated access locally for older migrants (sub-question 4). Therefore, Nicolini's strategy was useful to structure the research design of the study. In the following section, I will describe how I applied the strategy to collect data.

2.3.2 Zooming in on care spaces as sites of connection in the care landscape

I began the data collection by zooming in on a space of care that was visited by many older migrants, namely, minority-specific day care centres. I decided to zoom in on day care centres because these sites were well connected to other aged care practices. In the Netherlands, day care is a form of social care funded by municipalities. However, organisations offering day care often offer medical care like home care as well, and in some cases residential care. For this reason, the site is embedded both in the practices of the municipality, in the practices of the national health insurance companies and in the local social care and healthcare organisations that focus on older people. In addition, as per formal state regulations, the practice of day care is subjected to national healthcare inspection. Hence the day care centres were useful sites from which to trace connections to other practices in the local care landscape.

Day care centres were also suitable because they welcomed the involvement of volunteers. In addition, since students of social care are required to do internships, staff at day care centres were used to having outsiders who needed to be taught about the practice. In both Nijmegen and The Hague, there were day care sites with different religious, linguistic and cultural profiles. This allowed me to recruit a highly diverse sample of older migrants to interview. As noted in Section 1.1, few older migrants use aged care services. Furthermore, the group of older migrants is generally hard to reach for researchers because of language barriers and, in some cases, because of a lack of trust (Conkova and Lindenberg, 2019). Through participant observation in the day care centres, I was able to build trust with staff and older migrant clients. The staff in the day care centres encouraged the clients' participation in interviews and supported me in recruiting interviewees in a fashion similar to the study of Shanley et al. (2013).

During participant observation in the day care centres, I took on the role of a volunteer. This entailed helping staff with serving meals, fetching coffee and tea and organising activities for the clients. To support data collection I took field notes following an observation protocol (see Appendix A). In total, I conducted participant observation in

four day care centres in Nijmegen and two day care centres in The Hague. These were selected based on the minority groups they catered to since to answer sub-question 4 I wanted to come into contact with as many minority groups as possible. In addition, I also included one day care centre which targeted neighbourhood residents rather than older migrants. Conducting research at multiple sites allowed me to appreciate common elements of day care practices. Furthermore, by comparing the variations in how day care was practiced at the different sites, I was able to appreciate how day care staff adapted the practice to make it more responsive to older migrants' needs.

During the participant observation, I also made notes regarding the connections with the wider care landscape as these emerged through the day, for instance, in discussions about primary care, the arrival of transport services to take clients to and from the centres, visits by family members, and visits by the healthcare inspection. I also traced connections by interviewing staff about their relationships and interactions with other care organisations, with the municipality, and with older migrants' families and their communities. Lastly, I inquired about how local and national policies ruling the practices in both the landscapes and the nexus had affected their work over time. In this way, I was able to identify actors, practices, and artefacts in the form of policy documents, which I could follow in order to 'zoom out' on the wider landscape/local bundle of practices and the national policy context c.q. the political and institutional nexus.

2.3.3 Zooming out on the landscape as a bundle of practices

In order to zoom out on the landscape I used three methods: semi-structured interviews, document analysis, and participant observation.

Firstly, I zoomed out by interviewing the actors I had identified as being engaged in practices involving older migrants locally. This was done either through observation in the day care centres or via gatekeepers that knew the care landscape well. Examples of interviewees identified at the day care centres included local policymakers concerned with day care, public health nurses working in the neighbourhood with older migrants as patients, and intercultural aged care advisers referring older people to the day care centre. Actors who were identified via gatekeepers, which were interviewed, included social workers in multicultural neighbourhoods, members of municipal advisory committees on diversity and older people, and a coordinator of all day care provision in Nijmegen. I used different interview guides depending on the work of the interviewee. Examples of interview guides for care workers and policymakers can be found in Appendix C and D. These semi-structured interviews provided me with an overview of the local formal and informal relationships of care that made up the care landscape. To study the care landscape from the perspective of the receivers of care, I interviewed older migrants who had accessed formal aged care. The interview questions covered current and past experiences with formal care; which types of care they received; and how they accessed

these care forms, independently or with support. This interview guide can be found in Appendix B.

Secondly, I zoomed out by studying local policy documents on topics of care, welfare and diversity. The examination of these artefacts showed how local policies caused limitations to the responsiveness in the practices. For example, the policy documents revealed which practices were supported and what the rules were for setting up activities, such as a preference for neighbourhood-focused rather than group-focused activities. Furthermore, the policy documents revealed how much attention was given to the inequities in access to aged care faced by minority groups. Understanding the local policies helped me appreciate how these were adapted during the implementation. Examples of this are that care workers tinkered with the policy that all activities should be accessible to all neighbourhood residents, or that managers negotiated the policy that day care should cater to a neighbourhood, rather than to a target group like older migrants.

Thirdly, I observed events that brought together different actors involved in aged care for older migrants. Some of these events occurred regularly, like public debates about culturally sensitive care, a professional network on older migrants and dementia, and an expert group of older migrants advising a large social care organisation. I also attended one-off events, like an information event about residential care for Chinese older people and a training session about intercultural competence in the care and welfare sector. During these events I followed a simple observation protocol of describing the events and discussions chronologically in as much detail as possible. Observing these events allowed me to study the relationships between different local actors as manifested in practices of networking and debating.

To summarise, to establish an overview of aged care practices and sites that sought to respond to older migrants' care needs in some way I zoomed out on the landscape using semi-structured interviews, document analysis and participant observation. Furthermore, I zoomed out to map connections between these practices and the actors performing them, that is, 'what' and 'whom' the local configuration of caring relationships consisted of, and 'how' individual older migrants were embedded in these relationships.

2.3.4 Zooming out on the care landscape as embedded in an institutional and political nexus of practices

In the first stage of zooming out, I mapped responsiveness to older migrants' needs in the local care landscape. However, to appreciate how national policies and political discourses on localism and diversity-mainstreaming delimited the scope for responsiveness locally, I needed to zoom out further. Hence, I included two case studies: the cities of Nijmegen and The Hague. As discussed, the aim of the comparison of these two cities was to identify the aspects of the care landscapes that were particular to each site, and, also, which aspects could be related to the political and institutional nexus in which they were

both embedded. The first step to do this was by reviewing the literature on localism and diversity-mainstreaming in the Netherlands, followed by analysing the data on the practices of policymaking and caregiving in the respective care landscapes against this background. To identify which local relationships of care facilitated access to formal aged care in both landscapes, I compared the narratives of older migrants between and within the two care landscapes.

The cities of Nijmegen and The Hague were chosen because of their characteristics and the availability of gatekeepers in both cities, a factor which was important considering the multi-sited nature of the study (Marcus 1995). Both cities have a history of minority-specific and intercultural aged care practices. For example, in both cities there were welfare organisations targeting migrants during the multicultural policy era. Both cities also had intercultural aged care advisers and minority-specific home care, home aid and day care. Moreover, both cities represent, in the national context, urban areas with a high degree of ethnocultural, religious and linguistic diversity (Jennissen et al. 2018). Table 2.1 provides an overview of these aspects.

Table 2.1 Overview of the care landscapes of Nijmegen and The Hague[14]

City	Population composition	Ethnic composition of older migrant population	Neighbourhood characteristics	Minority-specific service provision	Cultural/Ethnic/Religious Self-organisation
The Hague	538,000 residents of which 14 % are aged 65+; Older population consist of 32,9 % first-generation migrants	Suriname (22,2%) Indonesia (22,4 %) Germany (12%) Morocco (7,5 %) Turkey (6,9 %) Antillean (3,9%) Other (37,1 %)	Migrant populations predominantly live in Laak, Schilderswijk and Transwaal; neighbourhoods with long history of in- migration and diverse populations	Intercultural aged care advisers (Cantonese, Berber and Arabic, Turkish) Home care offered in different languages/multicultural profile Day care for Indonesian, Chinese, Turkish, Moroccan, Hindustani, and multicultural groups Residential care for Chinese, Dutch Indonesian, Moluccan, Surinamese, Hindustani and multicultural groups Co-housing for Chinese, Turkish, Surinamese, Surinamese-Creolean, Surinamese-Javanese, Hindustani, Antillean, Dutch-Indonesian and Moroccan groups	Hindustani temple Hindustani organisations; Surinamese organisations Javanese Surinamese Carribbean organisation Turkish mosques; women's organisation; labour organisation; cultural organisation; Islamitic organisation; Kurdish organisation; Turkish-Azerbadjani organisation Moroccan mosque; Moroccan women's organisation; Moroccan men's group Indonesian mosque; cultural organisation; sport organisation; music organisation Javanese organisation Foundation The Chinese Bridge Armenian; Ghanean; Sudanese; Papua New Guinea; Somalian; Bulgarian; African organisations

14 Data on population composition is retrieved from municipal overview of older migrants (Nijmegen 2017, available upon request) and Ouderenmonitor 2018 (The Hague 2018, https://ckan.dataplatform.nl/dataset/dba52bda-3178-48f8-9b75-2faf4048d6d7/resource/8ee46bb8-c1a6-430f-9fce-e1b6615d1473/download/ouderenmonitor2018.pdf retrieved on July 1 2021)

Table 2.1 Continued

City	Population composition	Ethnic composition of older migrant population	Neighbourhood characteristics	Minority-specific service provision	Cultural/Ethnic/Religious Self-organisation
Nijmegen	175,000 residents, of which 15% are aged 65+; Older population consist of 20,0 % first-generation migrants	Germany (41,9%) Indonesia (15,6 %) Turkey (7,4%) Morocco (4,6%) Antilleans (2,8%) Suriname (3,4%) Other (24,3 %)	Migrant populations dispersed across several neighbour-hoods and surrounding villages, with some concentration of migrants in Neerbosch Oest, Dukenburg, Oud-West and Hatert	Intercultural aged care advisers (Berber and Arabic, Turkish) Home care offered in Turkish Day care for Indonesian and Turkish groups Meeting group for Chinese older people Multicultural meeting group	Hindustani temple Surinamese group Surinamese Islamic group Antillean organisation Turkish mosques Turkish secular organisations Turkish Islamic organisation Turkish Alevi organisation Moroccan mosques Moroccan women's organisation Indonesian organisations Moluccan organisation

The case studies were conducted sequentially. I collected data in Nijmegen from June 2017 to July 2018. Since Nijmegen was my first case study I began the fieldwork by defining the local care landscapes as an empirical object. Thereafter, I applied the research strategy of zooming in and out to identify relevant practices and actors to include in the study. This was followed by an intermittent period of data analysis lasting from August 2018 to December 2018. When conducting multi-sited research on practices, the phenomena studied often evolve during the fieldwork, as researchers deepen their understanding of practices and their connections in the early phase of research (Jarzabkowski et al. 2015). By incorporating a period of analysis in which I withdrew from the field, it was possible to reflect and recalibrate the analysis and methods, and focus for subsequent fieldwork. This turned out to be important for the direction of the study.

At the outset of the research, the primary focus was on how localism influenced local responsiveness to older migrants' needs. However, through the analysis of the data gathered in Nijmegen, the conclusion was drawn that the notion of 'diversity' was an equally, if not more, important notion in the national policies which all actors in the care landscape needed to position themselves to. Based on these new insights, as I set up the fieldwork in The Hague, I reworked the interview guides and observation protocols and adapted the selection of documents for analysis. The fieldwork in The Hague took place during the period January 2019- July 2019. In The Hague, I studied similar sites, actors and artefacts as in Nijmegen and used the same methods of data collection so as to be able to compare the two cases. The reason I spent more time in Nijmegen was that it took time to become familiar both with the aged care practices and the landscape. Once I had established this understanding and had decided on the relevant actors and sites from which to collect data, I was able to proceed more quickly with the fieldwork in The Hague. Interviewing older migrants took longer than planned because of the time and effort it took to find and train interpreters[15]. For this reason, I proceeded with fieldwork in The Hague while still being in the process of conducting interviews with older migrants in Nijmegen.

Taking together fieldwork in both Nijmegen and The Hague, a total of 76 interviews and 325 hours of participant observation were conducted. Five of these interviews were conducted by the principal investigator (PI) of the wider project in which this study is embedded[16]. The PI also identified and collected a majority of the documents which were to be analysed. Four interviews were conducted by a student whom I supervised within the framework of the project. All other data were collected by me. Table 2.2, 2.3 and 2.4 provide an overview of the data set, organised by method of data collection.

15 The methods section of Chapter 6 includes a reflection on the use of interpreters.

16 This thesis is a subproject in the research project 'Caring for Diversity' which investigated responsiveness to sexual and migration related diversity in Dutch municipalities after the decentralisation of aged care from the state to municipalities in 2015. The principal investigator (PI) of this project was Dr. Roos Pijpers, the primary supervisor of this doctoral thesis.

Table 2.2 Data collected using participant observation

Nijmegen	Organisation	Nr. of observations	The Hague	Organisation	Nr. of observations
	Day care provider with multicultural/ Islamic profile	27*3 hours		Mainstream care provider with culturally specific day care groups	5*6 hours
	Day care provider with Turkish profile	6*5 hours		Day care provider with a group with Hindustani profile	6*7 hours
	Mainstream day care provider with a group with Indonesian profile	6*7 hours		Chinese self-organisation	2 hours
	Mainstream Day care provider	5*6 hours		Volunteer support organisation	4 hours
	Information and advice centre	8*2,5 uur		Diverse City	2 hours
	Diversity café	5*3 hours			
	Working group: Dementia and older migrants	4*3 hours			
	Expert group older migrants (facilitated by mainstream welfare organisation)	5*3 hours			
		245			80
Total		325 hours			

Table 2.3 Data collected using semi-structured interviews

	The Hague	Nijmegen
Type of actor	**Profession**	
Policy officers	Policy officer diversity (1) Policy officer older people and social support (1) Former policy adviser older people/ current senior adviser mainstream residential care organisation (1)	Policy advisers (3) Contract manager (1)
Managers	Coordinator day care initiative (1) Manager minority-specific day and home care organisations (2) Manager umbrella organisation for social care organisations (1) Manager and trainer volunteer support organisation (1) Board member diversity-mainstreaming network (1) Director diversity-mainstreaming network (1) Course coordinator and teacher diversity-mainstreaming network (1)	Coordinator of pool of intercultural advisers (1) Project leader municipal platform day care organisations (1) Manager minority-specific day and home care organisations (2) Coordinator neighbourhood information centre (1) Manager diversity and informal care social work organisations (1)
Frontline workers	Day care coordinators and activity leaders of minority-specific groups (3) Intercultural aged care adviser (1) Aged care adviser (6)	Day care coordinators and activity leaders of minority-specific groups (5) Intercultural aged care adviser (1) Team leader social neighbourhood team (1) District nurse elder care (2) Manager Information centres Nijmegen (1)
Other	Chairman older people's city council (1)	Muslim chaplain (2)
	22	22
Older migrants	Dutch-Turkish (3) of which 3 in Turkish Dutch Surinamese (5) Dutch-Chinese (3) of which 3 in Cantonese Dutch-Indonesian (1) Dutch-St.Vincent (1)	Dutch-Turkish (8) of which 6 in Turkish Dutch Surinamese (1) Dutch-Curaçao (2) Dutch-Chinese (3) of which 3 in Mandarin Dutch-Indonesian (3) Dutch-Iranian (1) in Farsi Dutch-Afghan (1) in Farsi
	13	19
	35	41

Table 2.4 Overview of documents collected

Nijmegen	Content of document	Year of publication
	Policy framework for the Social Support Act and the Youth Act 2015-2018	2014
	Response to proposal 'Divers is sterk' [*Diverse equals strong*], with an overview of policies and practices concerning diversity developed by care and welfare providers	2017a
	Progress report about social neighbourhood teams and information and advice centres	2017b
	Health agenda 2017-2020	2017d
	Two documents on the funding of the basic welfare infrastructure 2017-2020	2017c, 2018
The Hague		
	Den Haag, seniorvriendelijke stad [*Age-friendly city*] 2015 – 2018 Action program for policy	2015
	Conference report Bijzonder Dichtbij [*Extraordinarily close*] Interculturalisation of care and welfare in The Hague	2010
	Ageing trend monitor The Hague	2017, 2018a
	Reply to the motion Interculturalisatie van de gezondheidszorg [*Interculturalisation of healthcare*]	2018b
	Policy plan welfare infrastructure 2015-2016	2015

2.3.6 Data Analysis

To process the data for analysis, all semi-structured interviews were transcribed *ad verbatim*. Field notes from participant observations were typed up in a Word document the day after the observations. In cases where I was able to make fieldnotes on paper during the activity, these were also typed up in a Word document shortly after the observations to prevent the loss of details.

Analysis was conducted in several rounds. In the first round, the aim was to determine whether I had collected enough data in Nijmegen to adequately represent the local care landscape. To determine that such data saturation had been reached, I drew on insights from practice theorists Jarzabkowski et al. (2015) and Nicolini (2012), particularly on their approach to multi-sited, practice-oriented research. To decide when data saturation has been reached, it is suggested by Jarzabkowski et al. (2015) that the researchers consider whether the ethnographic object, in this case the local care landscape, has become stable in terms of the elements of the practice bundle that is observed. Stability can be confirmed by looking at the coding structure. When the data are richer but the themes and related codes remain the same, it is likely that saturation has been reached. In this study, a defining feature of the care landscape as an ethnographic object was the spatial configuration of formal and informal relationships of care, as manifested in social practices. When

collecting and later coding the data, it became apparent that saturation had been reached when I was no longer able to identify new practices related to aged care for older migrants, or new actors involved in such practices.

The second indicator that data saturation has been reached is when the data collected could explain "how the local practice connects with non-local effects" (Nicolini 2012: 238). This threshold was reached when I could link data from the local care landscape to the first of the two trends I wished to investigate, namely, localism as expressed in neighbourhood governance (see Section 1.4.2). Although the analysis of the data raised questions about another non-local issue, that of diversity-mainstreaming, the first round of coding ascertained that enough data had been collected to separate the local care landscapes from the nexus in which they were embedded. On the strength of this I decided to proceed with the data collection in The Hague by interviewing similar types of actors and by conducting participant observation at sites similar to the ones studied in Nijmegen.

To decide when data saturation to answer sub-question 4 had been reached, a different approach was taken. The aim of interviewing older migrants was to investigate their access in the care landscape from as many perspectives as possible. Therefore, I aimed to recruit as diverse a sample as possible in terms of ethnicity, Dutch language proficiency, gender, migration trajectory, and religion. In the day care centres I selected suitable interviewees with the help of centre's staff. Once the interviews with day care clients had been completed, it turned out that I needed more male interviewees as well as interviewees who had arrived in the country as labour migrants. It was possible to find these with the help of gatekeepers at a Turkish mosque and through some minority-self organisations, that is cultural, ethnic or religious organisations set up by minority groups. I stopped recruiting older migrants once I had a sample of older migrants with diverse backgrounds that was similar in both cities. This meant that I conducted 32 interviews in total, of which 19 with older migrants in Nijmegen and 13 with older migrants in The Hague.

As mentioned earlier, after the initial round that aimed to determine whether data saturation had been reached with regards to the ethnographic object of the care landscape, there were several, additional rounds of data analysis. In general, an interpretative qualitative approach was taken with several rounds of first and second-order analysis, which were done in conjunction with ongoing literature reviews (c.f. Gioia, Corley and Hamilton 2012). The process of data analysis varied per empirical chapter since the chapters differed in regard to which concepts and frameworks that were used to structure the analysis. The data analysis was conducted together with the first supervisor Dr Roos Pijpers (Chapter 3 and 4), with the first supervisor Dr Roos Pijpers and the second supervisor, Dr Rianne van Melik (Chapter 5), and by me individually (Chapter 6). The software Altas. Ti 8 was used to aid the analysis. This software facilitated the organisation of the data and the cooperation between the co-authors during the analytical process.

2.4 Positionality, ethics and data management

2.4.1. The influence of researcher positionality on the data collection

Like the feminist theorists Haraway (1988) and Rose (1997), I believe that the construction of all knowledge is influenced by the position of the researcher. To be transparent about the limitations of the study I will, therefore, reflect on my positionality in the context of the study and society at large in this section.

I am a white woman who was born in Sweden. I came to the Netherlands in 2014, and was still taking Dutch language courses at the beginning of the fieldwork in 2017. Even though I could pass for a white, Dutch person in superficial interactions, my accent revealed my migrant identity in the field. My limited fluency in Dutch and my identity as a Swede influenced my positionality in several ways.

As a highly educated person with a university position, I could speak about care from a position of relative authority in many situations. However, during fieldwork, I struggled to maintain this position because of my limited fluency in Dutch, which meant that I was not able to express myself with the certainty and nuance that I master in the English and Swedish languages. In interviews with other highly educated individuals, such as managers and policy officers, I felt that Dutch not being my native language was a disadvantage. However, even though I felt less 'professional' working in Dutch than, for instance, in English, the interviewees did not seem to regard me as 'less professional'. The fact that I sometimes needed to clarify my question might have been an advantage, since this entailed that a shared meaning of the question had to be established rather than assumed.

In the day care centres where I participated as a volunteer, my migrant identity and intermediate Dutch skills made it clear to the care workers that I needed training. Being an outsider was an advantage when collecting data as it made care workers express more explicitly how practices were to be performed. Furthermore, my Swedish identity separated me from other observers such as the healthcare inspectors and quality label inspectors, who visited two of the day care sites during my fieldwork there. As noted by Balogh (2013), having an outsider role can be an advantage when researching issues that are contested between social groups. For me, it was an advantage to be an outsider when speaking to care workers and managers with a minority background about the tensions they experienced with respect to the healthcare inspection and local policymakers.

When interviewing older migrants, the language of the interviews shifted my positionality. Sixteen of the first-generation migrants who were interviewed did not speak Dutch. This meant that I had to work through several interpreters. I found that introducing an interpreter to interviewees created a relationship that was different from the one I had with the same interviewees, despite the fact that I had known the interviewees for several weeks as part of my observations. The possibility to speak in one's language often led to instant connection and trust. This allowed me to generate rich data despite the limitations

of working with interpreters[17]. Working with interpreters therefore greatly facilitated data collection (Shanley et al. 2013).

In cases where the older migrant interviewees spoke Dutch, I was generally able to build a personal relationship before the interview through regular conversations at the day care centres where I conducted participant observation. These relationships helped me to collect rich data both during the participant observation and in the semi-structured interviews. In some cases, it also granted me access to other activities participated in by older migrants, like meetings of an Indonesian organisation in Nijmegen and a Holi-celebration of a Hindustani neighbourhood organisation in The Hague. Participating in these events helped me to gain a better understanding of the care landscape from the perspective of some older migrant groups.

2.4.2 The influence of researcher positionality on the data analysis

Because of my prolonged engagement with the field in Nijmegen, my positionality in relation to practitioners and policymakers shifted over time. At first I was considered to be an outsider who was met with a certain degree of suspicion as to whether my activities would be beneficial to those I observed and/or interviewed. Over time I grew to be seen as an insider through my relationships with key stakeholders and community figures from minority groups, and through my engagement in the participatory valorisation activities which are described in section 2.5. My engagement in ENIEC, an European Network for Intercultural Elderly Care, similarly transformed my positionality in The Hague to some extent. ENIEC is a network for practitioners and researchers, many of which live in the Netherlands. Through ENIEC-related meetings, I met several actors in The Hague, who in this way came to regard me both as a researcher and a colleague. My positionality could therefore be described as being on an 'insider-outsider continuum' (Soni-Sinha 2008). Through my long-term engagement with the field, I came to develop new, insider subjectivities as a co-organiser and ENIEC member (Cahill 2007)

Considering the context of my study, I believe that moving along the insider-outsider continuum gave me an analytical advantage. By becoming an insider through prolonged engagement with the field, I became familiar with the concerns and questions that were relevant to policymakers and practitioners. This helped me to more effectively share relevant knowledge. Furthermore, becoming an insider made it possible for me to gain access to multiple sites and actors within a limited time frame, which was crucial for the success of my study.

A disadvantage of being an insider could be that it may become difficult to maintain a critical distance to the data, and to question common understandings and assumptions.

17 For a more detailed account of the limitations and advantages of working with interpreters in the context of the study, see Chapter 6.

Seeing this danger, I ensured that this critical perspective would not be lost by engaging in regular conversations about the fieldwork with my supervisors as well as discussing the analysis with them. My positionality as a Swedish migrant also made me an outsider to some extent. My initial unfamiliarity with the Dutch care and welfare system and with Dutch culture made me more sensitive to the majority culture. Also, me being Swedish might have coloured my analysis, since growing up in Sweden has meant that I have a high level of trust in and a supportive attitude towards the welfare state and its institutions (Svallfors 2011). Discussing the analysis with a supervisor who is Dutch and with international colleagues helped maintain the much needed critical distance (Gioia et al. 2012).

While I was able to become an insider in the field from the perspective of care workers and policymakers, my positionality also meant that I was an outsider with respect to how older migrants experienced the local care landscape. Because older migrants often are 'Othered' by researchers (Torres 2006) and practitioners (Berdai Chaouni, Smetcoren and de Donder. 2020; Torres Ågård and Milberg 2016), it was important for me to have the voices of older migrants represented in the study. I, therefore, included the perspective of older migrants in sub-question 4. By including older migrants in the study, I strived to 'speak about' (Alcoff 1991) older migrants in a way that emphasises the multiplicity of their experiences and highlights the structures of oppression that limit their access to aged care. I have, furthermore, sought to look at the care landscape 'with' older migrants, as opposed to only gazing 'at it' by zooming in and out on the landscape as an outsider to the process of receiving care.

2.4.3 Ethics

When I began my research, there was no requirement for ethics approval by the University. However, the research proposal, which detailed how participants/interviewees were to be informed about the study and how their consent would be obtained, was approved by the Scientific Advisory Committee appointed by the Institute of Management Research in which the project was embedded. I opted for informing the participants/interviewees about the study orally and obtaining their consent orally. Before each interview I would introduce the study briefly and I would ask whether the interviewee had any questions. Then I would explain that I wished to record the interview, that the transcript would be stored securely, and that only I and my supervisor would have access to the transcript. I would also tell the interviewee that the findings would be published in scientific journals which would be publicly accessible. Lastly, I would inform the interviewees that they were not required to answer any questions and that they could withdraw from the study at any point if so desired.

When interviewing the older migrants in the study, I would explain that they would be fully anonymous: I would not mention their names and all identifying details would be removed in any published output. As a token of appreciation for their participation and

sharing of their knowledge, the older migrants who participated in the study were given a gift card of 20 euros. When interviewing care workers, I also told them that I would anonymise their names and the names of their organisation, but that there was a chance that they could be identified because there was a limited number of organisations and individuals in each municipality that provided minority-specific care and/or held functions such as neighbourhood team leader or intercultural aged care adviser. When interviewing managers and policy officers, I told them that I would anonymise their names but that they might be identifiable to a reader familiar with the local context.

Prior to conducting participant observation in a particular organisation, I would obtain consent to do this from the manager of the organisation, and I would discuss my role with all day care coordinators. I would then also be clear about my role as a researcher to those I interacted with. At meetings of professionals and at the expert group of older migrants in Nijmegen I was invited by a gatekeeper and introduced as a researcher to all participants, who then consented to my presence and to the fact that I would take notes. Because I do not provide detailed descriptions about specific individuals at the field sites in any written output, I did not ask for consent to observe all individuals at the site, e.g., staff and clients at a day care centre. When referring to events in the day care centres in the empirical chapters, the names of clients, staff and the organisation were anonymised.

The reason I chose to obtain oral consent from the older migrants was because most of these interviewees had a low level of literacy and/or did not speak Dutch. A second reason was that I was worried that asking for their written consent would discourage their participation. Oral consent was therefore considered the best option (Douglas, McGorray and Ewell 2021). I also chose to obtain consent orally from other interviewees since there is evidence that many people do not read the details of written consent forms (Douglas McGorray and Ewell 2021). By orally asking for consent and discussing what this entailed in terms of storage and publication of data, I could be certain that the interviewees had understood what they consented to, and that they, therefore, had had a chance to pull out of the study. This was particularly important since I could not guarantee all interviewees full anonymity.

2.4.4 Storage of data

I began my research before Radboud University introduced its current policy on data storage. Therefore I was not required to write a data management plan. However, my supervisors and I, nevertheless, made a plan to make sure the data could be stored safely. We chose to create a shared folder on a password secure university drive where all data were uploaded. This is where I uploaded and stored my typed-up field notes. In cases where external transcribers were hired, they were allowed temporary access to the drive. The journals where I wrote field notes were stored securely in my private home. The audio data were recorded on mp3 audio recorders bought on purpose for these

recordings. These recorders were stored in my private home prior to uploading the audio files onto the secure drive. At the end of the project, all audio files were erased from the audio recorders. Data were pseudonymised as soon as possible after the data collection. Because of the sensitive nature of the data about caregiving and care receiving, and the partial anonymity of many of the interviewees, we chose not to publish the data as part of open access. However, all research papers have been published in open access making the findings public.

2.5 Avoiding the football field: How practice-oriented methodologies support dissemination and valorisation of scientific knowledge

As noted in the introduction, there is no lack of studies on why older migrants do not access aged care (Arora et al. 2018; Koehn et al. 2013; Torres 2019). In the words of Fatos Ipek- Demir, cited in section 1.1: “We can fill entire football fields with reports on older migrants”. However, the persistence of inequities in access to care indicates that existing knowledge on older migrants and access to care has not been sufficiently mobilised by practitioners and policymakers. To make sure that the present study does not end up on an imaginary football field, I purposefully engaged in activities aimed at generating and sharing knowledge that would be useful for the existing aged care practices. In this section, I will discuss how this thesis has contributed to the aged care practice and policymaking. I will also reflect on how the practice-oriented nature of the study enabled me to co-create knowledge with practitioners that was actionable in the local contexts.

2.5.1 Dissemination and valorisation activities

To share the knowledge generated in the study I engaged in dissemination and valorisation activities. By dissemination, I refer to activities aimed at communicating scientific knowledge to a professional audience. By valorisation, I refer to activities through which the scientific knowledge is adapted to the needs and requirements of the field, which in this study, entails the fields of policymaking and care provision. In order to disseminate knowledge to care providers and policymakers I composed lay summaries of scientific publications in Dutch and English pertaining to aged care. These were shared as articles on the social media platform Linkedin. This platform made it possible for me to connect to many of my participants and/or interviewees who work in policy or aged care provision. I also shared findings in the ENIEC newsletter, which is read by care professionals, researchers, managers and intercultural trainers in Finland, Belgium, Germany, Hungary, Sweden, the UK and the Netherlands. Additionally, I shared the results of the study at a workshop for practitioners and managers of care organisations in Belgium (see table 2.5).

To translate the knowledge that was generated through the study into practice, I collaborated with gatekeepers in Nijmegen to organise action research meetings and webinars. Another way in which I shared and translated knowledge was by participating in meetings for practitioners and older migrants for the entire duration of the study. In table 2.5 an overview is given of both types of activities undertaken within the framework of the study:

Table 2.5 Overview of dissemination and valorisation activities

Dissemination	**Valorisation**
Talks	**Participation in local networks for knowledge sharing**
Talk at a conference for researchers and practitioners in the Netherlands (Leiden, February 2018) Workshop for residential care providers in Flanders, Belgium (Brussels, September 2019) Lecture at Radboud summer school "Migrant Inclusion in Policy and Practice" for students and professionals (Nijmegen, July 2019)	Participation in meetings of the Working Group: Older Migrants with Dementia (Nijmegen, October 2017-October 2020) Participation in the soundboard group Older Migrants, organised by the social care organisation *Stronger*[18] (Nijmegen, April 2018- August 2020)
Written outputs in Dutch	**Awareness-raising meetings**
Lay summary of Chapter 5 in Dutch, published online on the social media platform Linkedin Summary on insights on methods for outreach work generated in a webinar in November 2020, shared via email to participants	The organisation of meetings for policymakers, care professionals and representatives of migrant communities, in collaboration with the social care organisation *Stronger* (Nijmegen, February 2018; March 2019)
Written outputs in English	**Webinars**
Lay summary of Chapter 5 in English, published online in the ENIEC (European Network on Intercultural Elderly Care) newsletter Lay summary of Chapter 3 in English, Published online in the ENIEC newsletter	The organisation of webinars aimed at local network-formation, in collaboration with *Stronger,* RUNOMI (Radboud Network on Migrant Inclusion) and Pharos (Dutch knowledge institute on health inequalities) (Nijmegen, November 2020; June 2021)

In themselves the activities in the table are not novel. Over time societal impact has become more important to universities and funders, and it is common for researchers to find a variety of ways to disseminate their findings (Leask 2012), including the use of online outlets (Cooper 2014). In participatory action research, meetings that bring stakeholders together to raise awareness about issues and generate solutions to problems are also common

18 The name of the organisation is a pseudonym since all organisational names have been anonymised (or pseudonymised) in the study.

(Kindon, Pain and Kesby 2007). I argue, however, that undertaking these activities within the framework of a practice-oriented methodology affects *how* the activities are conducted, and by extension, how they create an impact on the field, as further discussed below.

2.5.2 Doing practice-oriented dissemination and valorisation

To disseminate knowledge online, I chose a social media platform based on insights into the preferred practices of knowledge sharing by participants in the study and other people in the field. In the health and social care domain in the Netherlands the social media platform Linkedin is commonly used to share event invitations, opinions and articles. The choice to publish in the ENIEC newsletter was based on similar reasoning, namely, that many practitioners read this newsletter regularly. Thus, joining these *existing practices* of knowledge-sharing, I made sure that the knowledge was accessible and that practitioners had the opportunity to inform themselves.

From the perspective of social practice theory, simply sharing knowledge in the form of a talk or a report is generally not seen as sufficient to generate impact. According to Cook and Wagenaar "knowledge cannot be seen as something static, something that can be stored away so that later it can be retrieved, distributed, and shared" (2012: 24). Rather, knowledge is inseparable from the practice and the "material and spatial arrangements" (Schatzki 2019) in which the practice is anchored. Hence, the reason why much scientific knowledge ends up as reports on 'football fields' is because researchers fail to share their knowledge in such a way that it becomes actionable. The aim of the valorisation activities was therefore to share the knowledge gained in the local context and as part of the ongoing performance of existing practices, thereby making it actionable for practitioners (Cook and Wagenaar 2012). To achieve such valorisation, I continued to engage in participant observation at meetings of professionals even after the data collection for the empirical chapters had been concluded (See table 2.5). It is important to note that the network meetings I attended pre-existed my study. This meant that the practice was already embedded in the work of all participants and arranged on a timeline that fitted the rhythms and requirements of their other work practices. In fields like health and social care, with a large degree of time pressure, joining existing practices rather than introducing new ones is key for the sustainability of the project (Sheard & Peacock 2019).

Through participating in the meetings I gradually became a member of the local 'community of practice' (Lave and Wenger 2001). This insider position had the advantage of attuning me to the meanings of caregiving practices as well as the challenges practitioners faced locally, including which concerns and issues they currently faced. A common problem with the valorisation of scientific knowledge is that research lags behind the developments in the professional field. Practices of scientific knowledge production have a different "rhythm" (Blue 2017; Blue and Spurling 2017) compared to practices of caregiving, contracting and policymaking. By staying involved, also during the data analysis, I could

open the process of knowledge production, share emerging insights and ask for input from actors in the field. Involving participants in knowledge production in this way meant that I could share findings before they were published and/or became irrelevant to the field.

Staying part of the field was particularly important for the co-organisation of the other two valorisation activities: action meetings and webinars. The insights of local actors helped to organise the events so that these were well-timed with other local events, and well-spaced so that momentum was gained rather than lost. The second action research meeting is an example of the importance of timing: One of the minority-specific care organisations closed down in the middle of my study. This meant that other residential care homes and day care centres in Nijmegen were suddenly required to accept several clients who were older migrants with a low proficiency in Dutch. We capitalised on this sense of urgency by setting up a second action meeting. Knowing about recent developments creates sensitivity to such a momentum and allows researchers and local actors to act at the right time.

When planning the action meetings, and later the webinars, my co-organisers and I spent much time considering how these activities could be organised in a way that would have an impact on local practices. My co-organisers, who had advocated for older migrants' care needs to be better responded to for several years, knew from experience that while local actors were good at generating ideas during action meetings, these ideas were rarely put into action after the meetings. To create impact, we, therefore, tried to invite the participants into the existing local practice of relational work[19]. This was done by organising a webinar for local practitioners. The webinars had the format of workshops with small groups of participants, which were led by local practitioners engaged in relational work. Through leading the workshops, these practitioners became visible as nodes of expertise in the local care landscape. Since discussing cases is a common element of relational work, all participants were required to give input in the form of a question or case related to working with older migrants. In addition, the workshop groups were set up to have participants from different organisations and professions so as to stimulate local networking, another important aspect of relational work. To strengthen the network, an additional webinar was held, to which past participants were invited. The intention of local stakeholders is to continue to arrange meetings in a face to face format when possible.

2.6 Conclusion

The multi-sited and comparative research design of the study was guided by the strategy of zooming in and out on sites and practices, a strategy drawn from social practice theorist

19 Relational work is defined as "actions aimed at improving access to services by bridging the relational distance between residents and service providers" (Section 4.3). For a more in-depth discussion, see Chapter 4.

Nicolini (2009; 2012). To collect data, the methods of participant observation, semi-structured interviews and document analysis were used. In total 76 interviews and 325 hours of participant observation were conducted in two locations, the cities of Nijmegen and The Hague.

The inclusion of multiple sites and actors allowed me to study the care landscape from the perspectives of care practitioners and older migrants, as well as from the perspective of care spaces and the nexus in which these landscapes were embedded. Zooming in and out, therefore, helped me to answer the sub-questions pertaining to the limits and scope of responsiveness to older migrants' needs from each of these perspectives in the local care landscapes (see Section 2.3). By comparing the two cases, I was able to appreciate which aspects of the practices were specific to each locality and which aspects were better explained by the connectedness of the landscapes to policies and politics related to post-multiculturalism and localism, two trends which characterised the national political and institutional nexus in which both landscapes were embedded.

A limitation of the original care landscape framework is that it does not explain how researchers are to connect what occurs in spaces of care with trends in the wider landscape in a methodological sense (see also Chapter 5). This thesis contributes to the health geography literature by offering a methodological operationalisation of the care landscape framework which does support geographers to study the interactions between national and local policy, care provision at the local level and the performance of care in care spaces.

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CHAPTER 3

DIVERSITY-MAINSTREAMING IN TIMES OF AGEING AND MIGRATION: IMPLEMENTATION PARADOXES IN MUNICIPAL AGED CARE PROVISION

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3.1 Introduction

In the past, the Netherlands were at the forefront of healthcare policies targeting migrants and ethnic minorities in Europe (Mladovsky et al. 2012). However, due to a growing disaffection with policies aimed at supporting minority groups, subsidies for intercultural[20] programmes and institutes were withdrawn in the early 2000s in favour of diversity-mainstreaming policies (Helberg-Proctor et al. 2017). This strategy has been defined as "the effort to embed diversity in a generic approach across policy areas as well as policy levels, to establish a whole-society approach to diversity rather than an approach to specific migrant groups" (van Breugel and Scholten 2017: 512), and has become the preferred national strategy to govern the increasingly 'super-diverse' populations of European countries such as the Netherlands, Great Britain, Belgium and France (Vertovec 2010; Boccagni 2015).

Undoubtedly, this transition to diversity-mainstreaming policies will have affected care provision for ethnic minority elders. However, to our knowledge, little research has been conducted on how diversity-mainstreaming affects aged care (for an exception see Brandhorst, Baldassar and Wilding 2021). This constitutes a significant gap since ethnic minority elders represent a growing population not only in the Netherlands, but in many immigration countries (de Valk and Fokkema 2017). Furthermore, a large share of this population experiences worse health conditions than their counterparts in the majority population, and they are known to underuse aged care services (Greenwood et al. 2015; de Valk and Fokkema 2017). One reason for why this is the case is the lack of sensitivity to diverse needs and preferences within care services (Ahaddour et al. 2016; Berdai Chaouni, Smetcoren and De Donder 2020). Therefore, this paper sets out to answer the research question: "How does the implementation of diversity-mainstreaming policies in aged care provision affect the scope for local stakeholders to address the care needs of older people from ethnic minorities?"

To answer the above question, we conducted a two-year (June 2017-July 2019) qualitative study of how diversity-mainstreaming policies were implemented in aged care for older people in Nijmegen and The Hague, the Netherlands. We focus on the urban level since the Netherlands, like Germany and the UK, have seen a transition not only to diversity-mainstreaming but also to localisation[21] of service provision (Bailey and Pill 2011). Therefore, to analyse the implementation of national diversity-mainstreaming policies at the urban level, we draw on literature in Public Administration studies on policy implementation of the localisation of aged care services (Durose 2007; Bannink, Bosselaar

20 In health and social care in the Netherlands, "intercultural" is a term indicating responsiveness to cultural differences in understandings of sickness, health and care needs (see Mladovsky, P et al. 2012)

21 'Localism' refers to the trend of decentralising responsibilities for health and social care services to municipalities and the organisation of services within neighbourhood structures.

and Trommel 2013). More specifically, we use the concept of "crafting practices" as our analytical framework (Bannink, Bosselaar and Trommel 2013).

The term "crafting practices" refers to how policies are implemented in localised contexts. Bannink, Bosselaar and Trommel (2013) use it since they found policy implementation to be a relatively open process, which develops through working relationships between local stakeholders, and through the learning that takes place in these relationships (hence "crafting", after Sennett 2008). They argue that two elements are necessary for crafting practices to succeed in tailoring service provision to the local population. "Crafting space" refers to political empowerment granting room to model new practices and "Crafting tools" refers to "technical resources (e.g., money, staff, skills) as well as institutional and/or symbolic ones (e.g., legitimacy, support, ideas)" (Sennet 2008: 16). To study the extent to which diversity-mainstreaming policies provided local stakeholders with crafting tools and crafting space, we conducted 44 semi-structured interviews, 325 hours of participant observation and analysis of municipal policy documents. We included policymakers, managers of health, social and aged care organisations and frontline workers, since these actors have been found to be involved in policy implementation (Bartels 2018; Nugus et al. 2018).

In both cities, we found that crafting practices resulted in a mix of diversity-mainstreaming initiatives in the form of diversity networks, and ethno-specific aged care in the form of intercultural aged care advisers and day and home care services. While this service mix was the result of deliberate crafting processes and reflected an ongoing practical concern with existing diversity among older migrants and ethnic minorities, we question whether diversity-mainstreaming policies are suitable to address the care needs of both current and future super-diverse older populations.

Our findings show that diversity-mainstreaming policies are plagued by two related implementation paradoxes. The first one is that the vagueness of the term 'diversity' creates an ambiguous crafting space. In some interpretations of 'diversity' it inhibited concrete action to address inequalities experienced by ethnic minorities. When the interpretation of 'diversity' did provide crafting space, we encountered a second implementation paradox. Although stakeholders had enough crafting space to respond to current care needs, the diversity-mainstreaming discourse elicited an assimilationist framing which undermined necessary crafting tools in the long-term. For example, ethno-specific services were framed as a response to "temporary" populations with special, notably language-related needs, which were assumed to disappear with the next generation. We argue that framing these services as "temporary" undermines investment in the intercultural expertise we found to be necessary to reach out to and engage ethnic minority elders.

The article proceeds as follows: to provide context to our study, we explain the waning political support for migrant-related health policies in the Netherlands through three interrelated shifts. The first is a shift from multiculturalism to assimilationism in societal

discourses on immigrants and ethnic minorities. The second is a shift from targeted health and social care policies for minority groups to diversity-mainstreaming policies. This is accompanied by a third shift towards localism in the governance of social care, in which service users are framed as members of local communities rather than ethnic minority groups. We proceed by reviewing the related literature in Public Administration and Urban Studies on diversity-mainstreaming in Europe through the lens of "crafting practices". After discussing our research approach, we then present our findings. We conclude with a discussion of the long-term implications of diversity-mainstreaming policies and suggest that policymakers should meet the care needs of increasingly ethnically and culturally diverse populations by affirming difference rather than assuming future assimilation.

3.2 Crafting health and social care in the post-multiculturalist Netherlands

In the Netherlands, a shift from multiculturalism to assimilationism has taken place over the course of two decades, starting in the 1990s with the rise of societal concerns about the relatively negative outcomes of citizens with a non-Western migration background in statistics on education, labour market participation and crime (Schinkel and van Houdt 2010; Westerveen and Adam 2019). Whereas previously, differences between citizens with and without a migration background were mostly attributed to structural inequalities, which were to be addressed through targeted policies to support minorities, since the late 1990s the responsibility for closing societal gaps was increasingly put on the shoulders of immigrants and ethnic minorities themselves (Schinkel and van Houdt 2010, Westerveen and Adam 2019). As part of the shift towards assimilationism, people with a migration background were also expected to identify more with an (imagined) Dutch community than with an ethnic or cultural minority group.

Policy-wise, the growing dominance of assimilationist ideals has had the implication that policies intended to emancipate minority groups have been gradually abandoned, such as providing support to ethnic minority self-organisations. Health policies have also been influenced by the shift in national integration discourse and the subsequent policy changes. In the past, the Netherlands served as a leading example of migrant health provision in Europe (Mladovsky et al. 2012). However, investments in intercultural competence and services were largely abandoned during the early 2000s. The reason behind this change was that authorities feared that these services would hinder integration by undermining the need for ethnic minorities to integrate (Helberg-Proctor et al. 2017).

Although this shift to assimilationism has caused disaffection with multicultural policies at the national level, urban governments have not uncritically adopted the assimilationist discourse in policies. However, they have largely ceased to make specific policies to support minority groups (Poppelaars and Scholten 2008; Hoekstra 2015; Dekker and van Breugel

2019). The case of Amsterdam, in particular, demonstrates the effect of the shift from policies targeting minorities to diversity-mainstreaming policies. Uitermark, Rossi, and van Houtum (2005) show that policies targeting minorities had been replaced by a diversity-mainstreaming policy. The latter were oriented towards enhancing individual capabilities rather than addressing group problems and can be linked to the strategic positioning of Amsterdam as a diverse, cosmopolitan city. Under the city's diversity-mainstreaming policy, ethnic self-organisations were only eligible for funding if their projects promoted integration into the wider urban society, e.g. through neighbourhood projects aimed at intercultural communication and integration. Uitermark, Rossi and van Houtum (2005) found that the policy transition fuelled entrepreneurialism among well-established ethnic minority groups and disadvantaged new minority groups and groups with less social capital. In Rotterdam and The Hague, immigrants and ethnic minorities have, like their counterparts in the capital, similarly been "recast" as citizens of "diverse cities" with concomitant citizenship duties (Poppelaars and Scholten 2008; Hoekstra 2015; Dekker and van Breugel 2019).

In the Netherlands as a whole, in the last fifteen years, a turn to localism has further fuelled the incidence of policies that call on the membership of local (urban) communities (de Boer and van der Lans 2013). During this time, responsibilities for policymaking and policy implementation in the areas of youth care, employment, and social care for (older) adults have been transferred from the national government to local ones. "Localism" is underpinned by the idea that needs for practical and more long-term forms of support in the mentioned areas are best met at the level of neighbourhoods, physically "close" to (prospective) service users (Oldenhof, Postma and Bal 2016). Therefore, in the first instance, many policies and implementation structures target neighbourhoods and neighbourhood residents. This generic, place-based approach fits with the emphasis on assimilationism and urban citizenship, which places the expectation on minorities to identify with the neighbourhood as a local, imagined community. However, localism has been found to disadvantage minority groups, who have a larger relational distance to generic neighbourhood services (Carlsson and Pijpers 2020; MacLeavy 2008). It is therefore questionable to what extent diversity-mainstreaming policies, which we find to be intertwined with ideas about localism and urban citizenship, will lead to better service provision for ethnic minority elders.

3.3 Diversity-mainstreaming policies through a crafting lens

There is a burgeoning literature within Urban Studies on local adaptation and resistance to diversity-mainstreaming policies, particularly those which pertain to integration issues (see e.g. Uitermark, Rossi and van Houtum 2005; Poppelaars and Scholten 2008; Careja 2019). However, few studies investigate the implications of diversity-mainstreaming on the

provision of health and social care to minorities (for an exception see Brandhorst, Baldassar and Wilding 2021). Despite the limited literature, our review of the diversity-mainstreaming research through the lens of crafting practices helped us to identify potential problems and possibilities caused by the implementation of diversity-mainstreaming policies in the health and social care domain.

Critics have argued that diversity policy obstructs, rather than furthers the social justice it purports to achieve (Ahmed and Swan 2006; Faist 2009). Since 'diversity' is a broad and vague term, diversity policies have been found to miss concrete guidelines for implementation (van Breugel and Scholten 2017). For example, in Milan, Angelucci, Marzorati and Barberis (2019) found that 'diversity' remained ill-defined in local policy documents, and that there was a lack of clear strategies and plans regarding the management of diversity. The reason why some scholars (e.g., Boccagni 2015; Dobush 2017) are tentatively positive towards diversity-mainstreaming policies is because they believe that such policies can create categories that are less essentialising and more sensitive to different dimensions of inequality, including educational level and socioeconomic background (Scholten, Collett and Petrovic 2016; Dobusch 2017). Ambrosini and Boccagni (2015), Schiller (2015) and Cianetti (2019) found that local governments can pragmatically adopt the rhetoric of mainstreaming policies to include various facets of diversity. As such, diversity-mainstreaming policies might be able to grant the crafting space to better respond to citizens' needs.

While 'diversity' provides room for interpretation by individual policy officers to adapt services to meet local citizens' needs, Schiller (2017) cautions that overreliance on individual policy-officers to implement diversity-mainstreaming policies can result in path dependency with activities from previous, multicultural policies being continued rather than revised to fit the aims of diversity-mainstreaming. In her study of local implementation of diversity-mainstreaming policy in Leeds, Amsterdam and Antwerp, Schiller (2017) found that policy officers that previously worked with multicultural target groups often took over the new, diversity-related policy themes. As a result, they were likely to continue with activities targeting ethnic groups rather than addressing a broader range of differences in accordance with the aim of diversity policies. To summarise, we find evidence in the literature that diversity-mainstreaming policies are plagued by implementation paradoxes. They leave much crafting space but too few crafting tools in the form of technical, institutional, and symbolic resources. Therefore, little direction is provided regarding how inequalities in access to and use of services should be addressed.

To date, there have been limited studies on how diversity-mainstreaming policies are implemented by frontline workers in health and social care. The studies that do exist point to a second implementation paradox inherent to diversity-mainstreaming policies: the vagueness of 'diversity' can inhibit concrete action to address inequalities linked to ethnicity and race. For example, Nieswand (2017) and de Koning and Ruijtenberg (2019)

found that diversity-mainstreaming led to a 'colour-blinding' of care provision. As frontline workers attempted 'not to see colour', aspects of cultural and racial difference became unspeakable in conversations with and about families receiving care. Therefore, in this instance, diversity-mainstreaming undermined the ability of workers to reflect on and address race and ethnicity. This is problematic since it hinders conversations about how inequities caused by race and ethnicity can be addressed. Theoretically, diversity-mainstreaming policies offer an opportunity to avoid culturalisation and to instead respond to a range of differences influencing equality, such as socioeconomic background, gender and education (Boccagni 2015). In practice, diversity-mainstreaming might undermine investment in, and exchange of specific knowledge relating to cultural and ethnic diversity.

In the case of aged care for older migrants, the literature indicates that ethno-specific organisations are an important source of local knowledge to reach out to and support older migrant populations in Australia and the Netherlands (Brandhorst, Baldassar and Wilding 2021; Carlsson, Pijpers and van Melik 2020). In a study of aged care in Switzerland, which population can be characterised as super-diverse, Ciobanu (2019) found that the resources to meet individual care needs of older migrants instead were generated within mainstream care facilities through dialogue with individual clients and their families. Although this individualised approach can be beneficial to individual clients it has disadvantages at the population level. Without formal structures in place, it becomes a question of luck whether an organisation can match staff and clients with similar migration backgrounds or language skills (Cioubanu 2019).

It is yet unclear how the switch to mainstreamed services in the Dutch context will influence care provision for ethnic minority elders. Australia has, like the Netherlands, experienced disaffection with multiculturalism. In the case of Australia, Brandhorst, Baldassar and Wilding caution that "cost-reducing mainstreaming service approaches risk undermining the delivery of ethno-specific care (2021: 262). It may thus be that the diversity, in turn, undermines investment in local knowledge and services which constitute key crafting tools to reach ethnic minority elders.

3.4 Research approach

To research how diversity-mainstreaming policies were implemented, we used a multiple case study design. We chose Nijmegen and The Hague since these cities represent, in the national context, a middle-sized (177 000 inhabitants) and a large (545 000 inhabitants) urban area with a high degree of ethnocultural, religious and linguistic diversity (Jennissen et al. 2018). However, we did not undertake a comparative study tracing similarities and differences back to these parameters. Rather, we wanted to research where and how crafting practices in these two municipalities converged and diverged, similar to previous studies on the local implementation of national diversity-mainstreaming policies (Schiller 2015; Nieswand 2017).

We followed developments concerning reaching out to ethnic minority elders first in Nijmegen (2017-2018) and thereafter in The Hague (2018-2019). We are aware that the population of ethnic minority elders is highly internally diverse in both cities, and not emphasising this diversity (enough) in academic publications can lead to an 'Othering' of older migrants and ethnic minorities (Torres 2006). Nevertheless, we chose to refer to ethnic minority elders as one population group, since a lack of care which is sensitive to culturally and linguistically diverse needs and preferences constitutes a barrier to access aged care for this population as a whole (Ahaddour et al. 2016; Berdai Chaouni, Smetcoren and de Donder 2020).

We took an ethnographic approach to study "crafting practices" as defined by Bannink, Bosselaar and Trommel (2013). We used participant observation, semi-structured interviews and document analysis because these methods are suitable to expose knowledge about practices (Bueger and Gadinger 2018). We began each case study by conducting semi-structured interviews with policy officers who worked explicitly with 'diversity' or with ethnic minority elders. Through interviews we traced their connections to other actors, to gain a better grasp of the relevant services, organisations and individuals, which we then studied through semi-structured interviews and/or participant observation. Tables 3.1 and 3.2 provide an overview of the fieldwork, detailing the different actors interviewed (44 in total) and the organisations and activities where we conducted participant observation (325 hours in total).

Table 3.1 Overview of actors interviewed

	The Hague	**Nijmegen**
Type of actor	Profession	
Policy officers	Policy officer diversity (1) Policy officer older people and Social support (1) Former policy adviser older people/current senior adviser mainstream residential care organisation (1)	Policy advisers (3) Contract manager (1)
Managers	Coordinator Day care initiative Haags Ontmoeten (1) Manager minority-specific day and home care organisations (2) Manager umbrella organisation for social care organisations (1) Manager and trainer volunteer support organisation (1) Board member diversity-mainstreaming Network (1) Director diversity-mainstreaming network (1) Course coordinator and teacher diversity-mainstreaming network (1)	Coordinator of pool of intercultural advisers (1) Project leader municipal platform day care organisations (1) Manager minority-specific day and home care organisations (2) Coordinator Neighbourhood Information centre (1) Manager diversity and informal care social work organisations (1)

Table 3.1 Continued

	The Hague	Nijmegen
Type of actor	Profession	
Frontline workers	Day care coordinators and activity leaders of minority-specific groups (3) Intercultural aged care adviser (1) Aged care adviser (6)	Day care coordinators and activity leaders of minority-specific groups (5) Intercultural Aged care adviser (1) Team leader social neighbourhood team (1) District nurse elder care (2) Manager Information centres Nijmegen (1)
Other	Chairman older people's city council (1)	Muslim Chaplain (2)
	22	22
Total	44	

Table 3.2 Overview of participant observation sites

The Hague		Nijmegen	
Organisation	**No. of observations**	**Organisation**	**No. of observations**
Culturally specific day care group as part of 'Haags Ontmoeten'	6*7 hours	Day care provider with Turkish profile	6*5 hours
Manistream day care provider with Hindustani, Chinese and Javanese groups	5*6 hours	Mainstream Day care provider with Indonesian group	6*7 hours
Volunteer support organisation	4 hours	Information and advice centre	8*2,5 uur
Diverse City	2 hours	Diversity café	5*3 hours
Chinese self-organisation The Hague	2 hours	'Netwerk 100' Working group: Dementia and older migrants	4*3 hours
		Day care provider with multicultural/Islamic profile	27* 3 hours
		Expert group older migrants (facilitated by mainstream welfare organisation)	5*3 hours
	80		215
Total:	295 hours		

We included policy officers employed by the local governments since they occupy the lead role in shaping general diversity policies, policies for care and support, and the contracting of health and social care providers. We also attended meetings of *Diverse City* and the *Diversity café*, a soundboard group for older migrants and a network for professionals working with older migrants with dementia. These networks and groups were of interest because they were platforms for exchanging knowledge about care and

ethnic and cultural minorities. We also included providers of ethno-specific day care and professionals referred to as intercultural aged care advisers since these services targeted ethnic minority elders. The term "intercultural" points to the ability to navigate cultural difference[22]The intercultural aged care advisers provided support to access care to minority elders directly and assisted other frontline workers with intercultural communication. The observations were carried out by the first author who actively participated in debates and working groups and volunteered at the day care centres. Interviews were conducted at the workplace of the interviewees. All interviews were transcribed.

Table 3.3 provides an overview of the analysed public documents that contained information about the development of local aged care provision relevant to older people, ethnic and cultural minorities, 'diversity', and vulnerable groups. We selected documents from 2014 onwards as these were prepared with a view to a large-scale transition to localism in the Netherlands which took effect in January 2015.

Table 3.3 Overview of policy documents

Nijmegen	Content of document	Year of publication
	Policy framework for the Social Support Act and the Youth Act 2015-2018	2014
	Response to proposal 'Divers is sterk' [*Diverse equals strong*], with an overview of policies and practices with respect to diversity developed by care and welfare providers	2017a
	Progress report about social neighbourhood teams and information and advice centres	2017b
	Health agenda 2017-2020	2017d
	Two documents on funding of basic welfare infrastructure 2017-2020	2017c, 2018
The Hague		
	Den Haag, seniorvriendelijke stad [The Hague, Age-friendly city] 2015 – 2018 Action program for policy	2015
	Conference report Bijzonder Dichtbij [Extraordinarily close] Interculturalisation of care and welfare in The Hague	2010
	Ageing trend monitor The Hague	2017, 2018a
	Reply to motion Interculturalisatie van de gezondheidszorg [Interculturalisation of healthcare]	2018b
	Policy plan welfare infrastructure 2015-2016	2015

Fieldwork was conducted over two years and the analysis was carried out as an iterative process. We began by focusing on the impact of localism but observed during fieldwork

22 In health and social care in the Netherlands, 'intercultural' is a term indicating responsiveness to cultural difference in understandings of sickness, health and care needs (see Mladovsky et al. 2012).

that assimilationism and the abandonment of target-group policies were equally pressing issues for stakeholders involved in care for older ethnic minorities in Nijmegen. As a result, fieldwork in The Hague and the subsequent analysis focused on the interaction between the policy trends of localism and diversity-mainstreaming in crafting practices. All interview transcripts, field notes and documents were coded using the software package *Atlas. Ti 8*. We conducted analysis drawing on the principles of grounded theory (Charmaz 2014), by first conducting a round of descriptive coding. Thereafter, we discussed the meaning of the most grounded codes and identified interesting topics. These were further explored through a review of literature on localism and diversity-mainstreaming policies. The review was followed by a second round of axial coding.

3.5 Diversity-mainstreaming: limitations and scope for crafting responses to the care needs of ethnic minority elders

Our findings show that Nijmegen and The Hague adapted a diversity-mainstreaming discourse in local policies and implemented it through organisational networks, public debates, and, in the case of Nijmegen, in contracting procedures. Apart from these initiatives, ethno-specific services like intercultural aged care advisers, day care, home care and residential care were offered. Some of these services can be traced back to policies targeting ethnic minorities, whereas others were established after the turn to assimilationism had already occurred. The history and development of these services are further elaborated in the following sections. Table 3.4 provides an overview of diversity-mainstreaming activities and ethno-specific service provision.

Table 3.4: Overview of service provision

City	Services targeting cultural, ethnic and linguistic minorities	Services centred on intercultural competence	Initiatives and organisations centred around notions of diversity
The Hague	Home care offered in different languages/multicultural profile Day care for Indonesian, Chinese, Turkish, Moroccan, Hindustani, and multicultural groups Residential care for Chinese, Dutch Indonesian, Moluccan, Surinamese, Hindustani and multicultural groups Co-housing for Chinese, Turkish, Surinamese, Surinamese-Creolean, Surinamese-Javanese, Hindustani, Antillean, Dutch-Indonesian and Moroccan groups	Intercultural aged care advisers (Cantonese, Berber and Arabic, Turkish)	Diverse City: Learning trajectory about super diversity in the city; Debates and events around diversity-mainstreaming of organisations; Pep Den Haag: Volunteer trainings on diversity
Nijmegen	Home care offered in Turkish; Day care for Indonesian and Turkish groups Meeting group for Chinese older people; Multicultural meeting group	Intercultural aged care advisers (Berber and Arabic, Turkish) Meeting group for frontline workers in health and social care working with older migrants with dementia Intercultural pool (volunteers assisting with linguistic and cultural interpretation)	Diversity café: Debates and events around diversity-mainstreaming of organisations

The mix of diversity-mainstreaming activities and ethno-specific services resembles findings from other studies of the implementation of diversity-mainstreaming at the urban level (e.g. Schiller 2015). However, this paper sheds new light on how this service mix was achieved. Our findings show that the mix of ethno-specific and diversity-mainstreaming was the result of deliberate crafting processes and reflected stakeholders' ongoing practical concern with existing diversity among ethnic minority elders. The following sections detail how diversity-mainstreaming initiatives and ethno-specific services were crafted, respectively. In particular, we pay attention to the crafting space and crafting tools provided by diversity-mainstreaming policies (or the lack thereof), and whether these facilitated or hindered local stakeholders to meet the care needs of older people from ethnic minorities.

3.6 Crafting diversity-mainstreaming policies and initiatives

3.6.1 Interpreting 'Diversity': from culturally sensitive to colour blind

Our analysis of municipal policy documents shows that 'diversity' was an often-used term when describing desirable outcomes within the policy domains of health and social care. However, the term eluded precise definitions and was differently interpreted in each municipality. In Nijmegen, "cultural sensitivity" was used in tandem with 'diversity' in policy documents relevant to aged care from 2015 onwards. Policy officers used these terms both to encourage mainstream providers to be inclusive and to create space for ethno-specific services. To the latter end, the term "culturally sensitive working" was included as a contracting criterion for all services. "Culturally specific providers and products" (Municipality of Nijmegen 2017a), which in this paper are referred to as ethno-specific services, were also mentioned as included in a broader strategy to meet diverse care needs and preferences in the provision of home and day care.

In Nijmegen, ethno-specific services were partly framed as a response to the care needs of vulnerable groups. For example, mental health issues of older migrants are identified in the health agenda for 2017-2020 (Municipality of Nijmegen 2017d), and challenges to reach migrant family carers are mentioned in the policy for social support and youth (Municipality of Nijmegen 2014). However, ethnic minorities were not only marked as 'diversity-relevant' (Dobusch 2017) because of specific vulnerabilities but also because of diverse preferences. A policy officer responsible for day care provision in Nijmegen pointed out that the municipal strategy was to "provide something for every taste"; whether that was a day care in the Turkish language or the provision of social groups for highly educated men. As such, policy formulation in Nijmegen allowed space for a variety of service provision in affirmation of diversity associated with different life experiences.

Because of its historically large migrant populations, many ethno-specific services targeting different minority groups existed in The Hague at the time of the study. Most likely, they were still included because the responsibility for contracting lied outside the responsibility of policy officers in the domain of older people and diversity. The contracting of ethno-specific services conflicted with the long-term policy aim of diversity-mainstreaming of all services. In our interview, the policy officer stressed that ethno-specific services received little political support and that the municipality wished that these services would disappear over time:

> "If we have any influence, then we do not support it [ethno-specific services] financially. I also understand that you see initiatives that emerged long ago before this [diversity] was a topic. It would be logical that that knowledge can stream back into the broader health and social care network" (policy officer The Hague).

Nevertheless, the policy officer acknowledged the care needs of clients of ethno-specific organisations, and the expertise required to meet them:

> "You have a care home for Chinese residents here in the neighbourhood, and the care home staff definitely have a lot of knowledge and can provide quality care for that target group (I should not say target group). How they can provide good care, that is, of course, knowledge that you can use if you want to work more inclusively" (policy officer The Hague).

While the policy officer highlighted the local knowledge within ethno-specific services as a key to inclusive service provision, she did not articulate how such knowledge might be transferred into regular services. The recognition of ethnic minority elders' care needs paired with a lack of concrete plans for how these needs should be met without specific services can also be identified in policy documents. In a municipal report on older populations (Municipality of The Hague 2018a) older people "with a migrant background" are reported to have a high risk of depression, low satisfaction with housing and relatively low use of institutional care. While older minorities are framed as a group subject to health inequalities, vulnerability is only described as 'social, economic and health' related in a municipal report on older populations (Municipality of The Hague 2018b: 20).

The abstract and individualised approach to difference and inequality reflects colour-blind approaches found in Dutch youth work (de Koning and Ruijtenberg 2019). In the report, there were no recommendations to address inequalities experienced by ethnic minorities. The municipality of The Hague thus closely monitored ethnic minority groups without formulating approaches to address racial or ethnic inequalities. Westerveen and Adam (2019) use the term "monitoring the impact of doing nothing" to describe a similar phenomenon at the national level in the Netherlands, where challenges concerning ethnic minorities are hardly mentioned in general policies, while the performance of different ethnic minority groups on social indicators is regularly monitored. We thus find that the interpretation of the diversity-mainstreaming rhetoric limited the space to address health inequalities experienced by ethnic minority elders in The Hague.

An example of how diversity-mainstreaming policies limited the scope to address inequality can be found in the response to a motion to the local parliament to extend intercultural health care to address ethnic health inequalities. The mayor and the municipal executive board responded that health and social care professionals are "aware of the existence of all forms of diversity and act inclusively and sensitively" (Municipality of The Hague 2018a: 2) and denied the need for more intercultural services.

To summarise, we found, like Dobusch (2017), that the term 'diversity' was differently employed across municipalities. Local interpretations allowed for tailoring of services to ethnic minorities in Nijmegen but limited the scope for action in The Hague. This

difference in interpretation might result in spatial inequality in terms of access to culturally sensitive service provision (Cioubanu 2019).

3.6.2 Is too much space for interpretation inhibiting action?

The vagueness of 'diversity' did not only make for uncertain outcomes in municipal policy formulation. It also made it difficult to set aims in terms of concrete outcomes of diversity-mainstreaming activities organised by the municipalities. Both municipalities had launched organisational networks, staff and volunteer training trajectories, public debates, and professional meeting groups on the topics of diversity and cultural sensitivity. Because 'diversity' was loosely defined, we found that it was difficult for policy officers and managers of the diversity-mainstreaming networks to stimulate organisations participating in the activities to take concrete action.

Diverse City, an organisational network led by experts, regularly put diversity "on the agenda" via debates and staff training. However, policy officers encountered resistance when they suggested that member organisations would commit to embedding "diversity-sensitivity" in their quality frameworks:

> "At some point, I asked 'shall we focus more on access? Access to care is on the political agenda, and there is a concern with the question of how we improve access? Can't we embrace this as Diverse City to show what older people really need?' But that was not received very well over there. They did not want to single out [specific issues] and were more interested in showing that it is normal to look through a diversity lens" (former policy officer The Hague).

Because of the unwillingness of participating organisations and the organisers to undertake specific actions, the policy officer felt that the diversity network had a limited impact on ethnic and racial inequity regarding access to care. This concern was shared by a senior adviser of an organisation supporting inclusive voluntary work, who worried that some member organisations of Diverse City considered diversity-sensitivity to be a 'theoretical rather than practical' issue. A board member of Diverse City agreed that some organisations failed to act but felt that participation in the network still triggered a continued discussion about diversity with the organisational boards. We encountered different interpretations among our interviewees of the long-term effect of the network. Overall, our findings confirm that the degree to which diversity-mainstreaming leads to concrete action hinges on the commitment of individual organisations (Tandé 2017).

Our study does not evaluate the impact of diversity-mainstreaming initiatives on access to aged care for minority elders. However, what we do find is that the diversity-mainstreaming initiatives can limit the discursive scope to undertake action to increase equity of access to aged care. The former policy officer, who generally was in favour of

mainstreamed rather than ethno-specific care provision, pointed out the tension between the aims and the implementation of the diversity network:

> "You want to show that it is something very normal, it is very normal to be culturally sensitive. But at a certain point, it becomes so flat, that it is not much of anything anymore. You cannot even use the word 'culture' anymore. Then it becomes 'diversity'" (former policy officer The Hague).

What this quote points out, is that 'diversity' can render difference unspeakable and thereby hinder actors to address social inequalities.

In contrast to findings on youth care (Nieswand 2017; de Koning and Ruijtenberg 2019) colour-blindness was not common in the practices of the interviewed frontline workers. However, the discourse of colour-blindness did influence the public debates regarding service provision for ethnic minority elders. In Nijmegen, we followed a diversity-mainstreaming activity called the Diversity café. The Diversity café was a public bi-monthly event for professionals in health and social care. At one of the events, the topic was how to "diversity-proof" aged care, and representatives from mainstream and an ethno-specific organisation were invited to the discussion panel. In the debate, it was clear that despite the crafting space that the policies in Nijmegen provided, ethno-specific services remained politically sensitive. Representatives from the mainstream organisations defined diversity as a "space to be different but on an equal level". They also stated that; "no one should choose MultiCare (an ethno-specific provider) because they don't feel welcome elsewhere", propagating for inclusive services (field notes October 2017). However, there was no mention of how mainstream organisations worked to make their activities inclusive for minority elders. To fit within the diversity-mainstreaming frame, the ethno-specific organisation argued that they sought to meet the client's individual needs, particularly the need for care in the client's language. However, there was little mention of positive needs of minority elders, such as belonging and recognition.

The examples from Diverse City and the Diversity café highlight the tightrope that the diversity-mainstreaming discourse asks organisations, frontline workers, and municipalities to walk when crafting practices. One might expect that the normalisation of (cultural) diversity would lead to service provision that accommodates a broader range of cultural preferences and linguistic needs. Instead, the diversity-mainstreaming discourse in The Hague obstructed actions targeting inequality of access caused by linguistic or cultural diversity. In Nijmegen, the need for belonging and meaningful activities went unrecognised in discussions of diversity-proof care. Instead, tailored services were justified by the poor Dutch language skills of older labour migrants, an argumentation which reoccurred in our interviews with all actors. Our findings thus confirm the paradox of 'diversity' as identified in the literature review: simultaneously, it provides and limits the scope for action. In

addition, our study highlights how, in the case of aged care, this implementation paradox can cause actors to fail to recognise the full spectrum of care needs of ethnic minority elders, an issue which resurfaces in the crafting of ethno-specific services.

3.7 Crafting ethno-specific services within a diversity-mainstreaming discourse

3.7.1 Diversity-relevant care needs?

The existence of ethno-specific day and home care cannot be traced back to a bygone multicultural policy area in neither Nijmegen nor The Hague. Indeed, the ethno-specific care organisations in our research (Carlsson, Pijpers and van Melik 2020) and also in the research of Kremer (2019), which focuses on The Hague, have only existed for a decade. These organisations were established by local ethnic minority (notably Dutch-Turkish) entrepreneurs, with a professional background in healthcare, who wanted to provide appropriate care for ageing community members. Some of them had also been active in local politics or ethnic minority self-organisations and were aware that they needed to position themselves as relevant in a changing policy landscape. In interviews with two managers of such organisations, both stated that they had had to negotiate the necessity of their existence. The manager of one of the ethno-specific day and home care organisations explained that:

> "Along the way, we have made our point to several institutions, among which the municipality, that for some target groups you can't just assume that 'yes, your needs will be met by any day care, but no, that requires specific attention and knowledge.'" (manager ethno-specific day and home care organisation with multicultural profile).

The manager of an ethno-specific care organisation in The Hague echoed the experiences of managers in Nijmegen. She told us that her organisation was met with suspicion in the beginning. It was only after some time that the municipality recognised that "you are really good at reaching the target groups that we don't know how to reach". The expertise and skills within these organisations in reaching minority elders was an important reason as to why they were included in the provision structure (policy officer Nijmegen).

Even though some of these organisations effectively provided care to clients with the same ethnic background, they were marketed in a more general way, e.g. as having expertise in a client's language and culture. As a result, they were known to be culturally specific rather than ethno-specific organisations. A quote from a manager in Nijmegen highlights how crafting ethno-specific practices required them to frame their organisation within a diversity-mainstreamed discourse:

> "We are doing target group policy now, but it should not be a structural process. In a longer-term perspective, in 10 to 15 years, it must lead to a regular provision, that is an ideal that we have (...) we mirror society, that is our vision" (manager ethno-specific day and home care organisation with multicultural profile).

The framing of ethno-specific care as a temporal solution for older people with limited Dutch language ability was echoed by policy officers too (policy officer Nijmegen, September 2017). In crafting ethno-specific care practices, both healthcare managers and policy officers drew on an assimilationist framing, which assumes that language barriers are the only reason for ethno-specific meeting services and that such barriers, in all likelihood, will disappear as most second-generation labour migrants speak Dutch better than their parents. No reference was made to emerging ethnic and cultural minorities, such as late-in-life migrants coming through family reunification or as refugees.

Frontline workers in ethno-specific day care also referred to linguistic needs when framing the need for their services. A coordinator of day care activities pointed out how the weak language skills made the Chinese group dependent on ethno-specific services. Interestingly, this argument was also used by a frontline worker who worked with a Hindustani day care group where most clients spoke fluent Dutch. Day care and meeting activities are known to facilitate a sense of belonging, create a space free from exclusion, and to lower the threshold to other, mainstream services (Patzelt 2017; Carlsson, Pijpers and van Melik 2020). Although a sense of belonging and the accommodation of different preferences were mentioned both by a coordinator of day care in Nijmegen and by the manager of the ethno-specific home care organisation in The Hague, these arguments did not appear in the studied policy documents or the observed public debates. Ethnic minority elders were thus primarily framed as diversity-relevant on the basis of vulnerability and/or special needs, rather than in affirmation of a diverse set of preferences and lifestyles.

3.7.2 Local knowledge

Bannink, Bosselaar and Trommel (2013) argue that in a localised policy context, the knowledge and expertise of the local crafting community constitute a necessary tool to craft an appropriate response to local crafting challenges. In our study, all actors considered local knowledge and ties with local minority communities, contained in ethno-specific services, to be a key crafting tool. In this section, we will unpack how the framing of these services might undermine the role of local knowledge and networks as crafting tools, and how the different actors responded to this paradox.

Our first example of how actors rely on local knowledge to reach out to ethnic minorities concerns the work of intercultural aged care advisers. In both Nijmegen and The Hague, frontline workers with intercultural competence, and who speak the languages

of the largest minorities, provided aged care advice across the city (interviews intercultural aged care advisers Nijmegen 2017, The Hague 2019). These intercultural aged care advisers were available for appointments and walk-ins at several information and advice centres in neighbourhoods with a high proportion of minorities. Also, intercultural aged care advisers were available to support generalist frontline workers when they struggled to communicate with clients. Our earlier research shows that they play an important role in lowering the threshold of information and advice centres as well as other forms of aged care services for minority elders (Pijpers and Carlsson 2018).

In The Hague, intercultural aged care advice received less support than in Nijmegen, but the service was still described as part of the strategy to reach older minorities in policy documents (Municipality of The Hague 2018). Paradoxically, a manager of welfare providers in The Hague argued that while the policy is to "not focus on minority groups" this particular intercultural service, which was a remnant from the multicultural policy era (Helberg-Proctor et al. 2017) had gained importance with the growth of the population of older migrants. While acknowledging the high demand for intercultural aged care advisers, the manager expressed unease about the conflict between diversity-mainstreaming policy and continued multicultural service provision, similar to the findings obtained by Schiller (2015).

In Nijmegen, the introduction of intercultural aged care advisers constituted a more recent response to the failure of social workers organised in multidisciplinary 'social neighbourhood teams'[23] to reach minority populations. A policy officer in Nijmegen explained that:

> "When we didn't have target groups anymore and were in the phase of social neighbourhood teams and inclusion and person-centred care, we thought that all would be solved within that vision, but at a certain point we realised that it was not enough" (policy officer, Nijmegen).

We found that intercultural aged care advisers played an important role not only in direct work with minority elders but also in consulting generalist social workers. An aged care adviser in The Hague explained that intercultural aged care advisers were called in both to mediate with clients and to assist them and others in connecting to "hard to reach" communities:

> "We have a Turkish, Moroccan and Chinese aged care adviser available for those target groups and works Hague-wide. And indeed, there are cases where we notice that they let me in, but they do not tell me everything and they are not at ease. Then you ask yourself, gosh, is something else possible? Then we get in touch [with the intercultural aged care adviser] and ask, hey, can you get involved?

23 For a more detailed account on social neighbourhood teams in the Netherlands see Arum and van den Enden (2018) and van Zijl et al. (2019).

> But also, in situations when we notice that we cannot make enough contact with a certain target group" (intercultural aged care adviser The Hague).

From this description, we see that intercultural aged care advisers facilitate connections between clients and mainstream providers, and between communities and health and social care provision. Intercultural care advisers framed themselves as a source of expertise regarding how to connect and mediate between minority elders and mainstream providers. Similar to the managers of ethno-specific care organisations, intercultural aged care advisers felt the need to justify their roles in the current policy context:

> "I agree that if you only provide support in the client's language, then you do not support independence, then they become dependent. But, if you come to good agreements, we are going to stimulate these people to become independent (...) then you have to make good agreements with the policy officer and the municipality, like, hey I give money, subsidies, not only to solve problems for Chinese people, but to solve the problem together with the Chinese, and to stimulate that they can solve the problems independently in the long term, or come with their issues themselves to Dutch organisations" (intercultural aged care adviser The Hague).

The above quote illustrates how the intercultural aged care advisers engage in crafting practices by arguing for the need for their services and framing them in a way that fits the diversity-mainstreaming framework. Although most frontline workers in regular services mentioned intercultural aged care advisers as a source of expertise that they relied on to reach out to ethnic minority elders, there were only two and three advisers in Nijmegen and The Hague, respectively. Several of them struggled to manage the client load. The limited availability of intercultural aged care advisers carried the risk that not all citizens receive the support they need to access care and, secondly, that intercultural aged care advisers become overburdened. Since the population of older ethnic minorities is growing and diversifying in both cities, these problems are unlikely to diminish.

3.8 Conclusion and discussion

This paper investigated how diversity-mainstreaming policies in aged and social care providers may affect the scope for local policymakers and health, aged and social care managers and frontline workers to address the care needs of older people from ethnic minorities. The existing literature concerned with older migrants and/or older people from ethnic minorities, with few exceptions (Bolzman et al. 2004; Ciobanu 2019), has not drawn connections between policies relevant to older migrants/ethnic minority populations and policy implementation, particularly at the municipal level of aged care provision. As such,

our study contributes to closing this knowledge gap and responds to a call of the field for research to focus on how policymakers and practitioners can better meet the needs of minority elders (Torres 2019).

In addition to informing research on aged care for ethnic minorities, our paper contributes to scientific debates on how diversity-mainstreaming is implemented at the municipal level. In the Urban Studies literature on national and local integration policies, it is often assumed that partial implementation of diversity-mainstreaming policies reflects pragmatism and/or friction between local and national policy (Schiller 2015). By applying analytical concepts from Public Administration, this paper provides further insight into the process of implementing diversity-mainstreaming policies at the municipal level. We found that diversity-mainstreaming policies allowed local stakeholders to craft a mix of diversity-mainstreaming and ethno-specific services in response to ethnic minority elders' care needs. Considering the existing literature on older ethnic minorities' use of care and services, continued provision of some ethno-specific services paired with a call for diversity-sensitivity within all services can be considered a positive development. However, we also found that diversity-mainstreaming policies were riddled by two related implementation paradoxes which impaired their ability to facilitate inclusive services, particularly in a long-term perspective.

Because of vagueness of terms, the 'crafting space', that is the political empowerment that diversity-mainstreaming policies grant, highly depends on local interpretation. Therefore, we found 'diversity' to both inhibit and enable concrete action. When the interpretation of 'diversity' did provide crafting space, we encountered a second implementation paradox caused by the connection between diversity-mainstreaming policies and assimilationist assumptions. To craft services in response to the care needs of ethnic minority elders, we found that stakeholders found it necessary to frame ethnic minority elders to deserve specific services primarily because of problems they were assumed to be facing (Torres 2006), such as a lack of Dutch language skills. Underpinned by assimilationist assumptions, these services were framed as temporary solutions, rather than responses to long-term shifts in the ageing population. This was despite both the persistent demands for these services, and the literature showing that culturally appropriate services facilitate feelings of belonging and meet social needs, and facilitate care navigation (Ahaddour et al. 2016; Carlsson, Pijpers and van Melik 2020). We therefore argue that even when diversity-mainstreaming policies provide crafting space to meet current care needs, the assimilationist framing the diversity discourse elicits leads to the withdrawal of investment in ethno-specific services and intercultural expertise which represent local knowledge and networks. As a consequence, diversity-mainstreaming policies undermine the crafting tools necessary to achieve the inclusion it purports to achieve, particularly in the long term.

Older populations in Europe are becoming increasingly culturally and linguistically diverse (Ciobanu et al. 2017; Brandhorst, Baldassar and Wilding 2021). To address existing health inequalities and to make future care provision more inclusive, we argue that ethnic minority care needs warrant a more positive framing in local policy discourse and implementation. The migration background of ethnic minority elders can be understood as a source of meaning-making, community involvement, and quality of life, to be supported by a combined offer of ethno-specific, intercultural, and mainstream services. We suggest that policymakers take a more positive approach to the diverse cultural, linguistic, and ethnic preferences of older people. Affirming differences, including but not limited to ethnic background, constitute a more future-oriented governance response to the growing diversity of local ageing populations.

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CHAPTER 4

WORKING TOWARDS HEALTH EQUITY FOR ETHNIC MINORITY ELDERS: SPANNING THE BOUNDARIES OF NEIGHBOURHOOD GOVERNANCE

This chapter has been published as Carlsson, H. and R. Pijpers. 2021. "Working Towards Health Equity for Ethnic Minority Elders: Spanning the Boundaries of Neighbourhood Governance." *Journal of Health Organization and Management* 35 (2): 212-228 in a special issue titled *Boundary Organising in Health Care*. A previous version of this chapter was presented at the 2020 Organisational Behaviour in Health Care Conference (online), where it was awarded the OBHC 2020 Liz West Best PhD Paper Award.

4.1 Introduction

Neighbourhood governance of public services is popular among policymakers as a means to improve access to, and delivery of, public services (Bailey and Pill 2011; Kennett and Forrest 2006). Neighbourhood governance can be defined as "collective decision making and/or public service delivery at the sub-local level" (Lowndes and Sullivan 2008: 62). Although neighbourhood governance is increasingly common, there is disagreement among scholars about whether it is an effective way to address the disadvantages experienced by minority populations (MacLeavy 2008). One structural disadvantage that older ethnic minority populations are disproportionately subject to is health inequity. "Health equity" has been defined as the absence of systematic disparities in health between groups with different levels of social (dis)advantage (Braveman and Gruskin 2003). To achieve health equity, the care system must be designed in a way that addresses differences in access to, and availability of, services between disparate groups and differences in the utilisation and appropriateness of services for these groups (Ellencweig and Grafstein 1986). Neighbourhood governance can potentially increase health inequities within and between neighbourhoods (Bailey and Pill 2011; Lowndes and Sullivan 2008). Research shows that although interventions like neighbourhood governance, which target the general population rather than disadvantaged groups, might increase equality of access, they do not necessarily increase equity of access (Blacksher 2012). However, it has been found that neighbourhood governance of social care allows local authorities and frontline workers to tailor service provision to local needs, thereby increasing the utilisation and appropriateness of services (Bartels 2017; Durose 2009). Neighbourhood governance might thus both hamper and improve health equity.

There has so far been limited research on how neighbourhood governance affects (in) equity in access and use of social care services. This paper begins to address this gap by drawing on empirical material from two Dutch case studies on neighbourhood governance of social care. We answer the question of how neighbourhood governance of social care affects the scope for frontline workers to address the health inequities experienced by ethnic minority elders in their daily work.

To analyse our data, we draw on a relational approach to place, which is often used in Health Geography (Featherstone et al. 2012; Hall and McGarrol 2013). Researchers taking a relational approach to place emphasise socio-relational rather than physical distance between people and services. We argue, similar to Jupp (2013) and Smith et al. (2016), that a relational approach to place is an appropriate lens to look at frontline workers experience of working in neighbourhood settings because it assists the researcher in capturing the dynamics between residents and service providers. By analysing our data through this relational perspective, we identify social and cultural distances to social care

as a reason for low access and utilisation of services and understand efforts to bridge these distances as 'relational work'.

The Netherlands constitutes a suitable context for this study since social care for older people became the responsibility of municipalities in 2015 as the consequence of localisation. As a result, many municipalities adopted neighbourhood governance of social care (van Arum and van den Enden 2018). Compared to older people from the Dutch majority population, ethnic minority individuals experience more health problems (Suurmond et al. 2016; Verhagen 2015). Despite this fact, ethnic minority elders and their families make relatively little use of health and social care services in comparison with older people from the white Dutch majority population (Suurmond et al. 2016). The relatively low use of care services has been linked to a range of factors, including language barriers, limited knowledge about services, a lack of trust in services, and a lack of culturally appropriate services (Carlsson, Pijpers and van Melik 2020; Koehn 2009). The higher level of ill-health experienced by ethnic minority elders is not just a matter of low use of services, but also, or perhaps in the first instance, of socioeconomic disadvantage (Braveman and Gruskin 2003; Brotman 2003; Corburn et al. 2015). We know ethnic minority elders constitute a diverse population (Torres 2019); and that not all of them face the same barriers to access and use care (Koehn 2009). Also, we realise that the use of the term 'ethnic' is performative (Torres 2019) and may serve to reinforce ethnic lines while downplaying other explanations (linguistic, religious) for why the aforementioned barriers to health access persist. However, we have chosen to address ethnic minority elders as one population because low use of services is likely to deepen already existing health inequities caused by socioeconomic disadvantage.

This paper proceeds as follows. We start with a short introduction of neighbourhood governance of social care in the Netherlands. Next, we critically review the literature on neighbourhood governance in relation to health equity. Drawing on a relational approach of place, notably the notions of 'relational work' and 'boundary-spanning', we unpack possible opportunities and limitations of neighbourhood governance in this respect. Through the notion of 'moral conversations,' we also discuss the equity and social justice implications of a relational approach to place. Thereafter, we discuss our research methods. This is followed by a presentation of our findings, which moves from concrete opportunities and limitations that neighbourhood governance offers in overcoming the social and cultural distance with ethnic minority elders to examples of health equity considerations in these practices. We conclude by summarising how a relational approach to place provides a better understanding of the, often unacknowledged, relational work of frontline workers. We lastly reflect on the role of moral deliberations in the practices of frontline workers working towards greater health equity and suggest implications for research and policy aimed at achieving greater, non-ideal social justice.

4.2 Neighbourhood governance of health and social care in the Netherlands

In the Netherlands, similarly to the UK and Germany, recent models of neighbourhood governance are based on the idea that neighbourhoods are 'viable, recognisable units of identity and action, and are therefore the appropriate locus for the planning and delivering of a range of services and activities' (Chaskin 1998: 11, see also Lowndes and Sullivan 2008; Engelmann and Halkow 2008). While modes of neighbourhood governance have existed in the Netherlands since the 1970s (de Boer and Van der Lans 2013), in recent decades a new neighbourhood focus has developed alongside a wide-reaching decentralisation of public services. In 2015, following the implementation of the Dutch Social Support Act, responsibilities for policymaking and implementation in social care were transferred from the state to local governments, when it came to personal assistance for individuals and families, day care, and outreach and prevention work. Home and mobility aid were already a municipal responsibility.

Health care services such as home care and primary health care are not funded by the local government and are not usually part of neighbourhood policies. Some local governments, however, have encouraged the development of integrated services at the level of neighbourhoods and in rural areas, supporting older neighbourhood residents who live independently (Pijpers, De Kam and Dorland 2016; van Dijk, Cramm and Niebor 2016). In Nijmegen and The Hague, which were the subjects of our multiple case study, the local authorities stimulated collaboration between health and social care through day care contracting. Neighbourhood governance in Dutch social care is usually applied at the city district level, which is comprised of multiple neighbourhoods (or at the level of a rural municipality, comprising of multiple villages). In The Hague, city districts have between 40,000 and 60,000 residents, with two districts reaching 100,000 residents; in Nijmegen, a medium-sized city, city districts have between 10,000 and 40,000 residents.

4.3 Neighbourhood governance and health equity: a relational place approach

Neighbourhood governance is popular among policymakers as a tool to address problems of disadvantaged areas (Bailey and Pill 2011; Kennett and Forrest 2006; Lowndes and Sullivan 2008). However, it has been strongly criticised by researchers concerned with social justice. Levitas (2012), Papanastasiou (2017), and Andreotti et al. (2012) find localism unjust since it moves the responsibility for health inequalities from the state to local authorities, who have limited ability to tackle underlying structural inequalities. In the Netherlands, the risk that neighbourhood governance will increase inequality is

compounded by the fact that localism has been coupled with austerity measures in the last decade, similarly to the UK (Bailey and Pill 2011; Janssen et al. 2016).

Besides the issue of whether the shift of responsibility from the state to local authorities through neighbourhood governance is just, researchers question whether neighbourhood governance is effective. In a review of area-based approaches in Europe, van Gent et al. (2009) conclude that for area-based interventions to be the most effective, there is a need for a critical representation of the population group, e.g., poor and socially excluded individuals that such interventions target, in that area. However, most European cities do not meet this criterion, limiting the effectiveness of these interventions (van Gent et al. 2009).

Furthermore, a person's proximity to a service does not necessarily make it more accessible. To assume that location is the defining factor mirrors a 'conventional' understanding of the place (Cummins et al. 2007). An emphasis on physical distance can be contrasted with a relational approach to place increasingly common among human geographers studying the connections between health and place in policies and service provision (Andrews, Evans and Wiles 2013; Clarke 2013; Hall and McGarrol 2013; Jupp 2013; Rosenberg 2014). An overview highlighting the differences between a conventional notion of place can be found in Table 4.1, adapted from Cummins et al. (2007: 1827)

Table 4.1 Conventional versus Relational view of place

'Conventional' view	'Relational' view
Spaces with geographical boundaries drawn at a specific scale	Nodes in networks, multi-scale
Separated by physical distance	Separated by socio-relational distance
Resident local communities	Populations of individuals who are mobile daily and over their life course
Services described in terms of fixed locations often providing for territorial jurisdictions, distance decay models describe varying utility in space	'Layers' of assets available to populations via varying paths in time and space. Euclidian distance may not be relevant to utility
Area definitions relatively static and fixed	Area definitions relatively dynamic and fluid
Culturally neutral territorial divisions, infrastructure, and services	Territorial divisions, services and infrastructure imbued with social power relations and cultural meaning
Contextual features described systematically and consistently by different individuals and groups	Contextual features described variably by different individuals and groups

As Table 4.1 highlights, researchers taking a relational approach understand place to be "continually produced through interaction" (Clarke 2013: 499). In this paper, we follow Jupp (2013) and study social care from a relational place perspective. From this perspective, implementing neighbourhood governance of social care requires frontline workers to

tie people and places of service provision closer together. Access to care is facilitated through the bridging of the social distance and difference in cultural meanings and ideas between services and potential users (Cummins et al. 2007). To make services not just physically proximate but also close in the relational sense, professionals need to foster professional and informal networks (Stoopendaal 2015) and mobilise communities (Bartels 2017; Durose 2009; Tonkens and Verhoeven 2019; van Dijk, Cramm and Niebor et al. 2016) in addition to reaching out to individual neighbourhood residents. In this paper, we conceptualise actions aimed at improving access to services by bridging the relational distance between residents and service providers 'relational work'.

On the one hand, relational work highlights the naivety of the (conventional place) assumption that physical proximity will automatically result in meaningful bonds between neighbourhood residents and local public servants (Oldenhof, Potsma and Bal 2016). On the other hand, research shows that neighbourhood governance can enable relational work (Bartels 2017; Durose 2009; Jupp 2013). For groups that experience social and cultural distance to services, neighbourhood governance can, therefore, be an effective way of addressing one cause of health inequity: differences in the utilisation and appropriateness of services (Braveman and Gruskin 2003, Ellencweig and Grafstein 1986). The following sections unpack the existing literature to examine how neighbourhood governance can benefit minority residents with a large social and cultural distance to services.

4.3.1 Relational work in neighbourhood governance

One advantage of neighbourhood governance of health and social care is that it can provide frontline workers with the opportunity to use their contextual and local knowledge to reduce the social and cultural distance to services that population groups face in their area. Durose (2009) investigated how frontline workers adopted policies aimed at health improvement in neighbourhoods in the British city of Salford. She found that frontline workers adapted health improvement policies to include initiatives targeting financial exclusion, as they found that this was a major cause of ill-health. In a study of exemplary practitioners in neighbourhood governance in the Netherlands, van Hulst, de Graaf and van den Brink (2012) similarly found that the neighbourhood governance approach allowed frontline workers to use their understanding of local problems and to tailor services to address these problems in disadvantaged neighbourhoods.

The study by van Hulst de Graaf and van den Brink (2012) highlights how relational work involves translating local knowledge to policy officers of the local government and managers. As such, relational work involved "boundary-spanning". Drawing on Steadman (1992), van Hulst, de Graaf and van den Brink (2012: 439) define boundary-spanning as "building alliances between people in different (sub-) systems". To achieve this, they found that the frontline workers needed to be "both knowledgeable of and credible to people on different sides of the boundaries. They must be aware of norms – formal and informal

– of both systems, as well as of the operations and organisational politics" (van Hulst, de Graaf and van den Brink 2012: 439). Durose and Lowndes (2010: 356) draw further attention to the "multi-level and multi-actor governance environment" of neighbourhood approaches. Although neighbourhood governance takes place within the geographical and administrative boundaries of a neighbourhood, the work is shaped by "policy shifts and resource dependencies" (Durose and Lowndes 2010: 356) at other levels.

While boundary-spanning was possible in the aforementioned studies, it relied on the efforts of 'exemplary practitioners' (van Hulst, de Graaf and van den Brink 2012). The working methods of exemplary practitioners often defied common working practices, which could render them unpopular in their organisations. Bartels (2017) found that neighbourhood workers who used their local knowledge to engage in innovative work encountered resistance from managers and the local authorities in a city district in Amsterdam. Managers focused on quantitative outputs (e.g., participants in neighbourhood initiatives) and therefore lacked appreciation for the relational work required to mobilise residents faced with large distances to services (Bartels 2017).

The undervaluing of the relational work required to make neighbourhood governance a success (Bartels 2017), was echoed by Tonkens and Verhoeven (2019). They found that relational work that enabled citizens to participate in activities in deprived neighbourhoods became invisible in a system, which still focused on quantitative outputs. Another barrier to relational work is that it is time-consuming. Van Dijk, Cramm and Niebor (2016) who investigated a neighbourhood-based intervention of integrated care found that relationships with older people were person-specific and not easily transferred to other community workers. Frontline workers found that it took an entire year to "get a grip on the neighbourhood" (van Dijk, Cramm and Niebor 2016: 9) and to begin to implement integrated care. When neighbourhood governance is paired with austerity measures, like in the case of The Hague and Nijmegen, there is a risk that frontline workers lack the time needed for relational work, which is integral to the success of neighbourhood governance.

4.3.2 Relational work and situational justice

In addition to improving access to care, research shows that relational work can include moral conversations about care provision (Maynard-Moody and Musheno 2012). We believe that moral conversations embedded in the relational work of frontline workers might be part of such a movement towards non-ideal social justice, in the form of greater health equity. Moral conversations are conversations around normative issues in which stakeholders discuss experiences and come to new understandings of what could be reasonable to do (Edwards 2011; Maynard-Moody and Musheno 2012). Edwards (2011) argues that moral conversations may emerge in boundary-spanning settings, which they term boundary spaces. A precondition for moral conversations in boundary spaces is that the local organisational work culture enables relational work rather than leaving moral

judgements to individual frontline workers (Maynard-Moody and Musheno 2012). If this precondition is met, these conversations allow frontline workers to identify possibilities for greater health equity.

To reconcile this suggestion with the widely shared idea that localism is unjust (see above), we follow Levitas (2012: 332), who contrasts her own critique with a 'hermeneutics of faith' (based on Ricœur 1981), "an attempt to restore meaning to a narrative and its different voices and silences". For Levitas, the many citizen initiatives and self-organisations flourishing at the local level present just such alternative meanings. In the present study on neighbourhood governance, we argue that moral conversations in relational work offer alternative meanings and create opportunities for 'situational' social justice (Blacksher 2012; Bridge 2019; Meurs 2016). Situational justice is an emerging theory of social justice that conceptualises greater (health) equity as a process of local interaction around normative issues. The 'situational' in "situational justice" refers to specific situations requiring moral conversations: in which, in this case, frontline workers, align experiences, perspectives, and discuss possible solutions (Bridge 2019). Moral conversations in such situations are constitutive of justice (Bridge 2019).

As a so-called non-ideal social justice theory, situational justice posits that greater justice is more preferable as a goal than full equality or equity (Rosenberg 2014). Non-ideal, situational social justice takes seriously the call to represent the ideas and needs of targeted population groups (Blacksher 2012, Corburn et al. 2015, Meurs 2016), and is "radically open to new bases of support and aimed at building effective coalitions between different social movements and organisations" (Soja 2010: 23; Rosenberg 2014). Further, this justice movement is remedial as well as anticipatory, i.e., does not only address existing issues but is also oriented towards understanding future and yet unknown manifestations and dynamics of inequity (Powers and Faden 2006 in Blacksher 2012).

4.4 Methods

The research activities were framed by a multiple case study design. We chose Nijmegen and The Hague because they represent a medium-sized diverse and a large super-diverse urban context, respectively (Jennissen 2018). However, we were more interested in understanding how the practices of frontline workers converged and diverged, than in tracing similarities and differences back to these parameters.

Together, the cities offer many insights into practices of reaching out to older ethnic minorities. We studied local support structures and services which, during fieldwork, emerged as relevant in terms of reaching out to older ethnic minorities. We collected data using participant observation (295 hours) and semi-structured interviews (44) from June 2017 to June 2019. Table 4.2 provides an overview of the organisations, networks, and places in the two cities where observations and interviews were conducted.

Table 4.2 Overview of fieldwork activities

Nijmegen	Organisation	Nr. of observations	Staff interviews
	Day care provider with multicultural/ Islamic profile	27* 3 hours	Day care coordinator Operational manager Muslim chaplain Manager
	Day care provider with Turkish profile	6*5 hours	Activity leader Day care centre coordinator
	Day care provider with Indonesian group	6*7 hours	Day care centre coordinator
	Information and advice centre	8*2,5 hours	Aged care adviser Coordinator Supervisor/coach
	Diversity café	5*3 hours	
	'Netwerk 100' Working group: Dementia and older migrants	4*3 hours	Intercultural adviser District nurse elder care (2) Adviser diversity and informal care Muslim chaplain
	Expert group older migrants (facilitated by mainstream welfare organisation)	5*3 hours	
	Mainstream welfare organisation		Coordinator of pool of intercultural advisers Project leader municipal platform day care organisations
	Social neighbourhood team		Team leader
	Municipality of Nijmegen		Policy advisers (3) Contract manager
		Total: 215	Total: 22
The Hague	**Organisation**	**Nr. of observations**	**Staff interviews**
	Day care provider with groups with Hindustan, Javanese, and Chinese profile	5*6 hours	Day care coordinator Manager
	Culturally specific day care group with Hindustan profile	6*7 hours	Day care coordinator
	Home care organisation with multicultural profile		Manager
	Diverse City	2 hours	Board member Director Teacher learning trajectory
	Volunteer support organisation	4 hours	Adviser

Table 4.2 Continued

The Hague	Organisation	Nr. of observations	Staff interviews
	Chinese self-organisation The Hague	2 hours	Intercultural aged care adviser
	Home care provider with multicultural profile		Manager
	Mainstream long-term care provider		Adviser and former policy adviser The Hague
	Mainstream long-term care provider with culturally specific day care groups		Day care coordinator
	Welfare organisation		Manager/product developer Aged care advisers in multicultural neighbourhoods(6)
	Older people's city council		Chairman
	The Hague municipality		Policy advisers (2)
	Total: 80		Total: 22
Total	295 h		44

We included social neighbourhood teams since these were tasked with reaching out and with assessing requests for home/mobility aid and individual/family assistance and neighbourhood service centres. Meeting activities and day care services targeting ethnic minority elders, neighbourhood-based as well as city-wide, were also included. We studied local networks and public events organised to exchange knowledge about ethnic minority elders or diversity in social care, since such knowledge exchange has been shown to be integral to the development of service delivery, particularly for complex cases requiring inter-organisational collaboration (Edwards 2011). The observations were carried out by the first author. The interviews were conducted by the first and second author. All interviews were transcribed by both authors and a student assistant.

Since the fieldwork consisted of consecutive case studies conducted over a two-year period, the analysis was an iterative process. We identified the tensions between neighbourhood governance and the relational aspects of reaching ethnic minority elders during the Nijmegen case study (Pijpers and Carlsson 2018). We explored these topics further through interviews and participant observations in The Hague. All interview transcripts, field notes and documents were analysed using the software package *Atlas. Ti 8*. We conducted our analysis drawing on the principles of grounded theory (Charmaz, 2014), and began with a round of descriptive coding. Thereafter, the authors discussed the most grounded codes. These were further explored through a review of literature on neighbourhood governance of social care and boundary work in care. The review was

followed by a second round of axial coding in which we organised the data around concepts emerging in the comparison between our findings and the literature review; notably the concepts of multilevel relational work, boundary-spanning and moral conversations.

4.5 Findings

4.5.1 Limitations of neighbourhood governance

The neighbourhood-focused service structure in The Hague and Nijmegen was underpinned by the idea that physically close, generic services were the most efficient way to provide services following the implementation of the 2015 Dutch Social Support Act. This approach, which was generic in focus is rooted in a conventional notion of place, did not sufficiently reach ethnic minorities according to a policy officer in Nijmegen. This conclusion was echoed by a neighbourhood team manager in Nijmegen, who questioned whether older people from ethnic minorities "know what the neighbourhood centre is". She emphasised that to increase access to social care for this group, tailored outreach aimed at opening conversations around, for example, dementia and end of life was necessary (neighbourhood team manager, Nijmegen). The neighbourhood team manager thus found that although neighbourhood service centres could be beneficial, they were in themselves not enough to overcome the social and cultural distance that many minority elders faced when it came to social care. In The Hague, frontline workers and policy officers had a similar experience, but their concerns were met with a lack of understanding from politicians:

> "At the time of introducing the Social Support Act, for the politicians it was just, well it must be well organised and accessible. (...) we asked if we could set up a team to provide information to migrant groups. But that was very difficult, because then we faced a sort of equality principle, [the response was] 'well no we are just renting a tent and we are going into all neighbourhoods in The Hague, and then everyone, all citizens, can come to us'" (former policy officer, The Hague).

The quote illustrates how a principle of equality of access embedded in generic neighbourhood governance hindered the scope for activities aimed at addressing the health inequity that is caused by differences in the utilisation and appropriateness of services for specific groups. An adviser of a volunteer support organisation in The Hague highlighted how the shift to generic activities rather than activities targeting specific population groups often resulted in that advantaged groups accessed resources at the expense of disadvantaged groups:

> "Sometimes that [neighbourhood governance] is not good for diversity if it is about reaching [minority] groups. Say, I ask you to organise activities, and you have a couple of 'usual suspects', [frontline workers might think] 'that is easy, why do I need to establish a new group?'" (senior adviser volunteer support service, The Hague).

The quote above illustrates how the dedication to equality of access to activities resulted in inequity of access for minority groups. In addition to the fact that advantaged groups were likely to access generic activities, the senior adviser highlighted how the requirement to organise generic activities discouraged some frontline workers to invest in outreach. This issue was exacerbated by the organisational and financial pressures following the 2015 decentralisation. Frontline workers had too little time to 'get out' of the neighbourhood centres and build meaningful relationships with residents that had not yet accessed services, according to a policy-officer:

> "You can create an organisational solution by making sure that the people that do that work do not sit here in the city hall, but in the neighbourhoods. But that they also have time to do it, it is a challenge that they have an enormous caseload of applications that they need to handle. So, they say 'we have too little time to work on the network in the neighbourhood, although it is very important'" (policy officer, The Hague).

The high pressure on the frontline workers and civil servants constituted an obstacle to realising the ambitions of neighbourhood governance since building a relationship to local communities is a time-consuming activity (van Dijk, Cramm and Niebor 2016). In addition to time pressures hampering outreach work, not all frontline workers were "used to getting behind the front door" (interview policy officer, The Hague). The adviser of the volunteer training organisation pointed out that many frontline workers hesitated to reach out to minorities in unfamiliar places such as a mosque, despite the potential of such outreach:

> "Go to the mosque, try to do something there. Instead of thinking that oh, the mosque is difficult, all those Muslims have beards, they will eat me whole, I do not know. No, you are welcomed, you get cookies and tea (...) It is just planning and doing!" (senior adviser volunteer support service, The Hague).

Relational work requires frontline workers to adopt the working styles of exemplary practitioners by mobilizing networks with new key figures and organisations (Bartels 2017; van Hulst, de Graaf and van den Brink 2012). In The Hague and Nijmegen, engaging in such relational work was up to the individual, and not all frontline workers were equally proactive. This has possibly resulted in inequities both within and between neighbourhoods regarding which minority groups have access to care.

4.5.2 Possibilities of neighbourhood governance

The previous section showed that neighbourhood governance does not automatically create opportunities for frontline workers to increase ethnic minority elders' access to services. However, we did find cases where frontline workers' presence in neighbourhood centres facilitated relational work. At a centre in a multicultural neighbourhood in Nijmegen, we found that aged care advisers with a migrant background attracted ethnic minority elders through consistent relational work. We observed on several occasions that an older person from an ethnic minority entered the centre, asked for one of these advisers, and left when they were not there (field notes May 2017). This highlights how the connection to the centre was not a connection to the place, but the people there. One of the councillors with a migration background explained that building trust had been time-consuming but, eventually, fruitful:

> "There is mistrust among a lot of people. Therefore, it is good that I, how do you call it, that I still build, that I try to create that bond. I let them see that this is my work, and you do not have to worry about anything, if you have a help request then you need to be open with it" (interview aged care adviser, Nijmegen).

Because relational work is about long-term investment in relationships, such bonds sometimes pre-existed current neighbourhood governance policy and could be built upon in the new neighbourhood service structure. A Hindustan day care group in The Hague became more successful after moving from a care home to a neighbourhood centre since the latter location was well known by local minority elders with a Hindustan and/or Surinamese background. Long-standing positive relationships with frontline workers made the current neighbourhood model and outreach more successful.

On other occasions, it was ethnic minority elders themselves who reached out to frontline workers in the neighbourhood. A manager of a welfare organisation attributed cooperation with an Iraqi older couple to their visibility in the neighbourhood:

> "It was an Iraqi married couple who wanted to do something for Iraqi older people. (...) That came on our path recently. And they were talking about a group of 50 people that they knew and who wanted to do something together, or whom they wanted to organise something for. And that was in [the neighbourhood of] Mariahoeve where that group is the largest" (manager welfare organisation, The Hague).

We observed similar developments in Nijmegen, where frontline workers came into contact with key figures with a migrant background, with whom they initiated a multicultural meeting group. It thus seems that by enhancing the visible presence of frontline workers in the neighbourhood, frontline workers are better able to identify and work together

with key figures, which in the case of minorities has been found to constitute a key aspect of facilitating access to care (Green et al. 2014).

4.5.3 Spanning geographical boundaries of neighbourhood governance

Frontline workers with a migrant background often engaged in relational work which extended outside the neighbourhood boundaries. A day care coordinator at a residential care home with a section for older Chinese people in The Hague was engaged in the Chinese church. She was well known in the city-wide Chinese community, and the prospective clients referred to the care home where she worked as 'Min's care home' (day care coordinator, The Hague). A day care coordinator of a Hindustan and a multicultural group similarly engaged in outreach outside working hours:

> "On the weekend, if I'm in the church or wherever I am, I try to tell about it. That networking you have to keep doing" (day care coordinator, The Hague).

Networking was a form of relational work that was particularly important in the early phases of mobilizing minority communities. When establishing a multicultural group in The Hague, the frontline worker in charge was allocated time to visit information events. She also frequented a casino where she had heard that many older Chinese people congregated to drink coffee (day care coordinator, The Hague). By spanning the neighbourhood's geographical boundaries, she sought to connect clients with a large social and cultural distance to social care services with neighbourhood-based services.

Another form of spanning the boundaries to reach minority elders was to resist the generic approach to services preferred in the neighbourhood framework. An aged care adviser in a multicultural neighbourhood explained that he, like Tonkens and Verhoeven (2019), found that some groups tend to dominate shared spaces and activities.

> "We find that if a service is for everyone, the first target group that comes there turns out to be the only group to go there. (...) It is very difficult to bring different target groups and cultures together for the same activity, because, everyone chooses, and... finds it nicer to be with others who are similar, who have the same culture, the same norms and values" (aged care adviser, The Hague).

To reach under-serviced groups, the aged care adviser, therefore, was willing to organise separate activities to reach more diverse populations. In Nijmegen, older ethnic minorities were less concentrated in specific neighbourhoods. Frontline workers, therefore, bent the rule that activities in neighbourhood centres must target neighbourhood residents and be inclusive to all. To reach and mobilise older Cantonese and Mandarin-speaking people, who lived dispersed across the city, a frontline worker organised a meeting group 'open to

all older people' in such a centre. We thus found that relational work followed the logic of being sensitive to individuals' embeddedness in social networks. Frontline workers were pragmatic and willing to connect to social networks, whether they were located within or outside their neighbourhood boundaries.

4.5.4 Multilevel working to reach and service older ethnic minorities

Thus far, we have primarily discussed social care services, such as aged care advisers and day care for older people. Although health and social care are subject to different funding streams in the Netherlands, we still found that health care practitioners and social care workers collaborated on issues relevant to ethnic minority elders. Because of differences in geographical catchment areas, these networks were multilevel.

In The Hague, an information meeting about dementia care for older Chinese people exemplifies such multilevel work (field notes May 2019). The event was organised by the inter-cultural aged care adviser for older Chinese people, who was active city-wide but had visiting hours in two multicultural neighbourhoods. The meeting was held in the Chinese self-organisation's facilities in the city centre. At the meeting, a coordinator of day care activities in a multicultural neighbourhood and a nurse from a residential care home with a Chinese group, with clients who were residents of different neighbourhoods, were present. The meeting was well attended, likely because of the extensive network of the intercultural aged care adviser and the well-known location. This example brings to light the importance of networks that transcend neighbourhoods to effectively reach some minority communities. Furthermore, it highlights how frontline workers in social care can form an important connection to health care services, some of which are located within the neighbourhood structure.

Apart from connecting older people with services, multilevel networks allowed frontline workers to share knowledge. We found, like Edwards (2011), that the boundary-spanning setting of inter-organisational professional networks facilitated open-ended moral conversations. A city-wide network of professionals in health and social care who work with older ethnic minorities with dementia in Nijmegen is an example of such a boundary-spanning setting. This network was an important forum for improving access to care, via exchanging experiences with professionals of other specialisms, such as geriatric specialists, intercultural aged care advisers, Islamic hospital chaplains, one of the ethno-specific day and home care organisations, and the diversity officer of the largest welfare organisation in Nijmegen. The group helped participants to better signal the care needs of their patients to each other and to refer patients to other services such as home care (district nurse, Nijmegen). It also facilitated contact between aged care advisers, district nurses and members of neighbourhood teams who previously had little contact (district nurses, Nijmegen).

The participants in the group mirrored how intercultural competence and connections to migrant communities are centred in neighbourhoods with a historically large migrant community. District nurses and general practitioners from health care centres located in multicultural neighbourhoods were among the regular attendees. The district nurses had extensive experience of informing older ethnic minorities about common health problems such as diabetes and dementia. Over the years, they developed culturally sensitive working practices through contact with ethnic minority elders and their families. In addition to professionals working in multicultural neighbourhoods, professionals located outside the neighbourhood structures also participated in the group, such as the Muslim chaplain and a geriatric specialist from one of the city's hospitals. The participation of people in and outside the neighbourhood structures highlight how reaching ethnic minority elders relied on relational dynamics that included, but also transcended, specific neighbourhoods. While outreach initiatives often took place in multicultural neighbourhoods, these practices were organised through cooperation between the city-wide diversity officer and the inter-cultural aged care advisers, and members of social neighbourhood teams and district nurses in said neighbourhoods (field notes professional network dementia and older minorities 2018, 2019).

4.5.5 Moral conversations regarding health equity for minority elders

Thus far, we have discussed how neighbourhood governance can create scope for frontline workers to address health inequity through relational work within and outside neighbourhoods. The previous section showed how local networks facilitated relational work. In this final empirical section, we will provide examples of how moral conversations in relational work can gear practices toward achieving greater health equity for older ethnic minorities.

In the case of home aid, achieving greater health equity required frontline workers to negotiate clients' expectations on social care informed by their cultural background. At times, these negotiations led to discussions and bending of the generic rules regarding service provision. To be granted home aid, the social network of the (prospective) client is first checked for people who can provide help. To ascertain eligibility, the neighbourhood team pays a home visit. During a visit to an older woman with a Dutch-Turkish background, gender norms that differed from Dutch assumptions about the roles of men and women in providing care were encountered:

> "There was a grandson older than twenty years old registered on the address of this woman. So, this lady does not get home care since the grandson is supposed to help. And this she found very unfair, but yes that one over here and that one over there do get it, and these and these other people too, and I am old. And I thought, but this is really the rule, that your grandchild should help you. And then she was

like, oh but he is a man, and then I thought yes but he has a job so he could also organise [private] home aid himself" (neighbourhood team manager, Nijmegen).

Gendered expectations were not the only reason for conflict. Home aid providers also reported to the municipality that clients with a Turkish or Moroccan background wanted their homes to be 'cleaner than clean' (contract manager home care, Nijmegen). One provider reported that a client expected the home aid to prepare a massive amount of dough for a party and that the aid felt urged to respond by saying 'we can't do that because it is not our job!' These home aid-related examples show different (cultural) ideas about the social network criteria for granting a public service, and about what this service should entail. Making this distinction may be difficult for anyone who is gaining experience with social services, but particularly for people with a larger social and cultural distance to services who not only lack experience themselves but also lack family members or friends with experience of home care and home aid. Although bureaucracy offers some flexibility, in these cases frontline workers tried to convince ethnic minority elders of the limits to this flexibility.

The importance of communicating limits was widely shared. Nevertheless, a neighbourhood social team leader expressed a concern that rejections to service requests might increase the distance to services, causing them to refrain from contacting the social neighbourhood teams in the future (neighbourhood team manager Nijmegen; policy adviser, Nijmegen). To prevent these ethnic minority elders from opting out, boundary-spanning was explicitly considered as a possibility. However, that would imply using unequal means to achieve a more equitable process (policy adviser, Nijmegen). While at the time of our fieldwork (2017-2019) equality rather than equity of access was the preferred strategy, conversations around this normative issue were ongoing.

A second example of how moral conversation fostered equity concerns the city-wide resource pool of volunteers, many who were well known in their respective communities, and professionals with a migration background in Nijmegen. This resource pool can be used to find more informal support within people's social networks (policy adviser, Nijmegen). Volunteers participating in the pool received group training, individual coaching, and financial reimbursement for their work assisting social workers. The pool emerged out of a longer-standing discussion about how to give something back to the volunteers's contributions to relational work, which was referred to in various interviews. The neighbourhood team manager put it as follows:

"What do I give in return? It's very one-sided what I do. I get information from them, but what do I give back? What do I contribute to their lives?" (neighbourhood team manager, Nijmegen).

The training and reimbursement served to recognise key figures' contributions and complemented their informal knowledge with formal learning (policy adviser, Nijmegen).

4.6 Discussion and Conclusion

This paper set out to answer the question of "how does neighbourhood governance of health and social care enable and limit frontline workers to achieve greater health equity for ethnic minority elders?". Our findings support the relational critique of neighbourhood governance developed in recent years (Cummins et al. 2007; Jupp 2013). We found that increased spatial proximity to services did not in itself increase access for minority groups. However, our paper provides evidence that neighbourhood governance can enable frontline workers to increase minority ethnic elders' utilisation of services. Increased spatial proximity allowed frontline workers to engage in what we term *relational work*. The relational work identified in our study was open-ended and consisted of a continuous reorientation of goals and means. In some cases, this meant that frontline workers spanned neighbourhood boundaries to connect with key figures and places in and outside the neighbourhood. This may go against the grain of neighbourhood governance, especially in regard to its concern with equality over equity.

All in all, we find neighbourhood governance of social services to provide opportunities for frontline workers to address health inequity, despite the various drawbacks alluded to in our paper. Our study confirms previous research finding that neighbourhood governance can increase health equity in so far it allows frontline workers to mobilise local knowledge and multilevel professional networks to tailor services to disadvantaged populations in the neighbourhood (Bartels 2017; Durose 2009; Jupp 2013; Smith et al. 2016). We extended this literature by considering issues of health equity relevant to ethnic minority elders, which thus far have been understudied in the neighbourhood governance literature.

In addition to confirming the importance of relational work in neighbourhood governance, our study brings a relational geographical perspective on how health equity can be achieved in neighbourhood policies. In neighbourhood policies, health inequities are often articulated in comparisons of statistical and social indicators (Corburn et al., 2015, Rosenberg 2014). Based on these inequities, resources are made available for prevention and physically accessible health and social care services. Our analysis, guided by a relational place approach to neighbourhood governance, offers opportunities to understand how greater health equity can be achieved in daily practice. We show that next to expanding resources, work to increase health equity involves practices of reaching out which are sensitive to variation in ideas and needs with respect to social care. We found that relational work featured moral conversations about equity and justice that took place in situations where frontline workers made decisions about resources and working methods in response to the diverse needs of neighbourhood residents. Such

moral conversations were integral to frontline workers' efforts to make services more appropriate for older ethnic minorities and to increase utilisation through outreach. In this study, our attention to moral conversations and their health equity implications emerged as we compared relational work practices in the two cities. We think there is ample scope to develop the health equity implications of relational work in research with a more explicit focus on reconstructing, following and perhaps eliciting situated moral conversations. We also feel there is an added value in positioning such studies in the debate on situational justice, with its analytical attention to equity and recognition, and justice in practice.

On the basis of the present findings, we recommend policymakers, urban planners and service providers to acknowledge the contributions of relational work more explicitly (see also Smith et al. 2016). Policy documents could include examples and guidelines about how relational work in neighbourhood structures, places and multilevel networks improves outreach.

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CHAPTER 5

DAY CARE CENTRES FOR OLDER MIGRANTS: SPACES TO TRANSLATE PRACTICES IN THE CARE LANDSCAPE

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5.1 Introduction

In Western Europe, aging-in-place policies have led to fundamental changes to how and where older people receive care. The practice of care has moved out of the nursing home and is stretched out across what Milligan (2009: 144) has termed 'a new landscape of care'. The changing landscape of care has given rise to a rich literature describing how 'place shapes, and is actively shaped by, changing forms of care' (Milligan and Power 2009: 579). Geographers have found that the development of the care landscape has transformed existing care spaces, like the home, as formal care provision moves into the private sphere (van Melik and Pijpers 2017). In addition, new care spaces have emerged to support older people ageing-in-place, such as day care centres, community gardens, co-housing projects and service houses (Emami et al. 2000; Meijering and Lager 2014; Milligan, Gatrell and Bingley 2004).

Meeting the needs of an aging and increasingly diverse population poses one of the biggest challenges to local care landscapes across Europe (Lawrence and Torres 2015). One solution is the emergence of specialised care spaces and services targeting minority groups, such as LGBT and migrant older people (Emami et al. 2000; Heikkilä and Ekman 2000; Radicioni and Weicht 2018). For example, there is an increase in culturally specific care providers in the Netherlands, which offer day and home care with different ethnic, linguistic or cultural profiles. These providers cater to the care needs of older migrants for whom the Dutch language and a lack of culturally-sensitive services constitute barriers to access care (Leyerzapf et al. 2017).

Research has shown that culturally specific care spaces can improve the wellbeing of older migrants, by providing social connections, culturally appropriate activities and a sense of belonging (Emami et al. 2000). However, it is unclear how these new care spaces influence the responsiveness to cultural diversity of the wider care landscape. Therefore, this paper presents a study of how culturally specific care spaces are shaped by, and help to shape, the local care landscapes in which they are embedded. As such, it aims to advance our theoretical understanding of the connection between the notions of care spaces (Conradson 2003; 2005) and care landscapes (Milligan 2009) by using social practice theory. Specifically, we draw on the work of Reckwitz (2017) and Nicolini (2009; 2010; 2011), who engage with the role of space in the dynamics and evolution of practices.

The research is empirically situated in Nijmegen, a medium-sized city in the Netherlands with about 175,000 residents, of which 15% is older than sixty-five. Within this group, 20 % is from immigrant descent (first generation), mostly from Morocco, Turkey, and the former Dutch colonies[24]. Culturally specific day care in Nijmegen is provided by independent organisations, which are contracted as part of a broader approach to care

24 Unpublished municipal data, available upon request

and welfare provision. As such, day care organisations are embedded in the local landscape of care, while simultaneously operating independently and retaining their specific profile. Therefore, they offer the opportunity to advance our understanding of the relationships between care spaces, care landscapes, and the practices that connect them. Within this context, two questions guided our study: i) to what extent does the space of the day care centre allow staff to shape a care practice that is responsive to cultural diversity, and ii) how do these culturally specific care spaces interact with the wider care landscape in Nijmegen?

The research design is inspired by Nicolini's (2010) notion of 'zooming in' and 'zooming out' as well as his site-based approach to studying care; conducting participant observation at the day care centres and interviewing clients, staff and policymakers from the municipality and other relevant organisations. This combination of methods allowed us to zoom in on the activities of the care space, and zoom out to situate these in the dynamics of the wider local care landscape.

Zooming in on care spaces, we found that the affective atmosphere of the day care centres is instrumental in connecting day care to the life world of older migrants. Staff members play an important role as negotiators and interpreters between clients and the institutional world of the care landscape. However, the reinterpretation of care practices in culturally specific care spaces also creates tension, as day care centres struggle to both conform to, and reinterpret, dominant norms in the wider care landscape. However, this tension between care space and care landscape also has creative potential, producing new ways of doing care and increasing the visibility and awareness of culturally specific care.

Below, we first present a literature review on care landscapes and care spaces, outlining how the dynamics within and between these scales can be interpreted from a practice theoretical perspective. We also review literature on care spaces for minority groups. The paper then discusses our research design, followed by the results section in which we first zoom in on care spaces and then zoom out to the wider landscape, identifying moments and places in which translation and negotiation takes place. We conclude with a reflection on the theoretical and methodological potential of social practice theory to enhance geographies of care and aging.

5.1.1 Care Landscapes

Since frail older people often have several intertwined practical, social and medical care needs, the practice of formal care for older people includes a variety of services, ranging from home care and specialised nursing to social activities. Milligan (2009) terms this the 'landscape of care', since these organisations service the same group of older users of care. Each individual care organisation – whether providing home care, day care or primary care services – cooperates and is locally networked to various degrees on a daily basis. Furthermore, all organisations are influenced by the same or overlapping local and national

norms, guidelines and policies for aged care. As such, each space in which care occurs must be considered as embedded in local and national regimes of care (Dyck et al. 2005).

The notion of 'care landscape' highlights the interconnectedness of the spaces that are part of it, and the practices passing through these spaces. Despite Milligan's (2009) call for a geographical inquiry of how such places shape practice, few studies have since investigated this complex relationship (Andrews and Evans 2008). One reason may be the theoretical and methodological challenges such research poses, in terms of bridging scales and collecting appropriate data from various actors within the care-practice. Andrews and Evans suggest to focus on 'workers, their workplaces and practices' to reach a better understanding of how geographies of health are reproduced (2008: 774). Illustrative of such work is Martin et al.'s (2005) paper on rehabilitative care for older people, which highlights how policy priorities and care workers' decisions are instrumental in shaping the care landscape.

Social practice theory applied to the field of health and care also focuses on care workers, but places more emphasis on the spatial, organisational and institutional arrangement of practice. Nicolini (2007) studied the introduction of telemedicine to cardiological health centres. His work outlines the processes implicated in a spatial redistribution of a care practice; it shows that the introduction of telemedicine is accompanied by changes in ideas, identities and power relations between patients, doctors and nurses. The shift of some cardiological care to the home necessitates a reframing of patients as competent care-recipients, although nurses continue to determine what constitutes good care, sometimes dismissing and correcting patients' self-care practices. Furthermore, the reconstructed care practices brought by telemedicine require nurses to leave 'trails of accountability' in the form of notes and charts for distant actors, such as heart specialists in the hospital, to legitimise new practices within the regime of the hospital (Nicolini, 2007). Other practice theorists have also shown how places involved in a practice become arranged and connected to facilitate, and even transform, this practice over time (Blue et al 2016; Nicolini 2011; Schatzki 2009). With the introduction of a new space to a practice, there may be incremental changes to how actors perform the practice and how they relate to each other, within and outside the new care space. Places can thus influence the practice passing through them, and by extension, how that practice is performed elsewhere.

5.1.2 Care spaces

Nicolini's work (2010; 2011) emphasises how space reconfigures the power relations and the organisation of activities; consequently space both shapes, and is shaped by, 'bundles of practice' characterised by a certain degree of co-presence and spatial proximity (see Shove, Pantzar and Watson 2012). By studying these bundles of practice, geographers of

care can zoom out from the care space to the landscape in which it is embedded. Nicolini, however, does not fully account for the internal dynamics within care spaces.

Social practice theorist Reckwitz (2017) further unpacks the mechanisms that recruit people into social practices within the care space, using the concept of spatial atmosphere. He defines spatial atmosphere as occurring in places where objects and people interrelate in such a way that the place is 'entered and experienced' rather than merely used and argues that spatial atmosphere is important to social practice, since enrolling someone in a social practice requires not only 'skills and interpretation' corresponding with the practice, but also its 'corresponding desires and fascinations' Reckwitz 2017: 120). This means that the spatial atmosphere can motivate people to engage in the practice performed in that space.

The importance of atmosphere and sense of belonging in creating a therapeutic dynamic in care spaces is well-described in geographical literature. Bridging cultural and medical geography, studies on therapeutic landscapes and places explore how environmental, individual, and societal factors come together in healing processes (Gesler 1992). Early work often focused on healing in spaces that are considered inherently therapeutic, such as natural landscapes (Bell et al. 2018). Recent work instead investigates how (everyday) spaces come to achieve therapeutic qualities through relational processes. Both Lea (2008) and Foley (2011) describe such care spaces as assemblages, highlighting how therapeutic qualities of place are not inherent, but produced in relationship between people, places and connected discourses and practices.

Drawing on Conradson (2005), Foley concludes his discussion of care spaces as assemblages by stating that 'therapeutic benefits are negotiable, contingent and framed by affective and performative embodiment in place' (2011: 7). For a place to be therapeutic, a match is required between an individual's capabilities and the social, affective and material resources of the care space in question (Duff 2011), otherwise the care space might be experienced as exclusionary, as research on the experiences of indigenous people and migrants in different care spaces has shown (Bell et al. 2018). For Ahmed (2013), this match is not so much about being receptive to spatial atmosphere or not, but about experiencing shared feelings differently. Preferring the term 'intense' spaces instead of 'spatial atmosphere', she argues that shared feelings can actually heighten tension and be in tension. As such, Ahmed's (2013) interpretation of spatial atmosphere is better placed to recognise issues of conflict and power, for example in the form of exclusion.

To overcome experiences of exclusion and relational distancing from to care spaces by minority groups (Bell et al. 2018; Cummins et al. 2007), some interventions focus on adapting the cultural meanings and practices of culturally specific care spaces. For example, van Herk, Smith, and Tedford Gold (2012) examine how Aboriginal families in Canada experience preventative care in culturally specific care centres, in which co-ethnic staff familiar with Aboriginal culture incorporate Aboriginal rituals into the care practice. Consequently, the care space gives the visitors 'a sense of freedom to live out their cultural

values and views of wellness within their care encounters' (van Herk, Smith and Tedford Gold 2012: 654). As such, it enables the necessary 'affective and performative embodiment of place' (Foley 2011: 7) needed for visitors to reap the therapeutic benefits of the care space.

Van Herk and colleagues (2012) hence highlight the importance of relationships with care staff, and the incorporation of familiar practices in achieving an appropriate care space for cultural minority groups. Conradson (2003) also stresses the importance of interpersonal relationships in care spaces in his study of an English community centre. He shows how the working practices create a certain atmosphere through which visitors, staff and volunteers' bond and develop a sense of belonging. These belonging increases both visitors' wellbeing and their adoption of new skills. Through interactions with staff and other visitors, they feel more competent and become increasingly able to access information and services. Care practices can thus draw people in and enrol them in new practices, in addition to creating a sense of wellbeing (Conradson 2003). Similarly, Thelen (2015) argues that practices precede relationships. In other words, particular relationships will emerge from practices aiming to meet a particular care need.

5.1.3 Care spaces for Minorities

With societies becoming more diverse, there has been an increase in care spaces catering to particular groups, such as migrants, indigenous people and sexual minorities (Bell et al. 2018). Such care spaces aim to offer a safe space that relates to the life world of minority groups, which is of particular importance to older migrants. They are a highly diverse group, some of which are able to use general care and services effectively, while others struggle with ageing-in-place, having "unmet health and welfare needs and poor capacity to access advice and treatment' (Warnes et al. 2004: 307). The latter group does not have the capabilities to use available resources, because of language barriers and lack of knowledge on the health and welfare system (Suurmond et al. 2016). They might be recently migrated refugees or labour migrants with little education who did not have the opportunity to learn the local language or advance in their occupation.

To meet their needs, culturally specific care services for older people are becoming more common (Razum and Spallek 2014). Examples are culturally specific home care (Heikkilä and Ekman 2000), health promotion through ethnic organisations (Sverre, Solbrække and Eilertsen 2014) and ethnic day care centres (Emami et al. 2000). Emami et al. (2000) found that culturally specific care spaces improve the wellbeing of older Iranians in Sweden by facilitating social interaction and culturally appropriate activities. The day care centre functions as an alternative space of belonging, which is manifested by, but not limited to, attentiveness to older migrants' preferences and habits. In turn, this sense of belonging creates a motivation to engage in practices that help them to re-integrate, such as Swedish language lessons.

As described above, such care spaces also have the potential to change the local care landscape, as evidenced by Radicioni and Weicht's (2018) study on a community and residential building for lesbian, gay, bisexual and transgender (LGBT) older people in Madrid. They show that the building's emergence influenced formal care practices, by constituting 'different, novel understandings of what is public and acceptable' regarding aged care (2018: 377). Furthermore, the LGBT community challenged dominant norms by claiming spaces for care in the city and producing practices of 'caring democracies based on different gender and sexual norms' (Radicioni and Weicht 2018: 379). The existence of a dedicated space for LGBT older people is thus both meeting their specific care needs and making these needs more visible to other care providers.

Radicioni et al. (2018) argue that minority-specific care spaces can be conceptualised as contact zones, which Pratt (1991: 34) defines as: 'social spaces where cultures meet, clash, and grapple with each other, often in contexts of highly asymmetrical relations of power.' In the context of care spaces, these clashes and entanglements might be found in tensions between organisational culture, staff and clients' norms regarding care and national and local regulations governing the provision of care. Rather than 'spaces of encounter' (Valentine 2008) creating fleeting contacts between strangers, these contact zones potentially create prolonged, caring contact between groups, institutions and organisations. These engagements, within the atmosphere of the care space, have the potential to influence the practices of the institutional landscape in which the space is embedded.

In sum, we already know that culturally specific care spaces can increase older migrants' wellbeing. However, how these spaces actually co-shape practices in the wider care landscape is still unclear. This paper presents findings from research on how culturally specific care spaces are shaped by, and help to shape, the local care landscapes in which they are embedded. We aim to get a better understanding of these dynamics by drawing on the conceptualisations of the spatiality of practice offered by Nicolini (2007; 2011) and Reckwitz (2017).

5.2 Research Design

Similar to Nicolini (2011), we chose a multi-method approach to investigate how culturally specific care spaces shape and are shaped by the practice of care. This included 183 hours of participant observation in four day care centres, which provided insight into the daily performance of the practice of day care within these care spaces. We also conducted 42 hours of participant observation at several landscape-wide meetings to gain insight into the relationships between different actors in the care landscape. The landscape-wide meetings included a sound board group of a large welfare organisation, where city wide initiatives, services and signals were brought by community figures from different migrant

groups and discussed together with a diversity officer of the organisation and meetings of a network for professionals working with older migrants with dementia in Nijmegen. The meetings of the dementia network included general practitioners, geriatric specialists, hospital chaplains, geriatric neighbourhood nurses, day and home care workers and intercultural care consultants. In addition, we conducted 19 interviews with professionals, staff members and clients in the day care centres (Table 5.1 and 5.2). Throughout the paper, all quotes are derived from interviews, unless stated otherwise.

The fieldwork was conducted from May 2017 to June 2018 and involved comparison between practices at the four studied sites. Consequently, the data analysis became an iterative process. The coding of field notes and interviews was descriptive at first, focusing on day care practices including organised activities, care norms, administration, and relationships between staff and clients. We then compared how day care was practiced in each location and reflected on the role of staff and clients in shaping this practice. Furthermore, we analysed how the care spaces shaped older migrants' care-receiving practices and how the day care centres were connected to other care and welfare organisations, through cooperation, regulations and referrals. This iterative, multi-method process was required to achieve our aim: to zoom in on the dynamics of the care space, and to zoom out to trail the connections, negotiations and translations between the care space and practices in the wider landscape.

Table 5.1 Overview of fieldwork in day care centres

Organisation	**Number and duration (in hours) of observations**	**Interviewed staff (fictitious names)**	**Interviewed older migrants**
Multi-Care Culturally specific organisation (Multicultural/ Islamic profile)	27*3h	Afarin, Dutch-Kurdish intern Zeynep, Dutch-Turkish activity-coordinator Winifred, Dutch operational manager Youssef, Dutch-Moroccan Muslim chaplain Erkaslan, Dutch-Turkish director	3 Dutch-Turkish women 1 Dutch-Iranian woman 1 Dutch-Afghan woman
Colour-Care Culturally specific organisation (Turkish profile)	6*5h	Meryem, Dutch-Turkish activity-leader Azra, Dutch-Turkish day care centre coordinator	4 Dutch-Turkish women
Stronger-Care General organisation	6*7h	Anne, Dutch-Indonesian activity-coordinator	2 Dutch- Indonesian women 1 Dutch-Indonesian man
Better-Care General organisation	5*6h	Margareta, Dutch activity-leader	1 Dutch-Curacao woman
Total	**183h**	**8**	**13**

Table 5.2 Participant observation at landscape-wide meetings and interviews with associated professionals

Organisation or network	Nr. of observations	Observed activities	Interviewed professionals (fictitious names)
Diversity café	5*3h	Observation of the debate between volunteers and welfare- and care professionals in Nijmegen	
Monthly meeting hour for professionals	4*3h	Observation of the debate between welfare and care professionals in highly diverse neighbourhood	
Network 100 Work group Dementia and Older Migrants	3*3h	Observation of discussions between welfare and care professionals in Nijmegen	Amina, Dutch-Moroccan intercultural care adviser Linda, Dutch gerontological nurse Inez, Dutch gerontological nurse Yvette, Dutch municipal policy officer Floor, Dutch adviser diversity and informal care
Expert group older migrants (facilitated by Better-Care)	2*3h	Observation of the debate between volunteers and welfare and care professionals	Sara, Dutch project-leader for the municipal platform for day care organisations
Total	**42h**		**6**

5.2.1 Zooming In

Zooming in on concrete practices is an analytical move to begin to understand the more complex and layered reality of the wider regime (Nicolini 2009). Therefore, we first 'zoomed in' on day care spaces by conducting participant observation at four day care centres, one day a week for a period of six weeks at each place (Table 5.1). A total of 183 hours of observations gave an intimate insight into the daily workings of day care and allowed us to compare how day care was performed in culturally specific and general day care spaces.

For ethical reasons, the names of the four studied centres are fictitious. *Multi-Care* and *Colour-Care* are regarded as culturally specific, while *Stronger-Care* and *Better-Care* are categorised as general organisations. Multi-Care profiles itself as multicultural and has clients with diverse ethnic and cultural backgrounds. Staff spoke Dutch to each other and mirrored the clients in terms of their background. Quran reading was regularly arranged and attended by half of the clients. Colour-Care also profiles itself as multicultural, but only has Turkish clients and Turkish-speaking staff, many of whom were Muslims. Prayers in a dedicated room were common after lunch. Both organisations have directors of Turkish descent, and most staff are first, second or third-generation migrant. Stronger-Care and Better-Care were selected to provide insight into whether the practice of day care is

performed differently in culturally specific versus general organisations. Stronger-Care is the largest provider of welfare services for older people in Nijmegen. We conducted participant observation in a group for older Indonesians, although several clients were native Dutch or had another cultural background. Most staff members were Dutch and both clients and staff spoke Dutch. Better-Care is a small care provider. Staff and clients were native Dutch; the majority of clients have a working-class background. Better-care was chosen as a case since a policy adviser mentioned this day care as an example of best practice. We use the terms 'culturally specific' and 'general' for analytical purposes but acknowledge there are also differences between organisations within the same category. Table 5.1 provides an overview of the interviews and hours of participant observation conducted at each day care.

The first author acted as a volunteer during participant observation. She assisted in serving meals and drinks, doing dishes, playing games, and doing activities with the clients. Detailed notes were written at the end of each day, describing activities and conversations with staff in a chronological manner. Field notes and observations were guided by an observation protocol which prompted attention to elements of the care practices studied. The day care organisations consented to participate in the research; nevertheless, staff and clients often mistakenly assumed that the first author was an intern in the field of social work. Hence, she repeatedly underscored that she worked for an academic research project, and that the findings would be published but anonymised.

The position as a volunteer was helpful to the research. Seen as an intern, the first author was considered someone who needed to be introduced to and taught the practices we sought to study. It was a disadvantage to not speak the most common languages at the culturally specific day care centres: Turkish, Arabic or Farsi. Staff members or clients were asked for translation and assistance in understanding important events and conversations. Since the staff spoke Dutch, communicating with them was not a problem.

After a period of observation, we conducted semi-structured interviews with five staff members who were involved in daily activities at the day care locations. This gave us an opportunity to investigate how staff understood their work; how they characterised good and culturally specific care; and what their relationship to other care providers looked like in practice. Interviews were also conducted with thirteen older migrants, often with the assistance of students acting as interpreters. We only touch upon these interviews briefly in this paper, as they are discussed in more detail elsewhere[25].

5.2.2 Zooming Out

After thoroughly investigating the day care centres, we 'zoomed out' to the wider care landscape by interviewing municipal policy advisers, the coordinator for all day care

25 See Chapter 6.

organisations in Nijmegen, a Muslim chaplain, and a director as well as managers from both the culturally specific organisations. Furthermore, we attended fourteen landscape-wide meetings including a network of professionals working with older migrants suffering from dementia, and local debates on inclusion in care and welfare called 'diversity cafes' (Table 5.2). These events helped us to zoom out since they revealed how professionals working elsewhere in the care landscape discussed culturally specific day care within public and semi-public forums. The names of organisations and all interviewees have been anonymised throughout the paper.

5.3 Care Practices in Culturally specific Day care Centres

In the Netherlands, day care is a service offered to older people who live at home and are vulnerable to social isolation and depression. Day care provision is the municipality's responsibility (van Houten and Verweij 2015), who contracts different care organisations. The aim of day care is to 'improve the wellbeing of older by providing meaningful, structured activities which improve or support independence' (van Houten and Verweij 2015: 6). Clients attend regularly, from one to several days per week. Individual and collective activities are arranged and lunch is eaten together. In Nijmegen, all residents above sixty-five are eligible to attend day care; they do not need a medical referral or have to pay[26]. The municipality aims to cater to older people from all backgrounds, for example by including culturally-sensitive organisations when contracting day care. As a form of preventative care for older people, culturally specific day care centres have ties to the wider care landscape, through contacts with general practitioners, neighbourhood nurses, the municipality and welfare services.

5.3.1 Facilitating a Sense of Belonging

The spatial atmosphere was both palpable and different in the studied day care centres. The material aspects were most easily observed: the presence of prayer mats or old-fashioned Dutch furniture; the sound of Indo rock or Turkish TV; and meals with vegetable and rice dishes or potatoes with meat balls. By combining activities, foods, music and language, each day care centre created a particular spatial atmosphere through which the day care centre was 'entered and experienced' (Reckwitz 2017: 120).

The sense of belonging that the spatial atmosphere facilitated, manifested itself in interactions between clients and with staff. In the Indonesian group at Stronger Care, we observed the exchange of phrases in Malay, and friendly teasing of each other, a custom which both clients and staff identified as Indonesian (fieldnotes). At Colour-Care, spontaneous singing and dancing to well-known Turkish songs was a way in which staff and clients

26 Two documents on contracting and subsidizing of the Basic Infrastructure Welfare, 2017–2020.

connected to shared memories and customs (fieldnotes). Since Multi-Care had clients from many different cultural backgrounds, all did not share a language. Here a Muslim chaplain facilitated togetherness by offering weekly Quran readings. During this time, Iranian, Afghan, Moroccan and Turkish clients left their respective tables and sofa groups where they usually sat separately, to come together around the same table for weekly prayers (fieldnotes).

Although each studied centre welcomed older people from all backgrounds, clients chose day care centres with a familiar spatial atmosphere, where they could find a sense of belonging. One Iranian woman first visited a general day care but left because of the unfriendly atmosphere and a sense of exclusion by other clients. In contrast, she described coming to Multi-Care as 'visiting family', with staff happy to see her, attentive to her needs and interacting in a polite manner. A Turkish client of Colour-Care first attended Multi-Care's day care centre. However, Multi-Care facilitated fewer religious activities and many clients had a different religious background than herself. Hence, she found Colour-Care to be a better fit. Additionally, older migrants frequently emphasised the possibility to speak their own language as a key reason to attend a culturally specific day care centre.

5.3.2 Using the Familiar to Introduce New Practices

Apart from inviting clients to participate in day care, we found that the spatial atmosphere enrols older migrants in new activities (Conradson 2003). Familiar activities such as knitting and watching TV were appreciated and facilitated social interaction. However, as a practice, day care is not only aimed at fostering social interaction, but should – according to Dutch quality norms for day care[27] – also strengthen skills supporting independent living. Hence, day cares centres should also facilitate physical activity and other mentally stimulating activities, such as crafts, music and games. For staff at the culturally specific day care centres, it was not always easy to convince the older migrants to participate in less familiar, 'childish' activities. One way in which staff at Colour-Care motivated clients to engage in sports, was by including familiar elements of Turkish dancing and music in the activity. Losers in the ball game were punished by having to dance for the others, which caused much laughter in the group (Field notes).

Colour-Care's activity-leader Azra actively sought to also communicate new meanings of care, which were aligned with Dutch understandings of day care. She explained how she sits down with new clients to explain the purpose of day care:

> "You [the client] are coming here with a goal. It is nice and fun here and we are just like a family, but day care has a goal. You are not here for nothing (...). The municipality subsidises this for you, use it well; by being physically active, by taking part in activities. Think of it, you have many illnesses, physical complaints..."

27 HKZ National Certificate for Quality in Care: Norms for Day care (2015).

When Azra tries to explain the meaning of Dutch day care to her clients, she first emphasises that which is familiar: the atmosphere of the day care centre and the familial relationships between clients and staff. By appealing to shared ' desires and fascinations' she is then able to convey the 'skills and interpretation' she wishes her clients to gain, both which Reckwitz (2017) argues are necessary to participate fully in a social practice. By creating spatial atmospheres in which older migrants socially interact and feel a sense of belonging, the day care centres motivate their clients to gain the skills and interpretations necessary to also participate in less familiar practices, similar to findings by Conradson (2003).

5.3.3 (Re)-interpreting and Translating Practices

To better meet the needs of older migrants, staff adapted and extended the practice of day care in several ways. Most staff members had a migrant background, but were born in the Netherlands and had a Dutch diploma in care work. Their fluency in Dutch and knowledge of Dutch care and welfare systems meant that they often became interpreters. Though not being an official task of activity-leaders, they thus provided 'navigational assistance' (Green et al. 2014) to clients by translating formal documents and giving advice.

Another extension of the day care practice involved the incorporation of religious and cultural 'norms and values' (interview Azra). Contemplation in connection to mealtimes was observed at both Better-Care and Stronger-Care, through stillness and poetry recitals before eating. However, at Multi-Care, staff went one step further in incorporating religion into the daily routines of the day care. When a client passed away, they facilitated a mourning ritual that would normally take place at home. Instead, activity-coordinator Zeynep invited family, friends, clients and staff to come to Multi-Care and cooked a traditional meal for forty guests. To Zeynep, the willingness to go outside the daily routine and what could be formally expected, is the essence of day care at Multi-Care; 'It comes with what we do here.'

By going beyond formal requirements and being part of clients' personal lives, culturally specific day care centres reinterpreted the practice of day care. At Stronger-Care and Better-Care, staff addressed clients with last names to show respect, but also to 'create distance' (interview Margareta). At Colour-Care and Multi-Care, staff instead emphasised the importance of closeness to clients. Colour-Care's activity-leader Meryem explained that she approached every client 'as my own grandparent', a statement which was echoed by Multi-Care's manager Winifred stating that staff cared 'with their heart and soul, as if they were their own grandparents'. According to Multi-Care's director Erkaslan, this relational aspect of good care is the centre's key strength. In fact, Multi-Care's recruitment policy prioritises the ability to connect and empathise with clients over formal diplomas (interview Erkaslan). Empathy and close relationships were thus central meanings of the culturally specific care practice, as opposed to ideas of professional 'distance and closeness' common in Dutch care discourse (Dubbeldam and Mooren 2012).

The reinterpretation of care-meanings is central to how staff and care organisations resolve tensions between the 'system world of formal care' and the 'life world' of older migrants and their families (Froggatt et al 2011). Similar to Næss and Vabø (2014) and Palmberger (2017), we find that norms regarding filial obligations are changing within the Turkish labour-migrant community. Multi-Care's Muslim chaplain Youssef talked about a reinterpretation of the meaning of formal care. Formal care for older people is 'a rather unknown phenomenon' to Turkish and Moroccan migrant families (interview Youssef), generally considered a low-valued profession for those with few other options. However, Youssef's experience with his father made him re-evaluate this. The formal care his father received was 'very good, professional, far better than what a sister or daughter could do; I wished I had done it earlier!' Youssef now finds it his duty to explain to other families that formal care, done with 'professionalism and love', is an appropriate way to fulfil filial obligations to parents. By connecting the idea of professionalism to a loving relationship, care organisations have redefined formal care. This was also echoed in interviews with clients, with a Turkish woman at Colour-Care describing good formal care as someone 'caring like a son or daughter'.

We observed that this reinterpretation of good care extends beyond the internal practice of specific centres, for example when other services in the care landscape are invited into the day care centre. For the 'day of family carers', Colour-Care arranged an information evening for family members and invited municipal family-care consultant Lovisa to inform families about available municipal support. Staff translated Lovisa's talk in Dutch to Turkish, and Turkish traditional music was played and food was served. Turkish family carers were asked to share their struggles and how they came to understand the need for formal support. There was also traditional Turkish music and food. Lovisa received many questions and a goodie-bag was distributed with further information on available family-care support. By facilitating meetings in a familiar spatial atmosphere, Colour-Care could hence bridge the 'relational distance' (Cummins et al. 2007) between older migrants and another service in the landscape, the family-care consultant.

5.3.4 Conforming to Institutional Norms

Although staff reinterpreted certain aspects of day care practices, conforming to institutional norms was also important. Intern Aferin at Multi-Care had studied social work and was very aware of the importance of 'activating' older people. She therefore arranged group activities such as crafts and bingo, despite resistance from several clients who preferred to watch television. The organisation of particular activities, such as crafts and sports, aligns with Dutch norms of active aging (Katz 2000) and is considered a mark of quality and professionalism. Therefore, pictures were taken during such activities, according to an intern at Colour-Care 'for the inspection, we put it in a file' (field notes). Pictures from Multi-Care and Colour-Care were also shared on social media. Staff thus

left 'accountability trails' and performed certain routines to be recognised by the wider institutional practice (Nicolini 2007).

The choice of activities at Colour-Care and Multi-Care was not only shaped by the dominant discourse on healthy aging, but also by a pressure to showcase their integration into Dutch society. This became evident when comparing their activities with those of general day care Better-Care. The municipal policy adviser identified Better-Care as a positive example because of its efforts to activate clients (interview Yvette). Margareta, Better-Care's activity-leader, found that the group preferred hands-on activities such as crafts. She also arranged cognitive exercises, such as word games, but only for a short time since the group quickly lost interest. Since many clients smoked and suffered from lung disease, she no longer tried to persuade them to do sports. Margareta thus felt free to choose activities that connected to her clients' cultural background and avoid those that did not.

At Multi-Care and Colour-Care, staff felt more pressure to do sports and themed crafts with their clients. While sport was on the weekly schedule of the day care, intern Aferin confessed that it was difficult to motivate the clients: 'you really have to force them' and 'in the beginning they will complain'. Aferin still felt that this should be imposed on the group, and wished that her colleague would help her to do so more often. When the first author told staff at Colour-Care that she had also done research at Multi-Care, she was asked whether they also did 'activities and themes'. Activities following the calendar year, in addition to sport, was the defining factor of quality comparison. Choosing activities was a balancing act between what one 'must' do when practicing day care in the Netherlands and which activities the clients would enjoy.

To highlight their integration, staff organised both Dutch and Muslim celebrations. One of Colour-Care's activity-leaders took this practice for granted, saying that 'those are themes, we have to follow them' (field notes). When asked whether celebrating Easter made sense to Muslim clients, Multi-Care's intern Aferin gave a look of disbelief and exclaimed: 'But we have to! We are in the Netherlands!' Although there are no formal requirements to celebrate Dutch holidays at day care, staff at both Multi-Care and Colour-Care felt the need to demonstrate the centre's integration within the institutional context. This finding should be considered in the context of national discourses regarding migration and integration. Minority citizens are expected to demonstrate integration and affiliation with the values and norms of the dominant culture (Schinkel and van Houdt, 2010).

5.3.5 Tensions in the Care Landscape

Directors of the day care centres also struggled to meet their clients' needs in a way that fulfilled requirements of accountability and recognition from the national health inspection agency and the municipality. During interviews with municipal representatives Yvette and Sara, as well as meetings of the city-wide network for older migrants with

dementia, the culturally specific day cares are characterised as culturally competent and skilled in reaching older migrants. Cooperation between general and culturally specific organisations was considered desirable, for example in the form of knowledge exchange. However, both Multi-Care and Colour-Care were criticised for having limited engagement with local working groups and events relating to older migrants. Despite frequent invitations, their representatives rarely attended, which caused frustration within the wider care landscape.

For Sara, municipal project-leader of the platform for day care organisations, the directors' perceived unwillingness to translate their culturally specific activities into the broader institutional discourse was also problematic. Sara took Colour-Care's relatively large lunch budget as an example. In the Netherlands, sandwiches and milk constitute a common lunch, but at Colour-Care volunteers cook traditional meals with fresh ingredients every day. Sara did not oppose the value of this traditional meal, but felt that it was the organisation's responsibility to defend their budget priorities: 'The Dutch norm is the guideline. There are possibilities for exceptions, but then you need to have a very clear story about why you do it.'

In general, Sara saw the directors of culturally specific care centres as defensive of their way of doing day care, rather than open to discussion. She lamented this, wishing that culturally specific care organisations would take on an interpretative role as 'switch boards' between older migrants and general care organisations. Yet according to director Erkaslan, Multi-Care already functions as a 'bridge' to other care providers. He regarded the relationship with the municipality as largely positive and one that improved over time, as municipal staff had realised that 'although there were issues, the organisation still fulfilled many criteria'. The relationship had changed so that Erkaslan now felt that: 'Rather than being opponents, we have become partners, partners for care.'

There is an unmistakable tension between these different perspectives on the relationship between the day care centres and the municipality and other care providers, which hampers more intense collaborations in the provision of day care for older migrants. The tension around aligning with institutional norms is further fuelled by an on-going conflict between Multi-Care and the national health care inspection agency. During the study period, the agency repeatedly failed Multi-Care's nursing home, adjacent to its day care space. Although it acknowledged the 'warm' and 'positive' relationship between staff and clients in its latest report[28], the agency expressed significant concern about the quality of care provided at the nursing home, in particular with respect to the safe delivery of medications. It blames the governance culture at Multi-Care, including a poor division of responsibilities and a lack of communication.

28 Available upon request, but not included as reference to assure Multi-Care's anonymity.

In response, director Erkaslan saw these findings as evidence of prejudice on the part of the health care inspection agency: 'They came with the attitude that this is a migrant organisation, now we will turn everything upside down and find something wrong.' In a public response letter to the inspection[29], Multi-Care's board framed itself as a young, pioneering organisation, experiencing 'growing pains' required to align practices:

> "The organisation emerged and dreams, and this is still noticeable. The fast growth and sizeable ambitions have, however, left traces. Traces that fit with a pioneering organisation that is ready for the next step in its professional development. In this respect, quality and safety have indeed been given insufficient attention. After receiving a bad report we started working on these issues very hard, and we have gotten very far."

Over the years, the dispute between Multi-Care and the Health Care Inspection has left a considerable impression upon the wider care landscape, and beyond, since the publicly available inspection reports have resulted in bad press in local media. Consequently, some of Multi-Care's pioneering staff work is marginalised, as other actors in the care landscape continue to associate Multi-Care with poor-quality care instead of positively fulfilling a need for care in one's own language, let alone bridging a relational gap to other forms of care.

The day care centre of Multi-Care is embedded within the national practice of formal care, which the Health Care Inspection represents. Multi-Care's struggle to remain embedded in the landscape raises the question of how the wider fields of practice should deal with new care spaces. Furthermore, the changing relationship between Multi-Care, the municipality and the health care inspection agency shows both the tension and potential for cooperation that culturally specific organisations can encounter in relation to other organisations within the local and national care landscape.

5.4 Conclusion and discussion

This paper investigated culturally specific day care centres through the lens of social practice theory, highlighting how these care spaces are embedded in the wider care landscape. Our fieldwork shows that culturally specific day care centres are affective spaces, which function as contact zones between the life world of older migrants and the institutional world of the wider care landscape (Froggatt et al. 2011). Culturally specific day care centres are spaces in which the meanings, norms and activities of the practice of day care are translated and negotiated. As such, these spaces play an important role in sparking an atmosphere in which older migrants can be engaged. Following Reckwitz's

29 Ibid.

(2017) reasoning, spatial practices – practices pervading particular spaces – help create a particular spatial atmosphere which, in turn, 'recruits' people to said and other care practices. Staff members are key actors in creating and fuelling a spatial atmosphere. Space also allows for a transformation of material aspects of practice, such as meals, music and the style of furniture. Sometimes, these transformations are responsive to people's life worlds, such as their ways of grieving. In other instances, for example, when experimenting with physical activities, the staff is able to interpret 'Dutch' care norms for older migrants.

Although culturally specific care spaces have their own internal dynamic, we find that activities in these spaces remain part of wider practices. In the Nijmegen care landscape, both positive and negative emotions circulate about how culturally specific day care is currently practiced, although there is a shared aim of responding to the needs of older migrants. Using Ahmed's terminology (2013: 13), culturally specific day care is an 'object of feeling', which circulates between actors and hence becomes loaded with diverging emotions. Similar to Nicolini (2010), we found that while staff at culturally specific day care centres are able to transform practices to some degree, they also felt obliged to conform to the dominant practice to prove their professionalism.

The tension between transformation and compliance was also evident in the relationships between culturally specific day care centres and general providers. Culturally specific organisations integrated their practices with the wider landscape through the tendering process and participation in local day care platforms. Simultaneously, they resisted integration, for example in discussions with the Health Care Inspection, by defending their position as culturally specific, and therefore different from other types of day care. The relationship between care space and care landscape thus evolves in and through moments of translation, resistance and conformation.

Culturally specific care spaces are subtly shifting the power dynamic implicated in how aged care is performed and practiced. By bringing older migrants and staff with different cultural backgrounds together within an institutional environment, a space is created where care practices are contested, challenged and intermingled. Though the power relations between them are unequal, it can be argued that both clients and staff have some ability to influence the space and practices that they engage in. This idea of 'agency over care' provides scholars with a critical, yet hopeful lens through which to look at transcultural encounters. In debates on older migrants, this group is often portrayed as vulnerable and dependent (King et al. 2017), but culturally specific care spaces can provide settings in which older migrants can engage with formal care more on their own terms.

The changing nature of care landscapes, and the emergence of both new and reinvented care spaces, have opened exciting avenues of study within health geography. In this paper, we set out to bridge the concepts of care spaces and care landscape. This has proven a challenge, both theoretically and methodologically. We followed Andrews and Evans' (2008) suggestion to focus on how care workers reproduce the health care

system by investigating practices: meanings, norms, activities, and issues of administration which are shared among different actors who are part of the practice.

Social practice theory has allowed us to trace connections and interactions, and to zoom in and out. This theoretical perspective demands a multi-method research approach, in order to capture different dimensions of the studied practice. In this process we were confronted with various practical challenges. On one hand, there was almost too much data coming out of the observations. On the other hand, there was arguably too little data to show that the practice of culturally specific day care is influencing the way actors elsewhere in the landscape think about care provision to diverse older populations. For example, that the municipality had become open towards day care that meets the background and interests of specific cultural groups. Nevertheless, by considering a national policy that stated that day care spaces should cater to the neighbourhood in which they are located, instead of a previous focus on minority groups, we considered this enough evidence to support our finding. Questions we discussed in the course of using a practice approach include the issue of how to determine what the boundaries are of the care spaces and care landscapes under study. As a solution, we took moments of translation and negotiation of care practices as our analytical lens, which made the dynamic between care space and care landscape more concrete and narrowed our focus.

Despite its limitations, the use of social practice theory has helped us to consider the dynamics of the care landscape in all, or much, of its complexity. Previous work on care spaces for minorities primarily focused on processes of healing, exclusion and inclusion within care spaces themselves, making valuable contributions to our understanding of how, when and for whom places become therapeutic. However, with few exceptions (Radicioni & Weicht, 2018), most studies disregarded if and how culturally specific care spaces influence the wider care landscape. The use of practice theory has the advantage of shedding light on how power relations of exclusion and inclusion within a care space are part of a broader dynamic in the landscape. By analysing moments of translation and negotiation of social practices, we reach a better understanding of both the perils of being embedded in the wider landscape, and the possibilities of care spaces in making the care landscape more inclusive.

Radermacher, Feldman, and Browning (2009) argue for the benefits of partnership between places of culturally specific care and mainstream services, highlighting how the former might increase access to the latter. From this perspective, culturally specific care spaces become bridges to other services in the landscape. Furthermore, culturally specific care spaces invite us to take a critical view of norms regarding aging and good care inherent in our care practices, which might lack meaning to, or exclude, those who receive or are entitled to the care (Torres 2001).

By focusing on the role of culturally specific day care in Nijmegen, our research calls for further study on how the needs of older migrants are met in increasingly complex care landscapes. The older migrant population is growing, and their position in the care landscape is already a pressing issue. For the future, we hope for a deepened relationship between culturally specific care spaces and general care services, so that landscapes of care can become more inclusive for older people in all their diversity.

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CHAPTER 6

MIGRANTS' PATHWAYS TO AGED CARE: THE ROLE OF LOCAL RELATIONSHIPS OF CARE IN FACILITATING ACCESS FOR SUPER-DIVERSE OLDER POPULATIONS

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6.1 Introduction

This paper explores how care providers and policymakers facilitate older migrants' access to care in cities. There is evidence that first-generation older migrants in North-Western Europe, North America and Australia face inequities in health and use of care services (de Valk and Fokkema 2017; Karlis et al. 2018; van Gaans and Dent 2018; Salma and Salami 2020). Although older migrants in these regions tend to experience higher levels of ill-health, they are less likely to use aged care services than their native-born counterparts (de Valk and Fokkema 2017; Reus-Pons, Kibele and Janssen 2017). Within the field of health geography, it is well known that city and neighbourhood of residence can influence care access (Macintyre, Ellaway and Cummins 2002; Tunstall, Shaw and Dorling 2004; Cummins et al. 2007). However, gerontological researchers studying migrants' use of health and social care services have thus far paid scant attention to how the place of residence influences access to care. This paper begins to address this gap by presenting findings from 32 semi-structured interviews with older migrants who had accessed home care, home aid and/or day care. The interviews were conducted within the framework of a two-year (2017-2019) qualitative study on the organisation and delivery of aged care to older migrants in the cities of Nijmegen and The Hague, the Netherlands. The aim was to identify relationships of care in the two cities that facilitated older migrants' access to aged care.

To analyse the data, I draw together insights from health geography literature on relational approaches to place (Andrews, Evans and Wiles 2013; Conradson 2005; Cummins et al. 2007; Milligan and Wiles 2010; Duff 2011) and scholarship in migration studies on the super-diversity of migrant populations (Vertovec 2007; Boccagni 2015; Bradby et al. 2017). While the former approach can be used to gain insight into how places can enable access to services and support, the latter can help to explain how migration-related variables shape whether and how a place enables access for individual migrants.

To answer the questions outlined above, the paper proceeds as follows. First, I outline the theoretical framework of the paper, arguing that a combination of super-diversity and relational approaches to place enables researchers to identify possibilities for greater equity of access to aged care in cities. After a review on the literature describing working-age and older migrants' access to care, I describe the study's comparative methodology and the analytical technique of mapping what Milligan (2009, 2010) terms 'landscapes of care'. The findings section describes how a person's embeddedness in the local landscape of care can facilitate access to care services. Here, three types of relationships of care are discussed: those between individuals and minority-specific services, those within local communities of minorities, and historical relationships between care providers and minority groups. After showing how individual older migrants are embedded within these local relationships of care, it will be argued that variables of super-diversity are more useful than ethnicity in predicting for whom the care landscape of a city might enable

access to care. The paper concludes with suggestions for how policymakers and care providers might improve aged care access for migrants locally. These include (i) building long-term relationships of trust with new and incoming migrant groups and (ii) using the technique of care landscape mapping to identify shared migration-related (rather than ethnic) identities around which communities can be mobilised and targeted with culturally, linguistically and/or religiously appropriate services.

6.1.1 A relational place approach to investigating care access for super-diverse populations

Within health geography, relational approaches to place have become increasingly common (Cummins et al. 2007; Milligan and Wiles 2010; Duff 2011; Andrews, Evans and Wiles 2013; Andrews, Chen and Myers 2014). Relational theories of place constitute a family of ideas rather than a single school of thought (for an overview see Varró and Lagendijk 2013). In this paper, I draw on emerging literature that analyses care as practices across the city (Power and Williams 2020). In particular, I apply Milligan's (2009) 'landscape of care' approach to aged care delivery.

From this 'landscape of care' perspective, places are conceptualised as configurations of formal and informal relationships of care, which can be organisational, social or embodied in nature, depending on which actors are involved in the specific relationship of care (Milligan and Wiles 2010). While relationships of care can be spatially concentrated, they are not spatially confined. For example, informal social networks can stretch outside the confines of a city and even across national borders (Palladino 2019). Furthermore, as pointed out by Dyck et al. (2005: 173), care and welfare organisations are always 'embedded in and constrained by policies and practices constructed at a scale beyond home' – in this case, the city. Drawing on Massey (1995), I further understand relationships of care to have a temporal dimension: histories of encounters with services, as well as reorganisations and policies all leave a legacy influencing current relationships of care.

Milligan's (2009) work is focused on the delivery of care to older adults living at home. Such delivery involves a range of actors, such as home care, home aid, health care and welfare services, along with additional support from family, friends, neighbours and community groups. Because these actors often provide care in different places but are locally networked through their connections to each other and the older adults that they provide care to, Milligan (2009, 2010) speaks of 'landscapes of care'. When coining the concept of landscapes of care, Milligan was primarily interested in how 'place shapes, and is actively shaped by, changing forms of care' (Milligan and Power 2009: 579). In this paper, I am more interested in how people are embedded within the complex 'configurations' of relationships that constitute the care landscape.

Earlier research shows that this type of 'care landscape' approach is useful in investigating how migrants access care locally. Chakrabarti's (2010) study of access

to pregnancy care in New York constitutes such an example. Through interviews with Bengali women, she found that social class, socioeconomic status and length of residence in New York, more so than ethnicity, influenced the women's embeddedness in what Chakrabarti terms 'therapeutic networks'. Which types of formal and informal sources of care the women accessed depended on their embeddedness in the therapeutic network. Chakrabarti's (2010) study highlights how two individuals from the same ethnic background, living in the same place, can experience different 'socio-relational distances' to services, even when the physical distance is the same (Cummins et al. 2007).

To further explain how migration-related factors influence how individuals become embedded within their local landscape of care, and, hence, which socio-relational distance they experience to services, I have chosen to turn to the literature on super-diversity (Vertovec 2007; Boccagni 2015; Bradby et al. 2017). The term 'super-diversity' refers to the fact that migrant populations are highly diverse, not only in terms of countries of origin and ethnicity, but also in terms of language, religion, migration channels, immigration status, gender and age, all of which influence access to, and the need for, public services (Vertovec 2007). In addition, Vertovec identifies place of residence as a factor of super-diversity. He points to how the degree of establishment of migrants from similar backgrounds influences the ease by which individual migrants become embedded in social networks and gain access to resources (Vertovec 2007). The acknowledgement of the role that relationships between people and places have in facilitating or obstructing access to public services makes the super-diversity lens compatible with a relational approach to place.

Studies using a super-diversity lens tend to emphasise how individuals accessing care draw on a variety of resources in order to overcome any difficulties and barriers of access they might face (Green et al. 2014; Phillimore et al. 2018). Green et al.'s (2014) study on the 'pathways to care' of a super-diverse sample of care users in Sweden, Germany, England and Spain showed that most migrants drew on different forms of 'navigational support' to find their way within the health care system. Navigational support could come from a variety of sources including religious organisations, charities focused on migrants, internet resources and members from the same minority group who were more familiar with the national care system. When support and/or health care was not available locally, some migrants drew on transnational networks and/or accessed care in other countries (Sime 2014; Phillimore et al. 2018).

The studies discussed above mainly considered working-age migrants' access to health care. In comparison, very few studies use a super-diversity lens to study older migrants' processes of accessing aged care. However, research indicates that the process of accessing care might be different for people at a later stage in the life course. Older migrants might draw on transnational networks differently than working-age migrants. For example, transnational networks can lose importance with increasing age, both because of weakening ties in the country of origin and because of the loss of mobility often associated

with old age (Heikkinen and Lumme-Sandt 2013). Decreased mobility and a need for continuous hands-on care can also mean that travelling to receive care is not an option.

Secondly, for older migrants, experiences earlier in the life course, both in the country of birth and the country of residence, influence how this group accesses aged care. A study on Turkish older people in Sweden indicates that early care encounters, for example with pregnancy care, can be important in shaping their later views on aged care (Naldemirci 2013). Similarly, past experiences of racism and discrimination in encounters with health care services can deter older migrants' use of aged care services (Brotman 2003).

Thirdly, older migrants' processes of accessing care are likely to involve considerations of filial piety. Norms regarding filial piety prescribe 'how family members are expected to care for and provide support to elderly family members' (Songur 2019: 3). Some researchers find that many older migrants' views on filial piety change over time as a result of acculturation (Næss and Vabø 2014; Liversage and Mizrahi Mirdal 2017; Carlsson, Pijpers and van Melik 2020). Older migrants may also adapt their expectations regarding filial piety in cases in which family care is not practically feasible (Giuntoli and Cattan 2012; Næss and Vabø 2014). While it is known that there is much diversity within older migrant populations in terms of norms of filial piety, little is known about how the place of residence might influence how such norms are negotiated.

By reconceptualising migrants' access to aged care as an outcome of relationships of care in specific places, this paper responds to criticisms within the gerontological literature on older migrants and health inequality. Many scholars have argued that much of the gerontological literature relies on essentialist understandings of ethnicity, i.e., that ethnicity is seen as a fixed characteristic of a homogenous social group (Kramer and Barker 1994; Koehn et al. 2013; Torres 2015; Zubair and Victor 2015). This conceptualisation is problematic in research on health inequalities since many of the identified 'barriers of access' faced by different ethnic minority groups are related to migration rather than culture per se. Such barriers include, for example, limited knowledge about the health care systems, limited proficiency in the local language and low health literacy (de Graaff and Francke 2009; Greenwood et al. 2015; Suurmond et al. 2016; Czapka and Sagbakken 2020; Nielsen, Nielsen and Waldemar 2020). Furthermore, by focusing largely on the failure of minority groups to access care, rather than on what care providers can do to improve accessibility, the responsibility for health inequalities is located with the group itself (Torres 2019). By considering the role of place in facilitating access to care, and by broadening the focus from ethnicity to variables of super-diversity, this paper offers a way for researchers to shift focus from who 'older ethnic minorities are, and what they need, to what practitioners and policymakers can do to address these older people's needs' (Torres 2019: 117).

While the notion of super-diversity challenges essentialist views on ethnicity, it can be criticised for failing to acknowledge the influence of unequal power structures that precede

or trigger migration and migration-related health inequalities. As pointed out by Brotman (2003) and Hamed et al. (2020), racism in aged care and health care is a widespread issue. The reason I have nonetheless chosen to apply the concept of super-diversity, is that my aim is to shed light on the dynamics which generate (in)equity of access to services locally. While carrying an awareness of wider structures of oppression, investigating how racism influences relationships with formal care is outside the paper's scope.

6.2 Methodology

This paper draws on findings from a qualitative study of the organisation and delivery of aged care to older migrants in the cities of Nijmegen and The Hague, the Netherlands. The cities of Nijmegen and The Hague were chosen because they have highly diverse populations (Jennissen et al. 2018), with migrants constituting 20 % and 32,9 % of the older population (65+) in Nijmegen and The Hague respectively. These cities were also selected because of the presence of minority-specific services. These include intercultural aged care advisers, and minority-specific day care, home care and home aid.

The study is constituted by two case studies. Similarly to other comparative studies on super-diversity and place (Meissner and Vertovec 2015; Padilla, Azevedo and Olmos-Alcaraz 2015) the aim was to appreciate how variables of super-diversity play out in urban places, rather than to trace similarities and differences back to specific parameters, e.g. city size, demographic composition or individual characteristics like ethnicity.

6.2.1 Participant observation in day care centres and semi-structured interviews with older migrants

I conducted 32 semi-structured interviews with first-generation older migrants who had access to health and social care. Most interviewees were recruited at day care centres, where I conducted participant observation as well as semi-structured interviews with staff to study minority-specific care practices. An overview of the data collected in the day care centres can be found in Table 6.1. While reference is made to these interviews and observations in this paper, the findings are discussed in more detail in Carlsson, Pijpers and van Melik (2020).

Table 6.1. Fieldwork in day care centres and meeting groups

Nijmegen	Organisation	Nr. of observations	Interviews with older migrants	Interviews with staff
	Day care provider with multicultural/Islamic profile	27* 3 hours	5	Day care coordinator Operational manager Muslim chaplain Manager
	Day care provider with Turkish profile	6*5 hours	3	Activity leader Day care centre coordinator
	Day care provider with Indonesian group	6*7 hours	3	Day care centre coordinator
	Day care in neighbourhood Hatert	5*6 hours	1	
	Chinese meeting group		3	
	Secular Turkish meeting group		2	
	Multicultural day care provider		3	
		Total: 183		Total: 7
The Hague	Organisation	Nr. of observations		Staff interviews
	Day care provider with groups with Hindustan, Javanese, and Chinese profile	5*6 hours	6	Day care coordinator Manager
	Culturally specific day care group with Hindustan profile	6*7 hours	4	Day care coordinator
	Home care organisation with multicultural profile		1	Manager
	Mainstream long-term care provider with culturally specific day care groups		0	Day care coordinator
	Turkish Mosque		2	
		Total: 72		Total: 5
		Total hours of observation: 255		Total number of interviews: 12

When recruiting older migrants for interviews, I sought to recruit as diverse a sample as possible regarding variables of super-diversity. Since the study was explorative in nature, I did not aim to achieve data saturation for specific categories of interviewees. Most interviewees were recruited at day care centres where I conducted participant observation within the framework of the larger study. All interviewees received a gift card in exchange for contributing their time and knowledge to the study. Since most of the day care centre clients were women, I also recruited male interviewees from a mosque in The Hague and a secular Turkish self-organisation in Nijmegen. Two of these interviewees had not yet

accessed aged care. However, since they shared their considerations about aged care for the future, they are included in the sample. In total, I interviewed 10 men and 22 women ranging from the age of 55 to 80 years old and above. The interviewees were Dutch citizens and first-generation migrants from nine different countries of origin. Table 6.2 provides an overview of the interviewees' religious backgrounds, Dutch language skills, migration trajectories and care use.

Table 6.2 Overview of the characteristics of the interviewees

Total number of interviews	**32**
Gender	
Male	10
Female	22
Age in years	
55-69	10
70-80	12
81+	10
Religion	
Muslim	13
Christian	3
Jehovah's witness	1
Hindustani	3
No religion	2
Not known	9
Country of Birth	
Turkey	11
Indonesia	6
Surinam	4
China and Hong Kong	6
Iran	1
Afghanistan	1
Curaçao	2
Saint Vincent and the Grenadines	1
Migrant trajectory	
Labour migrant	17
Post-colonial migrant	13
Refugees	2
Dutch skills	
Fluent	16

Table 6.2 Continued

Total number of interviews	**32**
Limited	16
Health and Social care accessed	
Social activities in community centre	3
Day care (minority-specific)	27
Day care (mainstream)	1
Home and/or domestic care (minority-specific)	8
Home care and/or domestic care (mainstream)	11
Considering aged care	3

For conducting the interviews, I constructed an interview guide that was designed to elicit a narrative of how the interviewees accessed aged care. To this end, I asked them about their process of accessing care and which resources they drew on in doing so. The questions also covered past and current experiences with these services, along with past, current and future expectations and wishes regarding formal care and family care. All interviews were conducted by the author, except for three which were conducted by a student researcher. When necessary the interviews were conducted with the help of an interpreter. The interview guide, interview methods such as probing, and the study's aims were discussed with all interpreters before the interview sessions. Where necessary, the questions were adapted to be culturally appropriate, in line with Bradby (2002). For example, we reflected together on whether using the word 'friends' or 'acquaintances' would be the most appropriate to elicit information about the interviewee's informal social networks. The interpreters were master's students, except in two cases: one in which I relied on assistance from a volunteer at one of the day care centres and one in which family members present wished to act as interpreters. In these cases, and similarly to Kosny et al. (2014), it was not possible to follow the above procedure, which may have compromised the quality of these particular interviews.

All segments of the interviews in which Dutch or English was spoken were transcribed verbatim. Where interviewees spoke at length followed by brief interpretations by the student assistants, the interpreter was asked to translate the sections. The reason that sections were left un-interpreted was often that the interpreters thought that the level of detail was too high. In several cases, the translation of the uninterrupted sections afterwards added richness to the data. To prevent data misinterpretation, I also discussed the full transcripts with the interpreters and we clarified accordingly.

6.2.2 Analysis: mapping landscapes of care

To identify which relationships of care facilitated access to aged care in the two cities, and to investigate how super-diversity influenced these relationships, I used an analytical

technique I term 'care landscape mapping' to map the care landscapes of the two cities. Here, 'mapping' refers to creating overviews of the places in which the interviewees lived, and of their embeddedness within them. By contrasting and comparing the interviewees' narratives of accessing care with the care landscape maps of Nijmegen and The Hague in mind, it was possible to pinpoint the interactions within relationships of care that made the biggest impact in terms of facilitating access to aged care.

Firstly, I mapped the care landscape for each city. This was done using municipal documents[30] and a national overview of culturally specific health and social care providers.[31] In addition to this, I also drew on interviews with 40 health and social care professionals, managers and policy advisers. The result can be found in table 3. It should be noted that while I drew on interviews with health and social care professionals and managers to map the care landscape, I only touch upon the findings from these interviews briefly in the present paper since they are discussed in detail elsewhere (Carlsson and Pijpers 2020; 2021)

Secondly, I mapped how the older migrants were embedded in the two landscapes of care. 'Embeddedness' refers to relationships of care with care and welfare professionals, care organisations, family members, friends, neighbours and members of local minority communities (Green et al. 2014; Palmberger 2017). I first coded ways of accessing care, sources of navigational assistance and forms of care used. After that, I cross-tabulated sources of navigational support and informal and formal care used against variables of super-diversity. The final table only includes the migration trajectory, place of residence, country of birth and Dutch language proficiency, since these variables of super-diversity were found to influence the forms of care that an individual was using and the ways in which they accessed care.

30 Municipal overview of minority self-organisations provided by a social worker in Nijmegen and municipal overview of migrant organisations retrieved 06/03/2020 from: https://www.socialekaartdenhaag.nl/zoek/migrantenorganisaties

31 National overview of day care, co-housing and residential care published by Kennisplatform Integratie en samenleving in 2017 retrieved 06/03/2020 on: https://www.kis.nl/sites/default/files/bestanden/Publicaties/lijst-woongroepen-verpleeghuizen-dagbesteding-ouderen-met-migratieachtergrond.pdf

Table 6.3 Overview of the care landscapes of Nijmegen and The Hague[32]

City	Population composition	Ethnic composition of older migrant population	Neighbourhood characteristics	Minority-specific service provision	Cultural/Ethnic/Religious Self-organisations
The Hague	538,000 residents of which 14 % are aged 65+; Older population consist of 32,9 % first-generation migrants	Suriname (22,2%) Indonesia (22,4 %) Germany (12%) Morocco (7,5 %) Turkey (6,9 %) Antillean (3,9%) Other (37,1 %)	Migrant populations predominantly live in Laak, Schilderswijk and Transwaal; neighbourhoods with long history of in-migration and diverse populations	• Intercultural aged care advisers (Cantonese, Berber and Arabic, Turkish) • Home care offered in different languages/multicultural profile • Day care for Indonesian, Chinese, Turkish, Moroccan, Hindustani, and multicultural groups • Residential care for Chinese, Dutch Indonesian, Moluccan, Surinamese, Hindustani and multicultural groups • Co-housing for Chinese, Turkish, Surinamese, Surinamese-Creolean, Surinamese-Javanese, Hindustani, Antillean, Dutch-Indonesian and Moroccan groups	• Hindustani temple; Hindustani organisations; Surinamese organisations; Javanese Surinamese • Carribbean organisation • Turkish mosques; women's organisation; labour organisation; cultural organisation; islamitic organisation; Kurdish organisation; Turkish-Azerbadjani organisation • Moroccan mosque; Moroccan women's organisation; Moroccan men's group • Indonesian mosque; cultural organisation; sport organisation; music organisatio; Javanese organisation • Foundation the Chinese Bridge • Armenian; • Ghanean; Sudanese; Papua New Guinea; Somalian; Bulgarian; African organisations

32 Data on population composition is retrieved from municipal overview of older migrants (Nijmegen 2017, available upon request) and Ouderenmonitor 2018 (The Hague 2018, https://ckan.dataplatform.nl/dataset/dba52bda-3178-48f8-9b75-2faf4048d6d7/resource/8ee46bb8-c1a6-430f-9fce-e1b6615d1473/download/ouderenmonitor2018.pdf retrieved on July 1 2021)

Table 6.3 Continued

City	Population composition	Ethnic composition of older migrant population	Neighbourhood characteristics	Minority-specific service provision	Cultural/Ethnic/Religious Self-organisations
Nijmegen	175,000 residents, of which 15% are aged 65+; Older population consist of 20,0 % first-generation migrants	Germany (41,9%) Indonesia (15,6 %) Turkey (7,4%) Morocco (4,6%) Antilleans (2,8%) Suriname (3,4%) Other (24,3 %)	Migrant populations dispersed across several neighbour-hoods and surrounding villages, with some concentration of migrants in Neerbosch Oest, Dukenburg, Oud-West and Hatert	• Intercultural aged care advisers (Berber and Arabic, Turkish) • Home care offered in Turkish • Day care for Indonesian and Turkish groups • Meeting group Chinese older people • Multicultural meeting group	• Hindustani temple; Surinamese group; Surinamese Islamic group • Antillean organisation • Turkish mosques; Turkish secular organisations; Turkish Islamic organisation; Turkish Alevi organisation • Moroccan mosques; Morroccan women's organisation • Indonesian organisations; Moluccan organisation

Table 6.4 Embeddedness in the care landscapes

Number	City		Dutch skills		Migrant trajectory			Country of Birth								Sources of informal care and/or navigational support					Aged care providers used		
	Nijmegen	The Hague	Limited	Proficient	Labour	Post-Colonial	Refugee	Turkey	China and Hongkong	Surinam	St Vincent and the Grenadines	Indonesia	Curacao	Iran	Afghanistan	Neighbours and friends	Minority community	Family	Professional mainstream organisation	Professional minority-specific organisation	Minority-specific	Mainstream	Mix
Labour migrants Nijmegen																							
1F	x		x		x			x									x	x					x
2F	x		x		x			x									x	x			x		
3F	x		x		x			x										x			x		
4F	x		x		x			x									x	x		x	x		
5F	x		x		x			x									x	x		x	x		
6F	x		x		x			x									x	x	x	x	x		
7M	x			x	x			x								x	x	x				x	
8M	x			x	x			x								x	x	x	x			x	
9F	x		x		x				x							x	x	x			x		
10M	x		x		x				x								x	x			x		
11M	x		x		x				x								x	x			x		
Labour migrants the Hague																							
12M		x	x		x			x								x	x	x					
13M		x		x	x			x								x	x	x	x				
14F		x	x		x			x										x			x		
15F		x	x		x				x								x	x					x
16F		x	x		x				x								x	x		x			x
17F		x	x		x				x									x		x			x
Postcolonial migrants Nijmegen																							
18F	x			x		x				x						x		x		x	x		
19F	x			x		x							x				x	x					x

Table 6.4 Continued

Number	City		Dutch skills		Migrant trajectory			Country of Birth								Sources of informal care and/or navigational support					Aged care providers used		
	Nijmegen	The Hague	Limited	Proficient	Labour	Post-Colonial	Refugee	Turkey	China and Hongkong	Surinam	St Vincent and the Grenadines	Indonesia	Curacao	Iran	Afghanistan	Neighbours and friends	Minority community	Family	Professional mainstream organisation	Professional minority-specific organisation	Minority-specific	Mainstream	Mix
20F	x			x		x						x				x		x	x				x
21F	x			x		x						x				x	x	x					x
22M	x			x		x						x					x	x					x
23F	x			x		x							x			x		x				x	
Postcolonial migrants The Hague																							
24M		x		x		x				x						x	x	x	x	x			x
25F		x		x		x				x						x	x	x	x	x			x
26M		x		x		x				x						x	x	x	x	x			x
27F		x		x		x					x					x		x	x				x
28F		x		x		x						x											x
29F		x		x		x						x					x		x	x			x
30F		x		x		x						x				x		x	x				x
Refugees Nijmegen																							
31F	x		x				x							x				x	x	x	x		
32F	x		x				x								x			x	x				

In Table 6.4 interviewees are grouped based on their city of residence and migration trajectory. The table highlights that factors of super-diversity are better predictors of how care is accessed than ethnicity, but that even individuals with similar characteristics of super-diversity could still be differently embedded in the local landscape of care in terms of the types of care they used and the sources of navigational support they had access to.

Finally, the last analytical step was to compare the narratives of the interviewees of labour- and post-colonial migrants and refugees in each city, against the background of the care landscape maps. Through this process of comparison, it became possible to (i) pinpoint relationships of care that facilitated access to care and (ii) to investigate how variables of super-diversity influenced an individual's embeddedness in these relationships of care.

6.3 Navigating local landscapes of care: identifying relationships that matter

The care landscapes of Nijmegen and The Hague differed regarding their specific configuration of organisational, social and embodied relationships of care. Nevertheless, the analysis of the older migrants' narratives reveals three relationships of care that facilitated access to aged care within both landscapes. These are relationships with minority-specific services, relationships within local minority communities and historical relationships with care providers. The embeddedness of the participants in their place of residence mattered as much as migration backgrounds when it came to how individuals were situated in the landscape, and hence the degree of ease by which they accessed aged care. Certain characteristics known to be a barrier to access, such as low language proficiency, hindered access in the care landscape of one city but mattered little in another. In what follows, the multifaceted nature of the three relationships of care will be discussed, with reference to how they facilitated care in different ways depending on the characteristics of the local care landscape and the characteristics of the care-receiving group and/or individual.

6.3.1 'Minority-specific' services: reconfiguring relationships of care and migrants' shrinking socio-relational distance to services

In the literature, minority-specific services, often referred to as 'ethno-specific' or 'minority-specific', are generally seen as facilitating access to aged care for older migrants (Ahaddour, van den Branden and Broeckaert 2016). However, this approach to care provision has also been criticised for being unfeasible in the case of super-diverse populations (Phillimore, Bradby and Brand 2019). My findings show that in the case of aged care in the Netherlands, these services were much more diverse in terms of clientele than labels like 'culturally specific' or 'ethno-specific' would indicate. Depending on the diversity and size of the local minority populations, different identities became significant

as mobilising or dividing forces. For example, in The Hague, there were more internal divisions within the population of older people born in Indonesia than in Nijmegen, where this population was much smaller. Therefore, I refer to 'minority-specific' services. In this section, I describe the role that I found minority-specific aged care services to play in the wider configuration of the local care landscape.

A closer look at the interactions that older migrants had with minority-specific services reveals that these services had two roles. Firstly, the services reconfigured the migrants' relationship with family care, by supporting the renegotiation of norms regarding family care and by offering a pragmatic alternative to the need for support and belonging. Secondly, minority-specific services diminished migrants' socio-relational distance to services, by enabling direct interactions in migrants' preferred language and by offering more care choices to those with migration identities.

For older migrants belonging to well-established minority communities, furthermore, I found that minority-specific services reconfigured informal relationships of care by encouraging their clients to reinterpret their personal norms regarding filial piety (see also Carlsson, Pijpers and van Melik 2020). Observations of interactions in the day care centres showed that staff used their intercultural competence to shift negative attitudes to formal care. An Islamic chaplain who organised weekly Quran readings explained that he found it his duty to inform the community that ensuring that one's parents receive formal care, done with 'professionalism and love', is an appropriate way to fulfill filial obligations. For some interviewees, though, accepting formal care was difficult and only took place gradually. The daughter of a Turkish female home care recipient in The Hague (14F) described it as follows:

> "When we first requested home care she struggled with it, she felt that we abandoned her (...) but now she is happy that we did it (organised home care)" (daughter of interviewee 14F).

When asked about the role of family members in care provision, some interviewees, like the woman in the above example, expressed that it was the duty of children to care for their parents (12M;14F;19F;23F;27F;32F). Statements like the one below, from an Afghan woman who came to the Netherlands as a refugee, were not uncommon:

> "It is the duty of children to care for their parents because I and my husband have done so for them, so it is their duty to do it for us in return" (32F).

However, except in one case, the interviewees who expressed these views still received some form of aged care, indicating that abstract expectations of filial piety sometimes had to be adjusted to the actual ability of family members to provide aged care (Giuntoli

and Cattan 2012). The existence of minority-specific services can potentially facilitate such shifts in attitude, by creating a home-like environment. An Iranian woman, whose words are here paraphrased by the interpreter, described her minority-specific day care centre in the following way:

> "She feels at home because they are very friendly, it is like she comes to family members when she comes here, they care very well for her" (31F).

This experience stood in stark contrast to the interviewee's experience with a mainstream day care provider, where she felt excluded and discriminated against.

While some interviewees desired family care over formal care, this was not always the case. Several interviewees expressed a strong desire not to be a burden on family members when asked about care arrangements (1F;4F;6F;9F;10M;11M;18F;20F;21F;24M;25M;31F). This worry was mentioned by 12 interviewees with different ethnic, religious and migration backgrounds, indicating that acculturation to norms regarding filial piety and independence in old age was occurring across groups. For these older people, minority-specific services were an important resource in negotiating the need for social support in old age, against a backdrop of lowered expectations for their children to provide it.

A member of a Cantonese-speaking meeting group in Nijmegen illustrates this reconfiguration of informal care relationships. Referring to the decline of the custom of living with your children in old age in his community, he expressed a wish for a co-housing complex for Chinese people:

> "If the Dutch government could provide a house for Chinese people this would be the best case (...) Because our children have already grown up and gone to live on their own" (10M).

The interviewee thus hoped that sharing his language and customs with co-residents would help him overcome social isolation, similar to Antilleans in Groningen (Lager, van Hoven and Meijering 2012), as well as provide a pragmatic solution to his care needs, considering his adjusted expectations of his children's ability to provide care.

In addition to helping local communities and individual older migrants to shift and renegotiate norms about filial piety, minority-specific services can diminish migrants' socio-relational distance to services. The availability of organisations with Turkish-speaking staff in Nijmegen enabled non-Dutch speaking Turkish migrants and other non-Dutch speakers to make independent choices about formal care, which is illustrated by this quote from an interpreted interview with an older Turkish woman:

> "She knew for a long time that Multicare (an Islamic day and home care organisation) was here (...) She says that she already knew Erkaslan (the manager of Multicare) and says that she called Erkaslan and told him that she wanted to come" (4F).

Many of the Turkish female interviewees (1F;2F;4F;5F;6F) in Nijmegen emphasised that it was their own choice to come to the day care centres they made use of. Several had contacted the organisation themselves to express their interest in day and/or home care (4F;5F) or had been called by the director following a period of hospitalisation (6F). One interviewee (5F) also negotiated the hours of home care they received using these personal connections. Because of minority-specific services catering to the Cantonese and Mandarin-speaking population, similar pathways to care were found among interviewees from China and Hong Kong in The Hague (16F;17F). Thanks to the availability of services in their language, many interviewees were able to access services, despite facing significant barriers such as illiteracy and limited proficiency in the local language (Warnes et al. 2004).

Although minority-specific services can facilitate access, they can also create an overreliance on single relationships of formal care if options are limited. However, in this study, no interviewees raised this as a concern. This might be because most interviewees had access to several minority-specific providers. One interviewee (5F) arranged a work opportunity for her child in one minority-specific care organisation by promising to switch to a different minority-specific provider of day care if they would offer employment to her child in return. Other older people used the presence of other formal care organisations to compare the quality of care between mainstream and minority-specific care organisations. A Turkish woman (1F) using a day and home care provider focused on the Turkish community in Nijmegen explained that she had visited a Catholic residential care home for comparison and to prepare for her future care needs:

> "I want to see how they live, how they get good care in their language and culture (...) it is important to see other places so that you can say [to the present, Turkish provider] this is good, or it is not, therefore it is good to have seen other places [for comparison]" (1F).

The above quote stands out because the interviewed woman had limited proficiency in Dutch. Nevertheless, having access to a wide range of care providers allowed her to make an independent decision about care. While the options were limited by her preference for culturally appropriate food and Turkish-speaking staff, she could, nevertheless, negotiate the quality of her care. Two Turkish men interviewed in the study, with good proficiency in Dutch, had a similar approach to choosing aged care. They preferred an organisation that could provide care in the Turkish language but weighed this criterion against both the quality of care and the experiences of friends (12M;7M).

For older migrants that did speak Dutch fluently, minority-specific services were not necessary for access but were found to facilitate belonging (see also Carlsson, Pijpers and van Melik 2020). An interview with an Indonesian man (23M) provided an example of how national identity can help a person orientate oneself in a new care landscape. The interviewee had recently moved to Nijmegen and attended both the Indonesian day care group and the activities of an Indonesian self-organisation. Although he still felt like an outsider to the Indonesian community in Nijmegen, these activities helped him orientate himself in his new hometown and gain access to informal social networks. Another interviewee (21F), who, similarly to the Indonesian man, was proficient in Dutch and able to arrange care without navigational support, still chose to make use of minority-specific day care because it provided a sense of immediate belonging. She described her first experience with day care in the following way:

> "I was brought by the volunteers to the day care, we sat in the car, and straight away I could hear another client speak with the Indonesian accent, with Malay words in between, then I felt at home at once!" (21F).

The Indonesian woman claimed, in contrast to the man in the previous example, that she 'would not go looking for' contact with other older people with Indonesian roots and she was not a member of any Indonesian cultural organisations. The example highlights that, for some interviewees, minority-specific care was one option of many, and, while not necessary for them to access care, could still be a means for them to forge connections and experience a sense of belonging.

As the above examples already indicate, the potential of minority-specific services to reconfigure and thicken relationships of care for any individual depended on the configuration of the local care landscape. Both in The Hague and Nijmegen, interviews with clients from the so-called Chinese day care and meeting group respectively revealed that clients were from Hong Kong and various regions of mainland China. Shared languages and/or cultural backgrounds were the common denominators rather than ethnicity or nationality. In the Hindustani day care group in The Hague, some clients were Muslim but shared their country of birth with other group members. Other members came from a different country but shared Caribbean culture with the Surinamese clients. The aforementioned examples highlight the many different common denominators that may draw clients together in minority-specific services, even when they are assumed to target specific ethnic groups.

Although many groups were composed of clients from different backgrounds, this was not always the case. Some identities were a cause for division rather than belonging. Which identities came to matter mostly depended on the characteristics of the local community. In the Indonesian day care group in Nijmegen, older people from different

ethnic and racial backgrounds participated in the same day care group, and often bonded over words in Malay, 'indo music' and memories of Indonesia (fieldnotes day care centre). In The Hague, which has a particularly large community of Dutch Indonesians, there were more divisions within the group along ethnic and religious lines. The organisation where I conducted participant observation offered one group for Javanese older people, and one for Hindustani older people. Both groups had clients who had migrated from Indonesia. The reason there were two separate groups was that the Javanese older people were bullied by members of the other group, because of a belief that they belonged to a lower class in Indonesia (interview day care coordinator). In Nijmegen, where there is a large Turkish community, the religious background was important; there were two day care organisations, one which was found to cater predominantly to Alevi Turkish people and older people from other Islamic countries, and one with clients who were Sunni Muslims. These examples highlight that to know for whom minority-specific services facilitate access to care, it is important to have an understanding of the social dynamics of the local care landscape of the city in question.

6.3.2 Local (minority) communities: informal relationships of care as conduits to aged care services

Informal relationships of care, which can be defined as 'relations of trust and reciprocity associated with social capital' (Duff 2011: 150, drawing on Portes 1998) are known to enable health. Palmberger (2017) and Palaz (2020) both find that belonging to local minority communities is an important source of informal care and support for older migrants. The following section discusses how, and under which conditions, embeddedness in minority communities also facilitated access to aged care. I use the term 'minority communities', since the older migrants in the study often found connections through a range of identities, such as being a resident of a particular neighbourhood and/or a shared religion, culture or language.

One way in which being embedded in a minority community facilitated access to aged care was through relationships with care staff and managers with a shared minority background. Such relationships were particularly important for older people with low proficiency in Dutch. An older Turkish woman in Nijmegen exemplified this when stating how she had come to use home and day care provided by Multicare, a multicultural care organisation established by Dutch-Turkish second-generation migrants:

> "She knew for a long time that Multicare was here, and if you are part of the community, they will talk about it, at social events you hear it automatically" (4F).

Her experience was echoed by many of the other clients with a Turkish background. It should be noted that a strong local community might also present an obstacle for using

formal care services, especially if filial care is the dominant norm. I found that professionals' attempts to expand clients' norms regarding filial piety to include formal care made the presence of large informal communities of people with a shared minority background an asset in broadening access to care (see also Carlsson, Pijpers and van Melik 2020).

Another instance in which informal relationships of care functioned as conduits to formal care was when these relationships of care co-existed in the same physical location. A case in point is the narrative of one of the clients of the Hindustani day care group. He learnt about the day care groups because he often visited the community centre, and because he was acquainted with one of the clients:

> "I came to the community centre to read the newspaper and saw [an acquaintance]. We already knew each other, and he came in and saw me, greeted me and said, come along [to the day care group], so I did!" (25M).

The day care group that this interviewee accessed, through his acquaintance, when visiting the local community centre was labelled as Hindustani/Surinamese by the aged care adviser working in the community centre. However, during my participant observation in this day care centre, I found that clients in this day care group were, despite the name of the group, from different religious and ethnic backgrounds. The group included older people from Sint Maarten and Indonesia, as well as both Muslim and Hindustani Surinamese older people. All clients resided in the same neighbourhood in The Hague, where most had lived ever since they had arrived in the Netherlands. The neighbourhood had seen an influx in new migrant groups, like other neighbourhoods with large migrant populations in European cities (Buffel, Phillipson and Scharf 2013; van der Greft and Droogleever Fortuijn 2017). However, many of the interviewees' friends had stayed in the neighbourhood and regularly exchanged practical support (interview 27M; 28F). What's more, several had learnt about the group through each other, which, again, illustrates how informal and formal relationships of care can overlap in the context of minority communities.

While belonging to a local community often improved access to care, this was not always the case, particularly if members had low proficiency in Dutch and little formal education. An interviewee who regularly visited a Cantonese-speaking meeting group in Nijmegen told me that the members of the Chinese community in Nijmegen had a low education level and low proficiency in Dutch. He argued that this meant that they were poorly organised and were, therefore, struggling to make claims on minority-specific services:

> "It is not easy for us Chinese to have a community here, it is not easy to have this kind of organisation...because we have a closed community. We don't have much contact with Dutch society, and we did not get an education, we have a low education level" (11M).

The group where I met this interviewee was organised by a social care worker. She had struggled to find a Cantonese-speaking volunteer to lead the group (informal interview social worker). The difficulty of finding a volunteer reflects both the low education and limited Dutch skills of the first generation and the acculturation and low Cantonese skills of the second generation of Dutch-Chinese migrants (Bélanger and Verkuyten 2010). Once established, the group strengthened its informal network in Nijmegen. Furthermore, care providers could reach the group with information about care services, through outreach activities during informal meetings. However, the lack of both an informal organisation and minority-specific services with Cantonese-speaking staff still meant that members of the group could not access aged care easily.

While the Cantonese-speaking community in Nijmegen was weakly organised locally, this was not the case in The Hague. Because some of the Chinese older people had moved around the Netherlands before settling in Nijmegen, they had informal relationships of care that stretched across the country, in one case to The Hague. An interviewee explained that his friends in The Hague both told him about minority-specific services and offered to facilitate access for him by using their social network:

> "People in Nijmegen can also apply to live in Den Haag [The Hague], but sometimes the people from Den Haag will get the room first. His friend is a manager in Den Haag, and his friend once told him there is a room and asked whether he wanted to live there" (10M, conducted with an interpreter).

This particular interviewee chose to stay in Nijmegen, close to his children, like Turkish older people in Denmark (Liversage and Mizrahi Mirdal 2017). Although this interviewee chose to stay, members of other groups did not. As pointed out by a member of the Hindustani community in Nijmegen, the lack of services and housing options that met the preferences of older people with a Hindustani background meant that many of these older people ended up moving to The Hague and Amsterdam:

> "Over the years, the need for [minority-specific] services for older people have grown [in Nijmegen]. But there were no such services here and they have not been developed (...) So individual older people have not waited on policy, but have moved to places with more suitable services; The Hague was in the picture for Hindustani older people in Gelderland [the province in which Nijmegen is located]. There, there were already different 'specific' services for Hindustani older people, care homes, nursing homes, but also other extra-mural forms of care" (email exchange, Hindustani community figure).

It was not only older Hindustani people in Nijmegen who had moved to The Hague to access services. A Muslim Surinamese woman who had lived happily in the Dutch rural province of Brabant for most of her adult life, cited the presence of Surinamese Mosques, a Muslim cemetery and a community with a shared minority background as reasons to move to The Hague:

> "I was the only Surinamese woman there [in Dongen, Brabant] (...) And then you realise, you are getting older, and when I die I want to be buried according to my tradition. That is possible here in The Hague. There are many Islamic mosques here. For one person you are not going to make a fuss in a neighbourhood in Dongen, 'I want a mosque too'. No, I adapt to others, that is why I moved here" (26F).

These findings suggest that if there is a lack of services locally that meet religious, linguistic and/or cultural preferences, some older migrants may choose to relocate to care landscapes with minority-specific services and a larger minority community. Because informal relationships of care often stretch outside the spatial boundaries of municipalities, these bonds can function as conduits not only to local services but also to services elsewhere. This has implications for large super-diverse cities with many minority-specific services. As the older migrant population continues to grow in the coming years, some of these older migrants will likely move to cities where they can access services that meet their needs and preferences. It is questionable whether such migrations are desirable, as they might come at great personal cost to the older migrants and their families.

6.3.3 Historical relationships with formal care providers and minority self-organisations

When comparing the interviewees' narratives of accessing care, it became clear that relationships of care could often be traced back in time. Experiences with health and social care services earlier in life, both in their country of birth and in the immigration country were found to influence the level of trust that individuals had in aged care services. In addition, it was found that the history of relationships between formal care providers and minority self-organisations can also influence access to care for entire migrant groups.

Interviews with older migrants who came to The Hague after Suriname ceased to be a Dutch colony constitute an example of how the experience of care and welfare services upon arrival affects individuals' relationship to care services in the present. When interviewed, several of the Surinamese interviewees, unprompted, emphasised the support they had received from social workers when they arrived in the Netherlands and during their first years there, e.g., support to find housing (25M;26F;27M). The narrative of one of the interviewees exemplifies these positive first encounters with social care providers:

> "Someone from social services guided us through the process, took us to view houses. I said I don't need to look, it is good if it is in Brabant [a Dutch region]. It was very beautiful when the houses were finished, those had been furnished for us" (26F).

The narrative of this interviewee highlights how 'structural forces that occur over an extended period of time intersect with individual life trajectories' and continue to shape relationships of care into the present (Ferrer et al. 2017: 15). The quoted woman was not the only one with this experience, other interviewees who came to The Hague after Suriname ceased to be a Dutch colony also brought up positive experiences with social care services in the past and also expressed trust in services in the present. For example, a male interviewee of Surinamese origin emphasised the importance of asking for help from welfare services: 'You have to make your problems known, you have to get informed, then you get a solution' (25M). These examples highlight how support at the time of arrival can create relationships of trust with formal care providers which are sustained over time.

Just as positive early encounters can facilitate access to aged care later in life, negative experiences of racism and discrimination can hinder it (Ferrer et al. 2017). In the present study, no interviewees mentioned racism when asked about negative experiences with aged care providers. However, some interviewees spoke of communication difficulties (1F; 9F) and a feeling of not being listened to (12M). Despite difficulties with communication, the female interviewee expressed gratitude towards care services:

> "You should not complain about care...for [older] migrants, in general, it is difficult. We need a lot of care and we can not express it very well, so we are a difficult group, but that does not mean we should criticise too much, they do their job" (1F).

These findings echo results from a study on migrants' unsatisfactory experiences with the Swedish health care system, in which migrant women were found to express gratitude for the care they received, despite having unsatisfactory experiences with some services (Bradby, Humphris and Padilla 2020).

Thus far, the discussion has focused on how individual experiences with health and social care services throughout the life course can generate trust in services in the present. However, this was not the only way in which past experiences concerning relationships of care could facilitate, or obstruct, access to care. Another historical care relationship that was found to be important in facilitating access was that between care organisations and minority communities. The case of the so-called Hindustani day care group in The Hague illustrates this point.

The day care group had originally been established by the Hindustani neighbourhood organisation to allow older members to meet. Some years later, a mainstream care

provider offered to facilitate the meetings. The group began to meet in the community centre and a woman with a Surinamese background was hired to coordinate the group's activities (interview 27M; day care coordinator). In addition to facilitating activities, the day coordinator engaged in outreach during festivities organised by the neighbourhood organisation for Hindustani people (interview day care coordinator). Interviews with several of the day care coordinators and activity leaders of other groups revealed that outreach activities were common practice. Ongoing relationships between care providers and minority self-organisations can thus facilitate older migrants' access to aged care services.

It should be noted that these relationships do not always have to be between specific care providers and minority self-organisations. In Nijmegen, I found evidence that the presence of historical relationships between local care professionals and specific minority communities facilitated access to care. During the study, a multicultural residential care home and day care centre which primarily targeted Turkish older people in Nijmegen closed its doors. In response, a mainstream social care organisation started a Turkish day care group (informal interview staff member of a mainstream care organisation). This new initiative is evidence of well-established relationships between professionals, older people and informal organisations. Communities that care professionals have experience reaching are more likely to continue to receive minority-specific care in the future, which, as mentioned above, is known to facilitate access to aged care services. For example, the daughter of an interviewee (14F) heard about home care for the first time at a women's group in a multicultural neighbourhood in The Hague:

> "I was at a women's group, they gave information, and then I thought, this is something for my mother, and then we came to [minority-specific home care provider]" (daughter of 14F).

The fact that well-established communities with existing relationships with care organisations are more likely to access care also sheds light on the position of older migrants belonging to smaller and/or less established minorities locally. Individuals from smaller or recently arrived minorities, such as Iranians in both Nijmegen and The Hague (interview social worker Nijmegen; aged care adviser The Hague), are likely to have low access to care both because of a higher likelihood of limited proficiency in the majority language and because of a lower likelihood of a well-established minority community.

6.3.4 Increasing older migrants' access to care in urban places

Drawing on the findings from this study, several suggestions can be made for what policymakers and care providers could do to address local inequities in access to and use of aged care. Studies on inequalities in access to care faced by older migrants often call

for more services that better meet older migrants' cultural and linguistic preferences (Koehn 2009; Ahaddour, van den Branden and Broeckaert 2016). This study confirms that what is here termed 'minority-specific' services do facilitate access. It also brings nuance to the understanding of how and for whom these services are beneficial. For older people with little proficiency in the local language and/or a large socio-relational distance to mainstream services, minority-specific services facilitate the negotiation of norms regarding filial piety and/or enable older migrants to be more independent in arranging their care. For older migrants who were proficient in Dutch, the existence of minority-specific services was not a prerequisite for accessing care, but an option that promoted their sense of belonging and facilitated connection to informal networks. Some researchers in the field of health and social care have been sceptical of minority-specific services that target ethnic groups, as it is not considered feasible to provide such services to super-diverse populations (Phillimore, Bradby and Brand 2019). This study shows that minority-specific services can be feasible in the case of aged care provision, since the findings highlight that most minority-specific groups gather clients from more diverse backgrounds than might be expected. The findings highlight that a shared place identity (i.e a common place of residence), religious background and/or language can constitute unifying factors for aged care services. This insight is significant since it opens possibilities for service providers to target groups with multiple shared backgrounds, in some cases drawing on already-existing communities.

While the descriptions of the situation of different migrant groups in relation to aged care are specific to the two case studies, the method of care landscape mapping can be used to tailor service provision in other cities. Policymakers and care providers are advised to map the local landscape, by using and/or producing overviews of existing services and the different local communities, drawing on census data and the local knowledge of care workers and minority self-organisations. While the study shows that ethnicity is a poor proxy for an older person's ability to access aged care, it does show that a person's ethnic, cultural and religious background can indicate their embeddedness in the local landscape of care. For example, older people belonging to locally small minorities or older people who have migrated recently are more likely to struggle both to access care and to find care options that meet their preferences. By establishing and continuously updating their knowledge about the make-up of the care landscape, care providers and policymakers can begin to think creatively about how to reach individuals from groups with a large socio-relational distance to aged care services.

Apart from providing a method for analysing access to care locally, the paper sheds light on how the local configuration of relationships of care stretches over time and space. Experiences with health and social care services earlier in the life course can either serve to narrow or increase the socio-relational distance to services in the present. For that reason, it is important to support migrants when they arrive, as positive first encounters

can establish a relationship of trust with formal care (Naldemirci 2013; Suurmond et al. 2011). While immigration policies often are decided on the national level, policymakers at the urban level can still incorporate recommendations and funding for health and social care workers to invest in building relationships with minority communities in local policies (Carlsson and Pijpers 2020).

By seeing urban places as configurations of informal and formal relationships of care, the study highlights that informal networks of care can function as conduits for accessing formal care. If there are minority-specific services in a particular city, being part of a well-organised minority group in that city often means that one has connections to providers targeting minorities, through staff and managers with a shared background. Whether minority-specific services exist locally or not, communities that are well established are more often subject to outreach activities by care workers, which can also narrow the socio-relational distance to care services (see also Carlsson and Pijpers 2020). Policymakers and care providers are, therefore, encouraged both to support existing communities and to look for opportunities to mobilise communities of older people that are currently weakly embedded in informal networks. Because informal networks can stretch outside the boundary of the local care landscape, such relationships of care can also facilitate access to care services in other cities. As the population of older migrants grows, it can, therefore, be expected that cities with well-established minority communities and large numbers of minority-specific services will see increased pressure on the latter.

6.4 Conclusion

Older people with a migration background constitute a growing and increasingly diverse population in many immigration countries in Europe and North America (de Valk and Fokkema 2017; Karlis et al. 2018; van Gaans and Dent 2018; Salma and Salami 2020). Despite a growing awareness of the barriers that members of this population might face in accessing care, older migrants continue to experience inequalities in access to and use of care. The ambition of this paper was to offer an analytical framework that provides insight into what facilitates access to care where it takes place: in the cities and neighbourhoods where these older people live. To this aim, it offers a framework that combines relational approaches to place (Milligan 2009; Milligan and Power 2010; Milligan and Wiles 2010; Power and Williams 2020) with the notion of super-diversity (Vertovec 2009; Boccagni 2015; Bradby et al. 2017). From this perspective, access to aged care is perceived as an outcome of an individual's embeddedness in a local configuration of relationships of care, which is spatially concentrated in, but not confined to, the city. By shifting the focus from characteristics of ethnic groups to how variables of super-diversity play out in local landscapes of care, the paper responds to criticisms of gerontological research on older

migrants' access to care, which is accused of relying on simplified notions of ethnicity (Kramer and Barker 1994; Koehn et al. 2013; Torres 2015; Zubair and Victor 2015).

While the paper draws on findings from a larger study on aged care provision for older migrants in the Dutch cities of Nijmegen and The Hague (see also Carlsson and Pijpers 2020, 2021), the focus, here, is on the narratives of 32 older migrants who had accessed home care, home aid or day care. Most of these interviewees were accessed via minority-specific day care providers. It can be argued that this recruitment strategy gives a limited view of the care landscapes in question. However, it should be noted that this strategy was adopted because very few older migrants used mainstream care providers. Nevertheless, interviews with a larger number of older migrants using mainstream services might generate new insights into how these providers can facilitate access to care.

Although the older immigrants' narratives were central to the analysis, the aim of the study was to generate insight into how care providers and policymakers can facilitate access to care for those older migrants who continue to experience a large socio-relational distance to services. The study shows that by using local knowledge to mobilise and service migrant communities around the most suitable shared identities in a particular city, policymakers and care providers can take concrete steps to address health inequities at the urban level. Such local strategies do not address the structural inequalities and injustices that contribute to the health inequalities experienced by older migrants and minorities (MacLeavy 2008). However, local measures can still constitute a step towards greater justice, which is why I argue that they are both needed and worthwhile (Rosenberg 2014).

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CHAPTER 7
CONCLUSION

7.1 Introduction

The overarching research question guiding this study was: **What are the scope and limitations for responsiveness to older migrants' needs in aged care practices in local landscapes of care in times of post-multiculturalism and localism?** To answer this question a three-year, qualitative study was conducted in the cities of Nijmegen and The Hague, the Netherlands. Researchers from the fields of Urban Studies and Public Administration have found that while national institutions, policies, and politics influence service provision, individual policymakers and/or practitioners often adapt service provision in response to local needs (Durose 2009; Jupp 2013; Emilsson 2015; Barberis, Bergmark and Minas 2017; Martínez-Ariño et al. 2019). The empirical novelty of this thesis lies in that it extends the literature on local governance of diversity to include aged care provision for older migrants. Theoretically, the thesis contributes to the literature on aged care for older migrants as well as the field of Health Geography through a reinterpretation of the care landscape framework (Milligan 2009; Milligan and Wiles 2010; see also Section 1.3.2). Thus, I have been able to i) explain *how* the embeddedness of local care landscapes in localism and post-multiculturalism can limit local responsiveness to older migrants' care needs (Chapters 3, 4 and 5), and ii) identify how local actors can still work toward greater justice within the aforementioned limits (Chapters 3, 4, 5 and 6).

This concluding chapter proceeds as follows: In Section 7.2 I will provide an answer to the overarching research question. Upon summarising the key findings, it is then concluded that localism and post-multiculturalism provide the scope for local policymakers and practitioners to provide a mix of services that meet older migrants' needs in the short term. However, to justify such a service mix, local actors have had to frame older migrants' needs as a temporary issue predominantly caused by low proficiency in Dutch. Such framing may limit responsiveness in the long term as it undermines investment in local knowledge and networks necessary to address inequities in access.

While Section 7.2 provides a critical reading of the findings, Section 7.3 looks at the same findings through a more hopeful lens. Here I apply insights from relational Health Geography to suggest how policymakers and practitioners can work towards greater justice. Section 7.4 focuses on how the thesis advances theoretical debates on aged care for older migrants by i) offering conceptual tools to study local governance of aged care, ii) introducing a greater justice agenda, and iii) offering a relational re-interpretation of access to aged care. In this section I also reflect on how the thesis contributes to current theoretical and methodological debates in Health Geography. In Section 7.5 this is followed by suggestions for future research on the responsiveness to migrants' care needs in current and future care landscapes from an international perspective. The thesis concludes with a call to researchers to investigate aged care not only through

the hermeneutics of suspicion but also through the hermeneutics of faith (Ricouer 1981; Levitas 2012) in Section 7.6.

7.2 Answering the research question

In investigating the scope and limits for local responsiveness to older migrants' needs, I focused on two policy expressions of localism and of post-multiculturalism influencing aged care provision. The first is neighbourhood governance[33] in the form of neighbourhood-focused service delivery and the second is diversity-mainstreaming[34].

A shared characteristic of diversity-mainstreaming and neighbourhood governance is a preference for services that are tailored to all neighbourhood residents rather than the provision of services to disadvantaged minority groups, such as older migrants (Helberg-Proctor et al. 2017). Theoretically, the introduction of neighbourhood governance and diversity-mainstreaming could have led to the abandonment of minority-specific services and activities. However, I found that both cities of Nijmegen and The Hague provided a mix of minority-specific and diversity-mainstreamed services despite a preference for the latter at the national level (Chapter 3).

Diversity-mainstreaming creates scope for local responsiveness because of the space for different interpretations afforded by the term 'diversity'. This provided local actors with the freedom to continue with services that were found to meet older migrants' care needs. For example, in The Hague, intercultural aged care advisers received continued financing, despite a strong commitment to diversity-mainstreaming from the local authorities, with the caveat that such minority-specific services were only included in response to the language needs of the *current* generation of older labour migrants (see Chapter 3). In Nijmegen, policymakers allowed minority-specific day care centres to remain in their current location and receive clients from the entire city as long as they were committed to eventually move to more multicultural neighbourhoods 'should it be economically feasible' (see Chapter 5). Practitioners were also found to negotiate the spatial and organisational boundaries of neighbourhood governance and diversity-mainstreaming. They did so by mobilising local knowledge and multilevel professional networks to tailor services to the needs of older migrants, despite the formal requirements to focus their activities on all neighbourhood residents (Chapter 4, see also Bartels 2017; Durose 2009; Jupp 2013; Smith et al. 2016). The findings indicate that in the crafting of aged care practices, local concerns had greater weight than national policies.

33 Neighbourhood governance can be defined as "public service delivery at the sub-local level" (Lowndes and Sullivan 2008: 62), see also Section 1.4.2 and Chapter 4)

34 Diversity-mainstreaming refers to efforts to have attention for 'diversity' across all policy domains and within all public services (van Breugel and Scholten 2017), see also Section 1.4.1 and Chapter 3)

As shown above, during the study it was found that neighbourhood governance and diversity-mainstreaming provided scope for policymakers and practitioners to adjust the services provision to older migrants' needs. However, I argue that taking a long-term perspective, neighbourhood governance and diversity-mainstreaming may undermine the responsiveness to older migrants' needs. There are two, related reasons why this might be the case. Firstly, both policies elicited a framing of older migrants' needs as a temporary problem that was caused by the low language proficiency of the current generation of labour migrants. Because older migrants' needs were seen as a temporary issue, the cities had not developed strategies on how to maintain and develop local knowledge and networks. Often contained within minority-specific services, I found these to be vital if access to aged care was to be increased and the response to older migrants' care needs was to be improved (Chapters 4 and 5). As repeatedly shown by geographers, places are dynamic and change over time. For local knowledge and networks to be updated, continuous investment is therefore required.

Secondly, in addition to the framing of older migrants' needs as a temporary problem, I observed a tendency to describe older migrants' care needs as problematic and caused by their failure to integrate. By describing older migrants' needs in this way, no acknowledgement is given to the fact that migration-related diversity can be a source of belonging and meaning (Chapters 5 and 6, see also Emami et al. 2000; Patzelt 2017). Furthermore, framing older migrants' needs as a 'temporary problem' ignores the fact that future older populations in cities will become more, not less, 'super-diverse' (Vertovec 2007; Boccagni 2015; Phillimore, Bradby and Brand 2019), because of the intersection of the demographic trends of ageing, migration and urbanisation (Wanka et al. 2019). Local actors may well have chosen to draw on these frames for strategic reasons, i.e. to meet present care needs within the boundaries of policy and the political preferences of both local and national governments. Nevertheless, it is questionable whether diversity-mainstreaming and neighbourhood governance practices in their current forms prepare local care landscapes for future older populations because the aforementioned frames may continue to exist.

7.3 Implications for practice

The findings confirm that local actors are limited in their ability to address structural inequities in access to aged care (as also observed by Levitas 2012; Smith et al. 2016). While the current policies may not be ideal, if the goal is to achieve equity in access on a structural level, the thesis shows that policymakers and practitioners can still work toward greater justice in a local context. The thesis does so by applying a relational geographic lens (Cummins, Curtis, Diez-Roux, & Macintyre, 2007; Duff, 2011; Milligan, 2009; Milligan & Wiles, 2010) From a relational perspective, accessibility depends on the relational distance

that someone experiences to the services she/he wished to access. In addition to the physical dimension (spatial proximity) and the institutional dimension (right of access, need for referral), relational distance has a social dimension including trusting relationships and access to navigational support (Cummins et al. 2007; Green et al. 2014, see also Chapter 6). To reduce the older migrants' relational distance to aged care services, practitioners and policymakers will have to invest in relationships between individuals, local minority communities and care services.

7.3.1 Suggestions for practitioners

It is possible for practitioners and care organisations to reduce the relational distance in two ways. The first approach, as discussed in Chapter 5, is to create spaces of care that have a spatial atmosphere[35] that resonates with the older migrants one seeks to reach (Reckwitz 2017). Such places can facilitate the transformation of material aspects of practice, such as meals, music and furniture, so that these become a better fit with the life world of the care receiver. In addition, when staff communicates in the native language of clients and, so, makes it possible for older migrants to use their native tongue, such minority-specific spaces enhance not only a sense of belonging but also the clients' agency in terms of the care received (Chapters 5 and 6). Minority-specific spaces of care also provide practitioners with some scope to tinker with and translate other aspects of practices to create a better fit with the older migrants' needs and preferences, for example through staff relating with care receivers in a more familiar way, and by rethinking the role of the family, i.e. moving away from the idea that family must provide the care themselves to the family making sure that the older person is cared for (see Chapter 5).

The second approach, discussed in Chapters 4 and 6, focuses on building relationships of care with older migrants to reduce the distance to access aged care services. Practitioners did this by networking and conducting outreach activities in places frequented by older migrants (Chapters 4 and 5). This was done by participating in activities of minority self-organisations, visiting religious places frequented by older migrants, or, in the case of mainstreamed services, by collaborating with minority-specific care organisations. To carry out this 'relational work'[36] city-wide, inter-organisational networks were found to be instrumental. These facilitated collaboration and the exchange of knowledge. In addition, the networks allowed practitioners to engage in moral conversations about how to achieve equity and justice in specific situations (Chapter 4). All of these activities pre-existed the study. However, by articulating them as a practice it becomes possible

35 Reckwitz defines spatial atmosphere as happening in a place when objects and people interrelate to evoke emotions and motivations to participate in a practice, in this case formal care (2017: 120), see also Section 5.1.2.

36 Relational work is defined as "actions aimed at improving access to services by bridging the relational distance between residents and service providers" (Section 4.3).

for researchers to highlight and explain the value of such activities[37] to policymakers and practitioners, and in doing so supporting local 'exemplary practitioners' already engaging in relational work (van Hulst, de Graaf and van den Brink 2012).

7.3.2 Suggestions for policymakers

To increase older migrants' access to care, it is first suggested that policies are put in place which facilitate the relational work of practitioners. This entails that policies should support care organisations and individual practitioners in the creation of and/or the collaboration with minority-specific care spaces, as well as establish and work in city-wide, inter-organisational networks. Policymakers can play a crucial role by explicitly supporting these practices in their policies and by providing financial support since relational work is found to be particularly time-consuming (Chapter 5).

The findings show that access to services is dependent on factors of migrant-related diversity, such as migrant trajectory, Dutch language proficiency and a migrant's embeddedness in the local community, rather than on ethnicity (Chapter 6). The second suggestion is, therefore, that policymakers collaborate with practitioners working with older migrants to ensure they update the maps of the demographic, social and organisational structure of the local care landscape (Chapter 6). Such mapping can serve to identify which groups are likely to have low access to services, and how these groups can be targeted to access services through mobilising migration-related identities that are salient in the specific local context. An example may be to organise activities for older people from different ethnic backgrounds sharing the same religion (Chapter 6).

Lastly, the findings underscore the necessity of considering the long-term implications of integration, health care, and social care policies. The findings show that older migrants who had positive encounters with social services on arrival in the Netherlands were likely to use aged care services later in life. It could then be said that if the current generation of older labour migrants had experienced better access to social support and care, they would, in all likelihood, have accessed aged care with more ease and more readily than is currently the case (Chapter 6). By investing in social care for incoming migrant groups, policymakers might mitigate the struggle of future generations of older migrants to access care. Table 7.1 provides an overview of suggestions how policymakers and care practitioners could work towards greater justice through three approaches: i) generating and mobilising local knowledge, ii) establishing and working in local networks, and iii) by creating minority-specific care spaces, and/or including these in their services, and/or collaborating with minority-specific care spaces.

37 Personal conversations with D. Nicolini, Practice and Processes reading group 16 November 2020.

Table 7.1 Suggestions for policymakers and practitioners

	Policymakers	Practitioners
Local knowledge	Use the method of care landscape mapping to identify underserviced and vulnerable groups locally (Chapter 6). Incentivise minority-specific and mainstream care organisations to engage in collaboration and knowledge exchange (Chapters 3 and 4).	Participate in collaboration and knowledge exchange between minority-specific and mainstream care organisations (Chapter 4). Deliberate with colleagues about diversity-sensitive and equitable course of actions in specific situations (Chapter 4).
Local relationships of care	Apply a life course perspective to migration, integration and care policies (Chapter 6). Facilitate neighbourhood-focused and city-wide networks aimed at knowledge exchange and collaboration between minority-specific, intercultural and mainstream organisations (Chapter 4).	Build and maintain a network of key figures in local minority groups (Chapter 4). Cooperate with practitioners who have good relationships with underserviced individuals or communities (Chapter 4). Do outreach activities to communicate about available services in places that are visited by older migrants (minority self-organisations, minority-specific care spaces, religious spaces) (Chapters 4 and 5).
Include and utilise minority-specific spaces of care	Make provision in the policies for the establishment of a mix of minority-specific and diversity-mainstreamed care organisations (Chapter 3, 5 and 6).	Do outreach activities in minority-specific care spaces (Chapter 5).

The suggestions in the above table centre on methods for reducing the relational distance between older migrants and aged care services. Many of the practices listed in the table, such as outreach activities and deliberation with colleagues about cases, pre-existed the study. However, similar to the findings mentioned by Ciobanu (2019), I, too, found that efforts to be sensitive to migration-related diversity to a large extent hinged on the commitment of individual practitioners. To ensure that all older migrants receive high-quality care, it is therefore suggested that the above practices are prescribed in policies and are made part of the education of social work and health care practitioners. By making relational work, including the activity of moral deliberation on how to achieve equity, integral to the existing aged care practices, it can be expected that practitioners will be able to achieve greater justice in their daily work (Maynard-Moody and Musheno 2012, see also Chapter 4).

7.4 Contributions to the scientific literature

In this section, I will first discuss how the thesis contributes to the literature on aged care for older migrants by linking this debate to research on local governance in the disciplines of Urban Studies and Public Administration. Thereafter, I will reflect on how this thesis contributes theoretically to interdisciplinary debates on aged care by i) introducing a greater justice agenda, and ii) offering a relational re-interpretation of access to aged care. In the final section, I will discuss how the thesis contributes theoretically and methodologically to the subdiscipline of Health Geography.

7.4.1 Introducing a local governance perspective on aged care for older migrants

As discussed in Section 7.1, researchers on aged care for migrants and minorities have been slow to investigate how political and policy discourses shape local service provision. In this thesis, I have begun to address this gap by linking the literature on older migrants to current debates on local governance in the fields of Urban Studies and Public Administration. Furthermore, I have attempted to initiate innovation to both fields by applying two practice-oriented approaches to analyse local interactions between policymaking and caregiving. In addition, as discussed in Chapter 2, the thesis uses social practice theory to provide insight into how researchers can valorise findings in a sustainable way.

The first theoretical approach chosen aimed to apply the concept of 'crafting practices' (Bannink Bosselaar and Trommel 2013). In research on national and local integration policies in Urban Studies, it is sometimes assumed that partial implementation of national diversity-mainstreaming policies is caused by the pragmatism of local policymakers (Schiller 2015). By focusing on the interactions between a wider range of actors, including managers of care organisations and practitioners, this thesis has generated further insights into the local implementation of national policies. It was shown that local actors engaged in deliberate 'crafting' of practices, which reflected ongoing concerns with equity of access to aged care services for older migrants. 'Diversity' has become a common policy term not only in the Netherlands but also in many other countries. 'Crafting practices' can therefore be a useful concept for scholars interested in local interpretations and implementations of diversity in aged care elsewhere (Chapter 3).

The second theoretical approach, described in Chapter 4, was to focus on how practitioners negotiate and tinker with the boundaries of local policies and caregiving practices. From the perspective of social practice theory, one way in which practices can be transformed is when practitioners use opportunities for 'bounded creativity' (Nicolini 2012). This means that practitioners adapt how a practice is performed in order to achieve the formal goals of a practice while still responding to the unique needs of the situation at hand (Gibson et al. 2020). In Chapter 5, several examples are given of how staff in day care centres aim to align day care better with the life world of older migrants, by adapting

activities, like physical exercises, and norms, such as what the relationship between clients and staff should be like. By focusing on how practitioners work with and around policies, this thesis highlights the importance of understanding both the place- and policy context in which practitioners operate. Such a perspective is important if we are to understand the limitations on 'what practitioners can do' to meet older migrants' needs (Torres 2019: 177).

A methodological contribution of the thesis is that it outlines how insights from social practice theory can be used to inform the production and valorisation of knowledge. From a social practice theory perspective, a dilemma of valorisation is that the rhythms of the research practice lag behind those of the professional field (Blue 2017). As a result, scientific knowledge, once made public, might have become irrelevant to what is currently happening in the field. Furthermore, because of time and financial pressures, it is in many cases unsustainable for health and social care practitioners to enrol in new practices, for example, by participating in focus groups (Sheard and Peacock 2019). To resolve these issues the following was done: i) I engaged in existing practices of knowledge sharing, and ii) I worked together with local stakeholders to both articulate the practice of relational work and enrol more practitioners in it (see Section 2.5). Considering the increased emphasis on societal impact by funders and universities, as well as the problem of insufficient mobilisation of knowledge in the field of aged care for older migrants (see section 1.1), the practice-oriented participatory methodology reported on in this thesis could well assist researchers working with local policymakers and practitioners.

7.4.2 Introducing a greater justice agenda to the literature on older migrants

In investigating how urban practitioners and policymakers seek to respond to older migrants' needs, I decided to follow the empirical tradition of looking for possibilities for greater justice locally midway in the research process (see Section 1.3.1 and Chapters 4 and 6). At the outset of the project, the aim was to investigate whether localism would lead to spatial inequity in access to care. However, after having studied the daily work of several 'exemplary practitioners' (van Hulst, de Graaf and van den Brink 2012), this focus shifted towards investigating how practitioners sought to achieve greater justice locally, for example, by adapting practices and engaging in moral conversations (Chapter 4).

In contrast to the theoretical discussions on ideal and non-ideal justice (see e.g. Stemplowska and Swift 2012), empirical research on greater justice concerns itself with identifying principles in relation to how justice can be achieved in the present situation through shared understandings between local actors (Valentini 2012). While this approach is common in Health Geography literature (see e.g. Hall and McGarrol 2013; Jupp 2013; Smith et al. 2016; Williams 2020), it is not often applied in the literature on aged care for older migrants. Literature on older migrants that uses a justice perspective tends to identify structures of oppression to which older migrants are subjected. Examples include studies that identify a tendency of practitioners to 'Other' older migrants resulting in a

lower quality of care (de Graaff and Francke 2009; Jones, Moyle and Stockwell-Smith 2013; Torres, Ågård and Milberg 2016; Chaouni Berdai and de Donder 2019), and studies that highlight racism and discrimination as barriers to access (Brotman 2003; Iliffe and Manthorpe 2004; Ferrer et al. 2017). While actions to address these injustices are urgently needed, the injustices are unlikely to be resolved quickly, because of their institutional and systematic nature. Therefore, I argue that a greater justice approach is a valuable complement to the issues described in this literature.

In this thesis, I have given examples of how an empirical greater justice perspective can be applied to study care for older migrants. One example of how to do so can be found in Chapter 4, which articulates relational work as a practice through which practitioners can identify how greater justice can be achieved through moral deliberation. Similarly, Chapter 6 offers care landscape mapping as a tool to achieve greater justice by identifying i) which older migrant groups are locally vulnerable, and ii) around which identities aged care services can be tailored to include them. To summarise, empirical research informed by a greater justice agenda is important, because it can be used to identify feasible approaches to address inequities in access in the short term perspective.

7.4.3 Offering a relational re-interpretation of access to aged care

A common way to conceptualise why older migrants use less care than their counterparts in the majority population has been to focus on what is termed 'barriers to access'. Examples of such barriers include low health literacy, cultural norms limiting knowledge about health care systems, limited proficiency in the local language and low health literacy (Brotman 2003; Greenwood, Habibi et al. 2015, Ahaddour, van den Branden et al. 2016, Arora et al. 2018). Research investigating barriers to access has tended to focus on such barriers in relation to ethnic groups in the national context (Suurmond et al. 2016; Chaouni Berdai, Smetcoren and de Donder 2020; Czapka and Sagbakken 2020, Nielsen, Nielsen and Waldemar 2020). This thesis breaks with this tradition, and instead conceptualises access to care as a question of overcoming relational distance (Chapter 5), which is mediated by the characteristics of the city of residence and by individual factors of "super-diversity" (Vertovec 2007; see Chapter 6). This alternative theorisation has several advantages: i) it shifts the focus away from ethnicity as an explanatory model, ii) it emphasises the role of practitioners and policymakers to increase access, and iii) it sheds new light on minority-specific care.

A relational re-interpretation of access to aged care with a focus on migration-related diversity shifts the focus away from ethnicity as an explanatory variable for barriers to access to care. Such an alternative is needed considering critiques by gerontologists for relying on simplified notions of ethnicity (Kramer and Barker 1994; Koehn et al. 2013; Torres 2015; Zubair and Victor 2015). These authors have pointed out that ethnicity is irrelevant as an explanatory factor for some of the causes of inequity in access to care,

for example in the case of low proficiency in the local language and/or a low level of literacy. Furthermore, by centring on ethnicity, researchers can fall into the trap of over-emphasising cultural causes for low access to services.

The second advantage of a relational re-interpretation of access is that it conceptualises access as an achievement hinging predominantly on the efforts of practitioners. As shown in Chapters 4, 5 and 6, practitioners can facilitate access to services for older migrants, who face significant 'barriers to access', through relational work, for example, through outreach, and networking, and by translating the meaning of aged care practices. As such, a relational re-interpretation of access to aged care with a focus on migration-related diversity constitutes a significant contribution to the quest of shifting the attention of gerontological research from the characteristics of older migrants to the actions of practitioners and policymakers (Torres 2019; see also Section 1.1).

Thirdly, a relational interpretation of access that emphasises place and migration-related diversity, rather than ethnicity, puts so-called 'ethno-specific' services in a new light. In the case of superdiverse populations, service provision tailored to ethnic minority groups is often considered an unfeasible strategy (Iliffe and Manthorpe 2004; Phillimore, Bradby and Brand 2019). However, this thesis has shown that many aged care services tailored to older migrants are minority-specific rather than ethno-specific. As shown in Chapter 6, whom the services attract depends on which migration-related identities are salient in the local context. For example, a multicultural day care centre in Nijmegen brought together older people from Turkey, Iran, Morocco and Afghanistan who all connected because of their shared Islamic faith and/or their ability to communicate in Turkish. Minority-specific services centred on broader identities than ethnicity might, therefore, be a feasible approach to deliver diversity-sensitive aged care in cities (in combination with mainstreamed services, see Section 7.3.2)

7.3.4 Contributions to Health Geography

Within the field of Health Geography there is a growing "interdisciplinary scholarship encompassing the application of geographical perspectives, concepts and approaches to the study of ageing, old age and older populations" (Skinner, Andrews and Cutchin 2017: 3). The thesis has contributed to these debates through the practice-oriented re-interpretation of the care landscape framework (see Section 1.3.2), and the associated methodological approach (Chapter 2).

To date, researchers applying the original care landscape framework have generated studies on how changing regimes of care and welfare influence practices in places where care is provided (e.g. Conradson 2003; Dyck et al. 2005; Williams 2016). However, although Milligan and Wiles (2010) stressed that the concept of 'landscapes of care' should be used to investigate how "proximate and distant care relationships intersect and relate to one another" (Bowlby 2012: 2104), there has been little research into how organisational and

governance-related processes transpire through such caring relationships. One reason why the application of the care landscape framework has been limited when it comes to studying the governance and organisation of formal care is that the concept arguably lacks a way to articulate how practices in physical places reproduce or transform the care landscape as an entity. By understanding relationships of care as *manifested in social practices* (see Section 1.3.2), this thesis offers a theoretical operationalisation of the care landscape concept. As shown in Chapter 5, the reinterpretation of the care landscape concept can be used to analyse how practices in spaces of care may transform the wider care landscape. The framework of the thesis can also be used to analyse how national and local policies shape the scope and limitations for urban actors to respond to local care needs (Chapters 3 and 4).

In addition, this thesis has offered a methodological operationalisation of how geographers can study the interactions between national and local policy and care practices at the urban level. It is possible that a reason why the care landscape concept has had limited application is that it does not prescribe how researchers are to collect data that can be used to connect what occurs in spaces of care with trends in the wider landscape (see Chapter 5). As argued by Cutchin, Skinner, and Andrews (2017) scale is a "key part of the uniquely geographical gerontological imagination" which allows one to "zoom in and zoom out on a problem to discern different patterns and processes in the subject matter of ageing, old age and older populations" (2017: 314). By applying the research strategy of zooming in and out, inspired by Nicolini, (2009; 2012), this thesis provides geographers with a methodology to study phenomena operating at different scales (see Chapter 2).

Lastly, by describing how the valorisation and dissemination activities were informed by social practice theory, the thesis offers suggestions how researchers can work with local actors towards societal impact (see Section 2.5). As such, this thesis offers a methodological contribution to the Health Geography literature, particularly the strand of the literature concerned with identifying possibilities for greater justice locally (Jupp 2013; Rosenberg 2014; Smith et al. 2016).

7.5 Mapping current care landscapes and imagining better futures: A research agenda

In this thesis, it has been shown that, while neighbourhood governance and diversity-mainstreaming were found to provide scope for responsiveness in the current context, these may undermine responsiveness to older migrants' needs in the long-term. Based on this insight, I wish to sketch two possible directions for further research. The first line of inquiry concerns the reproduction of inequities in current local landscapes of care. To date, little attention in the literature on local governance has been given to the subject of

care for older migrants. While this thesis has made a begin to address this gap, questions remain about how local governance of care impact on older migrants' access to care in countries with welfare regimes, histories of migration and integration policies different from the Netherlands, and countries espousing different ideas about family carers' roles and their right to receive support.

The second line of inquiry concerns future landscapes of care. Critical literature on older migrants and care has tended to focus on how older migrants are structurally oppressed and disadvantaged (see Section 7.4.2). In this thesis, I have advocated for this literature to be complemented by studies that are focused on how greater justice can be achieved. In keeping with this hopeful approach, I would like to encourage researchers to investigate what a more future-oriented response to super-diverse older populations could look like. In the section below these two lines of inquiry are discussed further.

7.5.1 How are inequities reproduced in current local landscapes of care?

Whereas this study has begun to map how inequities in access to care are reproduced and contested in different localities, the study has two important limitations. Firstly, the present study has only considered cities in the Netherlands. Secondly, family carers were omitted from the study, even though family members carry out a large share of aged care for the population group because of the low use of formal aged care by this group.

As noted in Section 1.1, inequities in access to aged care is a persistent problem, also in other European countries where care is locally governed. Processes of local governance have been found to differ between countries (Arlotti and Aguilar-Hendrickson 2018; Martínez-Ariño et al. 2019). Furthermore, research on national care policies has revealed that there is much variation between countries in how migrants' care needs are framed and responded to (Mladovsky et al. 2012, Karl and Torres 2015, Brandhorst, Baldassar and Wilding 2021). Such variations are caused by different discourses on citizenship and differences in welfare regimes. It is therefore relevant to extend the present study to other national contexts which differ from the Netherlands in these regards. In all likelihood, there will be variations between countries pertaining to how localism and post-multiculturalism delimit the scope for local actors to respond to migrants' needs.

In addition to a comparison of countries, it would be useful to study differences in implementation between cities in countries with different policy histories and welfare regimes compared to the Netherlands. This thesis has shown that, indeed, there were differences in how 'diversity' and older migrants' needs were framed in Nijmegen and The Hague. However, the thesis did not explain which place-related factors create these differences in implementation. Research on the local adoption of diversity policy has shown that such factors differ per country. For example, in France the local political constellation is crucial, while the extent of population diversity is more important in Germany (Martínez-Ariño et al. 2019). If we are to understand how such characteristics

specific to places shape the responsiveness to older migrants' needs, comparisons of different cities regarding the approach taken need to be conducted.

A second limitation of this thesis is that family carers were omitted from the study. This is an important omission, considering how little formal care older migrants use. It is also a gap when considering the political trend toward responsibilisation of care receivers and their families, which has become a common phenomenon in many European countries (Milligan and Conradson 2006; Maarse and Jeurissen 2016; Grootegoed and Tonkens 2017; Power and Hall 2018). In the literature on aged care for older migrants, there is a strand that focuses on the experiences of family carers (Yerden 2013; de Tavernier and Draulans 2018; Berdai Chaouni and de Donder 2019; Arora et al. 2020). However, there is little research on the role of family carers in relation to other actors in the care landscape. Questions remain about how family carers are reached out to by local authorities and care organisations, and which policies and practices are in place to support them. Existing research shows that migrant family carers face challenges to access care (Berdai Chaouni and de Donder 2019). Investigating whether and how family carers are currently supported, and how such support can be improved, is therefore an important issue.

7.5.2 How can migration-related diversity in the older population be responded to in a more future-oriented way?

The study has shown that the framing of older migrants' needs in Dutch policy is focused on the short term, even though it is certain that migration-related diversity is a long term issue. As argued by Thelen and Coe, aged care "is an interactive process in which older persons, their caregivers, the state and other actors negotiate modes of political belonging that entail affect as well as rights" (2017: 279). The question is how migration-related diversity can be framed in a more future-oriented way, one that affirms older migrants' citizenship and rights. Based on the present study, three directions for such research can be envisaged.

The first direction is linked to the suggestion in the previous section to study the local dimension of aged care provision for older migrants in the contexts of other cities and countries. Research on diversity in the literature of Public Administration and Urban Studies has shown that there is variation between local authorities in terms of how diversity is framed and responded to. By studying European cities with a high level of population diversity that is migration-related and/or cities with certain political constellations (e.g. Martínez-Ariño et al. 2019) it might be possible to identify best practices in the sense of how to respond to diversity in care in a more affirmative way, for example, by acknowledging that migration-related diversity can be a source of belonging and meaning (see Chapters 5 and 6).

A second possibility, which is linked to literature reporting on the agency of older migrants (Lulle and King 2016; King et al. 2017) as well as emerging literature on older

migrants and citizenship (Millard, Baldassar and Wilding 2018; Torres and Serrat 2019), would be to invite older migrants themselves to discuss the framing of migration-related diversity in care, for instance, in focus groups (see e.g. Conkova and Lindenberg 2020). Much of the literature on aged care and older migrants has, with a few exceptions (see e.g. Giuntoli and Cattan 2012), focused on older people who have not yet been able to access aged care, for example by studying barriers to access. This thesis has shown that there is a small and diverse group of older migrants who do have experience with formal care and exercise agency by choosing which services to use. Bringing these older migrants in conversation with policymakers could realise the democratic ambitions of local governance (Ercan and Hendriks 2013) for this group.

A third option would be to study the potential of minority-specific care organisations to advocate for affirmative representations of migration-related diversity in local and national aged care policies and practices. To date, the literature on minority-specific organisations has primarily focused on the direct benefits of such services for older migrants (see e.g. Emami et al. 2000; Heikkilä, Sarvimäki and Ekman 2007; Verhagen et al. 2014). As shown in Chapters 3 and 5, minority-specific care organisations have been forced to frame and negotiate their services within the current, postmulticultural political discourse. However, what the thesis has not investigated in detail is the scope for minority-specific care organisations to influence the framing of migration-related diversity in local and national aged care policies.

This thesis has highlighted that minority-specific care organisations, as part of the local landscape of formal care, are familiar with the political and organisational practices through which aged care is structured (Chapter 5). Furthermore, as shown in Chapter 3, these organisations are familiar with the current policy and professional language in a way which family carers and minority self-organisations are unlikely to be. Hence, I suggest that researchers investigate whether minority-specific organisations are able to advocate for older migrants' needs in a way that is more attuned to political discourses and policies than families and minority self-organisations. This could be done by studying their interactions with local authorities through interviews or focus groups.

7.6 Final reflections

As discussed in the introduction of this thesis, there has been a call for a 'social-justice-informed agenda for ethno-gerontology' which shifts the focus of research from describing inequities to the investigation of what practitioners and policymakers can do to address them (Torres 2019). In this thesis, I have sought to respond to this call by analysing my findings both through the 'hermeneutics of faith' and the 'hermeneutics of suspicion' (Ricoeur 1981). According to Josselson, the former method of analysis aims to "restore meaning to a text" while the latter aims to "decode meanings that are disguised" (2004: 1).

My investigation of the local impact of post-multiculturalism and localism shows that both trends delimit the scope for responsiveness in the long term by undermining investment in the local knowledge and networks that are currently mobilised to reach minority groups. I am convinced that such a critical, even 'suspicious' analysis of current policies and practices is an important part of the struggle for social justice for older migrants. Nevertheless, whereas 'unmasking' the "disguised meanings and practical implications" of politics and policies of localism and post-multiculturalism is important, as Levitas (2012) asserts, this approach is not sufficient in itself. Equally important is to apply the hermeneutics of faith, that is, to seek to identify ways in which to "restore meaning to a narrative and its different voices and silences" (Levitas 2012: 332). For Levitas, citizen initiatives and self-organisation at the local level present just such alternative meanings. In this thesis, I have sought to restore meaning by investigating what local policymakers and practitioners already do to increase access to aged care for older migrants. In this final chapter, I have also made suggestions for future research which does not merely focus on and explain current inequities but also "involves the holistic and institutionally specific imagination of alternative societies" (Levitas 2012: 336).

Understanding how practitioners and policymakers can better respond to older migrants' needs is increasingly urgent, not only because the population is growing rapidly, but also because older migrants have a higher risk of an early onset of chronic and age-related disease, and a higher incidence of dementia (Kristiansen et al. 2016; Conkova and Lindenberg 2018). However, while the inequity in access to care faced by older migrants is certainly urgent, it must not be considered to be a short term issue. With the intersection of the demographic trends of ageing, migration and urbanisation, future older populations in cities will certainly continue to be 'super-diverse' (Vertovec 2007; Boccagni 2015; Phillimore, Bradby and Brand 2019). As argued by Brandhorst, Baldassar and Wilding (2021), this super-diversity requires a new response in terms of aged care policies and caregiving practices. The ultimate aim of this thesis, then, has been to contribute to the project of addressing the inequities that older migrants face in access and use of aged care. My hope is therefore that the readers of this thesis, whether they be researchers, policymakers or practitioners, will find inspiration to continue the work of making aged care more responsive to older migrants' needs.

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SUPPLEMENTARY MATERIALS

Supplementary Materials

Appendix A: Observation Guide Day care Centres

When coming for the first time

- Learn names: bring a small book and write it down. Use it as a way to get to know people and learn their language a little. Don't expect to learn names by listening in a language different than your own.
- Ask the managing staff about the clients' background: How they got there and what their reasons for coming are. Health problems, isolation, depression.

Observing

Points to take notice of when observing:

Wider care network

- Information about wider care practices. Staff, volunteers, relationship to managers and other care providers
- Information about the views and situation of the family members of clients

Elements of a care practice

A. Meanings

- How clients and care is spoken about. Do certain phrases come back often?
- How carers speak about their own practice: activities, administration, and other tasks
- How do carers speak to and about clients
- What is considered good care? (Norms) What are they proud of? What are they aspiring towards?
- How does the day care centre relate to rules and regulations outside the organisation, e.g. health inspection?
- How is self and other defined? In terms of class, language, ethnicity, temporality etc.

B. Materials

- What spaces are available for the clients? What do they look like? How is the place decorated?
- Food: what food is served? Who cooks? What are the rituals regarding eating?
- Touch: How do clients and staff approach each other?
- What resources are available for activities?
- What is said about funding? Are resources scarce? What resources do the elderly have themselves?
- How is the care space used? Who sits where? Does it change over time? What constellations within the group can be identified.

C. Competences

- What am I learning when I'm there? How am I becoming a competent volunteer?
- What competences do staff have? What knowledge about older people and about aging (diseases) is required? What interpersonal skills? How do they manage the group and differences within this group? What languages do they speak, do they share language with (all) clients? How do they communicate?
- How do I gain cultural competence? What are difficulties for me?
- When does good care fail? What are the reasons?

Field notes

Note who was there. Write down the events, from the beginning until the end, which wseem somehow relevant to the reflection points. Then reflect on each point, and consider whether there is additional information to add.

Appendix B: Interview Guide Older Migrants

Personal data, family and home situation

What is your first and last name?
How old are you?
When did you come to the Netherlands?
Have you always lived in The Hague/Nijmegen?
In which neighborhood are you currently living?
Who do you live with?
Do you have contact with your neighbours?
Do you have any children?
Do they also live in The Hague/Nijmegen? If not, where do they live?

Experiences and expectations of day care

When did you first come to this day care centre?
What are the reasons why you came here?
Who told you about this day care centre?
When you first came, did you already know one or more of the other clients?
What were your expectations for the daytime activities?
What do you think is going to happen here during the day?
How often do you come here, how many times a week?
What activities do you like? Is there anything you like less?
Do you also see the people you met here outside of the daytime activities?

Daily life

What does a normal day in your life look like? For example, what did you do yesterday?
From when you got up to when you went to bed?
Besides the daytime activities, do you also have other activities outside the house? Fir example visiting a self-organisation, mosque, acquaintances?
Who takes you to these activities?
If you don't go to many activities, is there anything you would like to do?
What would you like to do (more often)? If so, why is that not possible at the moment?

Family

How often do you see your family? (daily, weekly, monthly)
Do you think you see enough of your family?

Aged care

As one gets older, it can also become more difficult to plan daily tasks in advance, such as shopping, cleaning, cooking, remembering medications and going to the pharmacy.
Do you think you have enough support in your daily life?
What kind of support do you have?
Do you have someone to help you with one or more of the things I just mentioned, or something else? Who helps you?
If there is a family member who provides a lot of care, ask if he or she receives (financial support) for it. Do you have a personal budget (PGB)?
Do you (also) have home care or domestic help? Or, what company?
Who helped you get home care/home aid?
Do the carers speak your language?
Do you think they provide good care?
Why is it good or not good? Items such as: Religion, culture, quality of care - performing tasks well, showing empathy and respect, professional knowledge.

Care obligations

Who do you think is responsible or obligated to take care of you?
What is the role of daughters and sons in caring for their parents?
Did you also think this way in the past? Or not, what changed your mind?

Medical care

Do you have any illnesses and/or physical complaints? If so, what complaints?
What kind of treatment do you receive for your complaints? Are you satisfied with the care?
Are you satisfied with your GP?
Which practice do you go to?
Can you communicate well with your GP?
Who takes you there, or do you go independently?
(In the case of chronic diseases, such as COPD and diabetes) Do you also have contact with a practice nurse?
Does she/he come to your house, or do you go to the health centre yourself?
Do you have confidence in Dutch healthcare?
Do you think you have enough information about health and old age diseases?

Future

If you need more care/help in your daily life, who do you ask for advice?
If you got a serious illness, would you also go to your country of birth for a second opinion?
If yes, do you have a doctor there too?
Do you think you would like to move back to your country of birth? If not, why did you decide to continue living here?
What do you think of life for older people like yourself here in the Netherlands?
If you compare life for old people with life for older people in your country of birth, what are the differences?
What are the advantages and disadvantages of aging in the Netherlands?
What do you think is a good life for someone your own age?
When you think about the future, is there anything that worries you?

Appendix C: Interview Guide Co-ordinator Day care Centre (Example)

Background

Are you from The Hague?
What is your educational background?
What did you do before you got this role?
For which organisations have you worked?
How did you get into your current role?

Work as day care coordinator

Would you like to tell us about your current role at Florence?
What are your duties?
What does your week look like?
How do you plan activities for the different groups?

Establishing minority-specific care in a mainstream facility

How long has your group been around?
How long have activities/groups for older people of different backgrounds existed?
Why did they start? Who took the initiative?
What were reactions from other staff in the beginning?
How are culturally specific groups viewed now?
Do you think the need for these groups will remain or will it decrease?
Why is it necessary now? What needs does it fill?
What does intercultural work mean to you?
Is there attention for diversity within Florence? Is there enough attention?
How is it on the organisational agenda?
Are there trainings on cultural sensitivity? Do you discuss case studies together?
Are you approached from your intercultural expertise?
Chinese clients

- How do they find ther way to this day care centre?
- Are family members also involved?
- What are the most common reasons they come here? What problems do they have?
- Do the Chinese older people who come here live nearby?

Do you do outreach work yourself? Fir example by going to activities of migrant self-organisations?
Do you work together with a general practitioner / consultant for older people / intercultural consultant for older people?
Are mainstream daytime activities, activities in community centre and health centre accessible to Chinese older people? Other groups of older migrants that you meet?

Group of Chinese older people

From my research in Nijmegen I know that Chinese older people in the Netherlands can be a diverse group, in terms of origin, language skills, and experiences in the Netherlands.
Can you describe the group of Chinese older people in The Hague for me?
Where in China do they come from (Countryside, City Region, Mainland)?
What languages do they speak?
How integrated into mainstream society are they?
Have they often moved within the Netherlands? Why did they choose The Hague to grow older?
Are older people moving to The Hague to live in this residential care home?
Do your clients have a strong social network?
What is their family's role in healthcare?
Are there also people outside this network? What is the role of the church?
How do Chinese older people you encounter view formal care such as home care, day care and nursing home?
How do they see the division of roles between formal care and family care/care?
Do Chinese older people have specific care needs or wishes? What are these?

Diversity in care and well-being
In your opinion, what have been the biggest changes in care and welfare for older people in The Hague over the past 15 years?
What are positive changes? Are there also negative changes?
From the perspective of Dutch-Chinese older people, what are the most important changes?
Is the development of care and welfare going in a positive or negative direction for migrant older people?
What does the future hold for groups like this one?

Appendix D: Interview Guide Policyworker (Example)

Daily work
What is your role in the policy on older people and care in The Hague?
What is the structuer of your department?
How have tasks and responsibilities changed in recent years?

Diversity-mainstreaming and contracting of care
What attention is paid to diversity in The Hague's older people policy? Is this issue on the agenda with the administrators and in the municipal council?
How is diversity dealt with in the different phases of healthcare contracting: - purchase - Evaluation - other phases?
In which 'paper trails' can attention to diversity be traced in the cnotracting of care: - purchasing criteria - quality criteria ? Are these records public and if so, where can they be found?
How is work on diversity going in practice? What challenges do you face?
To what extent are these challenges a consequence of the broader problems that play a role in decentralisation: waiting times, cutbacks?
What about small providers in this discussion?
What about culturally sensitive aged care providers in this discussion? How are culturally specific providers perceived?

Attention to older migrants' needs
What does good care for migrant older people mean to you?
Do you think there is a need for culturally specific offerings for older migrants, such as unit intercultural? Why?
What kind of offer needs to be culturally specific?
What is the municipality's position on facilitating training courses on culture-sensitive care for healthcare professionals? Mandatory or not?
What do you think is the function of the The Hague Diversity network?

The Hague Age friendly city
What are the developments of the age friendly city program in the coming years?

ENGLISH SUMMARY

English Summary

Research context, design and methods

At a population level, older migrants have higher levels of ill-health, yet use aged care services to a lesser extent than native-born older people. To date, most researchers have approached this inequity in the use of aged care by studying the barriers to access that ethnic groups face in different country contexts. Examples of such barriers include limited knowledge about healthcare systems, limited proficiency in the local language, low health literacy, experiences of racism, a preference for family-based care, and a lack of culturally, linguistically or religiously appropriate services. While the barriers are well known, there is relatively little research on what local policymakers and practitioners can do to remove these barriers or help older migrants to overcome them. This thesis addresses this gap by presenting a study of responsiveness to older migrants' care needs in cities. The focus on aged care in cities is relevant for two reasons. Firstly, research shows that the historical, demographical, organisational and social makeup of cities influence how national policies on migration and care are implemented. Secondly, most older migrants in Europe live in cities. If we are to reduce the aforementioned inequities in access to and use of aged care, it is thus necessary to understand the local dimension of service provision. To this end, the thesis answers the research question: ***What are the scope and limitations for responsiveness to older migrants' needs in aged care practices in local landscapes of care in times of post-multiculturalism and localism*?**

Post-multiculturalism and localism are two trends that affect many European cities. Post-multiculturalism refers to a disaffection with multiculturalism and its associated policies in countries where such policies were previously common, such as Sweden, the Netherlands and the United Kingdom (Vertovec 2010). Localism is an umbrella term which here is defined as "the devolution of power and/or functions and/or resources away from central control and towards front-line managers, local democratic structures, local institutions and local communities, (Evans, Marsh and Stoker 2013: 405). The underlying belief of localism is that local actors, such as municipal politicians, care organisations and, notably, local citizens, are best suited to make choices about care provision.

In this study, the focus is on two policy expressions of these trends: diversity-mainstreaming and neighbourhood governance of care. Diversity-mainstreaming is defined as efforts to have attention for 'diversity' across all policy domains and within all public services (van Breugel and Scholten 2017). Neighbourhood governance of care here refers to "public service delivery at the sub-local level" (Lowndes and Sullivan 2008: 62). In this thesis, responsiveness refers to a relational and care ethical approach to determine what constitutes good care (Tronto 1993; Beausoleil 2016). Responsiveness is defined as attentiveness to the needs of the other in the specific situation at hand. To determine what good care is, deliberation between local actors is therefore required. As such, responsiveness is a quality that can be identified in a range of care-related practices, from policymaking to management of services and the delivery of specific forms of care.

The thesis is underpinned by a three-year (2017-2020) qualitative study of practices related to aged care for older migrants in the cities of Nijmegen and The Hague. The fieldwork was guided by four sub-questions (see the next section on research findings) that examine the care landscape from different perspectives: the situatedness of the landscape in a political and institutional nexus, sites/spaces of care, care workers and individual older migrants receiving care. Following the research strategy of 'zooming in and out' (Nicolini 2012), drawn from social practice theory, I collected data using participant observation, semi-structured interviews and document analysis. In total, 76 interviews were conducted with older migrants and local actors involved in aged care for older migrants, like policymakers, care workers and managers of care organisations. In addition, 325 hours of participant observation were carried out in mainstream and minority-specific day care spaces and at landscape-wide activities like outreach activities, network meetings of practitioners and public debates. The practice-oriented methodology is discussed in detail in Chapter 2. To analyse the data, I apply an adapted version of the care landscape concept (Milligan 2009). Drawing on insights from social practice theory and relational Health Geography I redefine this concept as *local configurations of formal and informal relationships of care, manifested in social practices, which are spatially concentrated but not confined to cities, and which are embedded within regional, national and global institutional and political nexus.* This framework is useful because it helps me to analyse both how the national context limits local responsiveness to older migrants' care needs and how local actors work toward greater justice within the aforementioned limits.

Research findings

Chapter 3 examines how post-multiculturalism, expressed in national diversity-mainstreaming policies, shapes the scope and limitations for responsiveness to older migrants' needs. It answers the question: ***How does the implementation of diversity-mainstreaming policies in aged care provision affect the scope for local stakeholders to address the care needs of ethnic minority elders?*** To analyse diversity-mainstreaming in Nijmegen and The Hague, I used the framework of 'crafting practices'. Crafting practices is a concept used to describe how policies are implemented in localised contexts. It assumes that policy implementation is a relatively open process, which develops through working relationships between local stakeholders, and through the learning that takes place in these relationships. By looking at the local implementation diversity-mainstreaming through a crafting lens, two paradoxes were identified. On one hand, the vagueness of the term 'diversity' meant that policymakers and practitioners could interpret diversity in a way that allowed them to respond to older migrants care needs with both minority-specific and mainstreamed services. On the other hand, it

was found that to include minority-specific services within the framework of diversity-mainstreaming policies, these services were framed as a response to language deficits that were expected to disappear with the assimilation of future generations of older people. As a result, there was little long-term investment in minority-specific services. This was despite the fact that practitioners working in such services had built local knowledge and relationships with minority communities which were found to be crucial to facilitate access to aged care for older migrants.

Chapter 4 takes the perspective of care workers and answers the following question: ***How does neighbourhood governance of social care affect the scope for frontline workers to address the health inequities experienced by ethnic minority elders in their daily work?*** Here I draw on a relational approach to place. From this perspective, older migrants may not access services because of social and cultural distance, even though these services are physically close. The findings showed that neighbourhood governance can both limit and create opportunities to address inequity in access to care. Physical proximity to older migrants and their communities, in combination with greater freedom for care workers to adapt practices, allowed care workers to be more responsive to older migrants care needs. However, the shift from target group policies to a focus on neighbourhood residents, which can be related to both localism and post-multiculturalism, negatively affected the scope for such responsiveness. Firstly, that was because many older migrants had a preference for minority-specific activities and not all such services and activities fit within a neighbourhood frame. Secondly, it was found that the abandonment of target groups created less incentive and time for care workers to reach underserviced groups like older migrants as general activities already attracted neighbourhood residents from other population groups.

In Chapter 5 the care landscape is discussed from the vantage point of minority-specific day care spaces. Looking at specific spaces of care was relevant since social practice theorists have shown that if a practice is performed in a new place, this can affect the wider practice arrangement bundle in which said practice is embedded. For example, if nurses deliver care through phone calls instead of face to face, this can shift not only how care is done but also the relationships between nurses and doctors. Against this background, it was investigated: ***i) To what extent does the space of the day care centre allow staff to shape a care practice that is responsive to cultural diversity,*** *and* ***ii) How do these culturally specific care spaces interact with the wider care landscape in Nijmegen?*** The findings revealed that the space of the minority-specific day care centres enabled staff to tinker with and negotiate the practice of day care in such a way that it better responds to the life world of older migrants, and hence to their needs and preferences. The findings also showed that minority-specific spaces of care, because of their embeddedness in the wider landscape, connect older migrants with other, mainstream services. The alterations in how day care practices were performed created some tension with national quality regulations on care and the policy of neighbourhood care. Nevertheless, the presence of minority-specific spaces of care was found to increase responsiveness to diversity in the wider care landscape in two ways. Firstly, by making older migrants' preferences and needs visible. Secondly, by modelling how mainstream care organisations can adapt existing care practices to be more responsive to older migrants' needs.

Finally, Chapter 6 looks at the care landscape from the perspective of older migrants. The research question answered in this chapter was: ***Which local relationships of care in the two cities facilitate access to aged care for older migrants?*** To theorise how older migrants access aged care in the local context, I combine relational approaches to place with the lens of super-diversity. The analysis reveals that historical relationships with formal care, relationships with culturally sensitive services and informal relationships of care, particularly those within local minority communities, play an important role in facilitating access to aged care. Which relationships were the most important for the individual migrant depended on factors of migrant-related diversity, such as migrant trajectory, Dutch language proficiency and city of residence. Ethnicity in itself was not a determining factor for whether and how the older migrants in the sample accessed care. In the chapter, the focus on ethnicity in previous studies of barriers to access is therefore questioned. Rather, migration-related factors, in combination with current and past characteristics of the city of residence, influenced how aged care was accessed.

Conclusions and recommendations for practice and future research

The thesis aimed to ***investigate the scope and limitations for responsiveness to older migrants' needs in aged care practices in local landscapes of care in times of post-multiculturalism and localism***. The findings show that diversity-mainstreaming and neighbourhood governance provided scope for policymakers and practitioners to respond to older migrants' needs in the short term. However, the thesis also highlights that the strategies used to respond to the needs of the current generation of older migrants may limit responsiveness in the long term.

Diversity-mainstreaming and neighbourhood governance are characterised by a preference for services tailored to all neighbourhood residents over services for disadvantaged minority groups, like older migrants. However, both in Nijmegen and The Hague a mix of minority-specific and diversity-mainstreamed services were provided. This mix was the result of the deliberate crafting of aged care by policymakers and practitioners in response to older migrants' needs. Policymakers and care organisations crafted aged care provision by strategically interpreting 'diversity' in such a way that a service mix could be provided. Practitioners engaged in crafting by mobilising local knowledge and multilevel professional networks to tailor services to the needs of older migrants, in some cases ignoring the policy requirement to focus all activities on neighbourhood residents.

While the study provides evidence of local responsiveness to older migrants needs, there is reason to be critical of the effects of localism and post-multiculturalism on aged care for older migrants in the long term. That is because local actors framed older migrants' needs as a temporary problem, caused by the low language proficiency of the current generation of labour migrants. This may have been a strategic choice to ensure that resources were directed towards older migrants and that minority-specific services were continued. However, by framing the issue as temporary, the cities lacked strategies for how to develop the local knowledge and networks necessary to meet the needs of future generations of older migrants.

To date, research on older migrants has largely ignored the local dimension of aged care provision for older migrants. In answering the research question, the thesis contributes empirically to the literature by providing a comprehensive overview of responsiveness to older migrants' care needs in Dutch cities. In addition, the thesis advances theoretical debates by introducing i) an empirical greater justice approach to study aged care and ii) a relational re-interpretation of access to care. The former approach is concerned with searching for possibilities for greater justice within the local context. I argue that a greater justice approach complements existing literature on older migrants that focuses on structural injustices, by identifying feasible actions to achieve greater equity in the short term. The latter approach, drawing on relational approaches to place, conceptualises accessing care as a question of overcoming relational distance, which is mediated by characteristics of the city of residence and by individual factors of "super-diversity". As such, the thesis provides an alternative to ethnicity as an explanatory variable for barriers of access to care, a use of ethnicity which has been criticised by critical gerontologists. In addition, a relational re-interpretation of access is that it conceptualises access as an achievement hinging predominantly on the efforts of practitioners. Hereby the thesis contributes to the quest to shift the attention of gerontological research from the characteristics of older migrants to the actions of practitioners and policymakers

Based on the findings of the thesis, policymakers and practitioners are recommended to adapt care spaces and practices in such a way that older migrants' relational, rather than physical distance to aged care services is narrowed. As the study shows, this can be done by including minority-specific organisations in care provision, supporting collaboration and knowledge exchange between organisations and professionals and other relational work such as outreach activities and moral deliberation. Some practitioners already engage in such practices. However, explicitly supporting them in policy and including them in social and healthcare education would ensure that accessibility of care does not rely on the presence of exemplary practitioners.

While the thesis begins to investigate how aged care for older migrants is locally governed, questions remain about the state of affairs in countries with different welfare regimes and different histories of migration and integration policies. Further research is therefore necessary to investigate how the national and local dimensions of care provision challenge or perpetrate inequities in access to aged care experienced by older migrants. The study has shown that at present, many researchers, practitioners, and policymakers frame migration-related diversity primarily as a source of vulnerability. Inadvertently, this negative framing does not leave room for the fact that migration-related diversity can be a source of meaning and belonging. Older migrants are a growing group, which is likely to become more, not less diverse. Therefore, this thesis is concluded with a call for scholars to research more affirmative approaches to migration-related diversity in order to better meet the care needs of both current and future super-diverse older populations.

NEDERLANDSE SAMENVATTING

Nederlandse samenvatting

Voor een niet-academisch publiek*

Zorg voor oudere migranten in Nederlandse steden

Oudere migranten hebben vaker een slechte gezondheid dan in Nederland geboren ouderen. Desalniettemin maken ze minder vaak gebruik van ouderenzorg. Deze ongelijkheid in zorggebruik is geen nieuw probleem, maar het wordt wel steeds urgenter. De aankomende 30 jaar zal de bevolking van oudere migranten fors stijgen, van 14 tot 20 procent van de Nederlandse bevolking die 65 jaar of ouder zijn.

Tot op heden hebben de meeste onderzoekers de ongelijkheid in het gebruik van ouderenzorg benaderd door te onderzoeken welke 'toegangsbarrières' verschillende etnische groepen ervaren. Voorbeelden van dergelijke barrières zijn beperkte kennis over gezondheidszorgsystemen, beperkte vaardigheid in de lokale taal, lage gezondheidsvaardigheden, ervaringen met racisme, en een gebrek aan cultuur-sensitieve voorzieningen.

Hoewel de barrières bekend zijn, is er relatief weinig onderzoek gedaan naar wat beleidsmakers en professionals in steden kunnen doen om deze barrières weg te nemen. Dit is een relevant kennistekort om twee redenen. Ten eerste toont onderzoek aan dat de historische, demografische, organisatorische en sociale samenstelling van steden van invloed is op de manier waarop nationaal beleid op het gebied van migratie en zorg wordt uitgevoerd. Ten tweede woont de meerderheid van oudere migranten in Europa in steden. Om de benoemde ongelijkheden in gebruik van zorg te bestrijden is het daarom noodzakelijk om de lokale dimensie van ouderenzorg in kaart te brengen. Tegen deze achtergrond beantwoordt mijn proefschrift de vraag: **Hoe wordt responsiviteit voor de behoeftes van oudere migranten in het lokale zorglandschap ontwikkeld in de context van de post-multiculturele en gelokaliseerde verzorgingsstaat?**

De reden waarom ik de term 'responsief voor de behoeftes van oudere migranten' gebruik, is dat ik ouderenzorg vanuit een relationele en zorgethische benadering onderzoek (Tronto 1993; Beausoleil 2016). Responsiviteit is gedefinieerd als aandacht voor de behoeften van de ander in specifieke situaties. Om te bepalen wat goede zorg is, is dus overleg tussen lokale actoren nodig. Daarom is responsiviteit een kwaliteit die kan worden geïdentificeerd in een breed spectrum van praktijken die onderdeel zijn van het leveren van ouderenzorg, van het maken van beleid en het beheren van zorg- en welzijnsdiensten tot de uitvoering van specifieke vormen van zorg.

Het concept 'zorglandschap' komt uit gezondheidswetenschappelijke literatuur en werd geïntroduceerd door Milligan (2009). Het zorglandschap bestaat uit relaties tussen lokale partijen die te maken hebben met zorg, zoals beleidsmakers, managers en medewerkers van zorg- en welzijnsorganisaties, leden van adviesraden, sleutelfiguren en familie en

vrienden die mantelzorg verlenen. Deze relaties worden gemaakt en onderhouden op de vele plaatsen waar zorg- en welzijnsdiensten waar ouderenzorg wordt uitgeoefend, bijvoorbeeld bij mensen thuis, in wijkcentra, op de dagbesteding, in gezondheidscentra en in ziekenhuizen. Terwijl de focus van dit proefschrift op lokale 'zorgende relaties' ligt, is het belangrijk te benoemen dat het netwerk van zorgende relaties zich ook tot buiten de stad uitstrekt. Veel oudere migranten hebben bijvoorbeeld vrienden en familie in andere steden of zelfs in andere landen die op verschillende manieren zorg verlenen. Ook is het lokale zorglandschap ingebed in een nationale politieke en beleidsmatige context, die van invloed is op wat er gebeurt op lokaal niveau. In mijn proefschrift beperk ik me tot twee beleidstrends die op nationaal niveau spelen: post-multiculturalisme en lokalisering van de verzorgingsstaat.

Postmulticulturalisme en lokalisering zijn twee trends die niet alleen in Nederland, maar ook in andere Europese landen spelen. Dit proefschrift focust op twee vormen van beleid die gekoppeld zijn aan deze trends: mainstreaming en wijkgericht werken. Mainstreaming wordt gedefinieerd als het streven naar aandacht voor 'diversiteit' in alle beleidsdomeinen en binnen alle publieke diensten (van Breugel en Scholten 2017). Mainstreaming wordt vaak gezien als een alternatief voor doelgroepenbeleid, beleid voor specifieke minderheidsgroepen, zoals Turken, Marokkanen en Antillianen. Wijkgericht werken in zorg en welzijn betekent dat beslissingen over en de uitvoering van dienstverlening worden genomen op sub-lokaal niveau, d.w.z.. in wijken. Het doel hiervan is dat het aanbod wordt aangepast zodat het aansluit op de behoeftes van wijkbewoners.

Om de onderzoeksvraag te beantwoorden, heb ik een drie jaar (2017-2020) kwalitatief onderzoek gedaan in Nijmegen en Den Haag. Het veldwerk werd gestuurd door vier deelvragen, waardoor het zorglandschap werd belicht vanuit verschillende perspectieven: het beleidsperspectief, het perspectief van zorgverleners, het perspectief van multiculturele en cultuurspecifieke dagbesteding en het perspectief van oudere migranten die al toegang hadden tot ouderenzorg. Data werd verzameld mede door participerende observatie (325 uur), semigestructureerde interviews met oudere migranten (32) en professionals en beleidsmedewerkers (42) en door documentanalyse van beleidsdocumenten.

Bevindingen

Hoofdstuk 3 beantwoordt de vraag: *In hoeverre creëert de implementatie van mainstreaming-beleid binnen de ouderenzorg beperkingen en/of mogelijkheden voor lokale partijen om in te spelen op de zorgbehoeftes van migranten ouderen.* de vaagheid van de term 'diversiteit' zorgde er in eerste instantie voor dat beleidsmakers en professionals diversiteit konden interpreteren op een manier die hen de ruimte gaf om te reageren op de zorgbehoeften van oudere migranten met zowel doelgroep-specifieke als reguliere diensten. Op de korte termijn is dit een positieve uitkomst omdat veel oudere migranten een voorkeur

hadden voor doelgroep-specifieke voorzieningen of een combinatie van zowel doelgroep-specifieke als reguliere voorzieningen.

Echter zijn er ook reden om kritisch te zijn als het gaat om de gevolgen van mainstreaming op de lange termijn. Binnen mainstreamingbeleid heeft een regulier aanbod de voorkeur. Om doelgroep-specifieke diensten toch te includeren in het aanbod, gebruikte beleidsmakers en professionals vaak het argument dat doelgroep-specifieke diensten slechts een tijdelijke oplossing zijn voor de huidige generatie arbeidsmigranten. Als reden werd aangegeven dat deze groep de Nederlandse taal niet machtig is. Vaak werd toegevoegd dat de ouderen die behoefte hebben aan 'zorg in eigen taal' verdwijnen, door de assimilatie van toekomstige generaties van migranten. Deze argumentatie dreigt de toegankelijkheid van de zorg te ondermijnen op de lange termijn. Dat is omdat het kan leiden tot weinig of kortzichtige investeringen in doelgroep-specifieke diensten, terwijl de bevindingen laten zien dat de competenties en kennis binnen deze diensten vaak een cruciale rol spelen in de toeleiding naar zorg. Ook wordt op deze manier een migratieachtergrond vooral gezien als een bron van kwetsbaarheid, terwijl het ook een bron van verbinding en zinvolheid kan zijn.

In hoofdstuk 4 wordt het zorglandschap bekeken vanuit het perspectief van zorgverleners. De vraag die wordt beantwoord luidt: *hoe beïnvloedt wijkgericht werken in sociaal werk de mogelijkheden voor professionals om gezondheidsongelijkheid onder etnische minderheden te verminderen?* In dit hoofdstuk maak ik gebruik van een relationeel geografisch perspectief. Vanuit dit perspectief wordt toegankelijkheid van ouderenzorg niet alleen bepaald door fysieke afstand, maar ook door de sociale en culturele afstand die iemand ervaart tot voorzieningen. De bevindingen laten zien dat wijkgericht werken zowel kansen beperkt om ongelijke toegang tot zorg aan te pakken, als creëert. Aan de ene kant creëert de toename in fysieke nabijheid tussen zorgmedewerkers, oudere migranten en hun gemeenschappen kansen voor professionals om ook de relationele afstand te verminderen. Aan de andere kant werden deze kansen beperkt door de verschuiving van de focus van doelgroepen naar wijkbewoners. De reden hiervoor is dat wijkgerichte, algemene activiteiten vooral deelnemers trokken uit de meerderheidspopulatie (witte Nederlanders). Om migrantenouderen te bereiken kozen sommige professionals er daarom voor om doelgroep-specifieke ontmoetingsactiviteiten te organiseren die ouderen vanuit verschillende wijken verwelkomden. Ook werkten de professionals samen in wijkoverstijgende netwerken om lokale kennis en interculturele competenties te uitwisselen en om outreach-activiteiten te organiseren zodat ze oudere migranten beter kon bereiken.

In hoofdstuk 5 wordt de rol van cultuurspecifieke dagbesteding binnen het zorglandschap onderzocht door twee vragen te beantwoorden: 1) *in hoeverre maakt het bestaan van cultuurspecifieke dagbesteding het mogelijk voor personeel om zorgpraktijken te veranderen zodat ze beter inspelen op culturele diversiteit?* en 2) *wat zijn de interacties*

tussen cultuurspecifieke zorgvoorzieningen en andere partijen in het Nijmeegse zorglandschap? Cultuurspecifieke dagbesteding bood de professionals de ruimte om de praktijk van dagbesteding te vertalen zodat het beter inspeelde op de leefwereld van oudere migranten. Activiteiten zoals sporten werden bijvoorbeeld aantrekkelijker door aanpassing van de muziek en de oefeningen. Ook gingen professionals de activiteiten letterlijk en figuurlijk vertalen, door cliënten in hun eigen taal uit te leggen waarom sporten hun welzijn kon verbeteren.

Cultuurspecifieke dagbesteding werd als laagdrempelig ervaren door oudere migranten. Deze laagdrempeligheid zorgde ervoor dat oudere migranten kennis konden maken met andere vormen van zorg die als minder toegankelijk werd ervaren, zoals mantelzorg ondersteuning en valalarmen. Terwijl cultuurspecifieke dagbesteding een verbindende functie kon hebben, ontstonden er soms spanningen tussen deze organisaties en andere lokale en nationale partijen. De gemeente en de gezondheidsinspectie vonden dat de organisaties niet aan de kwaliteitseisen voldeden, terwijl de cultuurspecifieke organisaties vonden dat ze aan hogere eisen moesten voldoen dan andere organisaties. Deze spanningen terzijde, bleek de cultuurspecifieke dagbesteding de responsiviteit voor diversiteit in het bredere zorglandschap op twee manieren te vergroten. Ten eerste maken ze door hun bestaan de voorkeuren en behoeften van oudere migranten beter zichtbaar. Ten tweede laten ze zien hoe reguliere zorgorganisaties bestaande zorgpraktijken kunnen aanpassen om beter in te spelen op de behoeften van oudere migranten.

In het laatste empirische hoofdstuk (6) wordt het zorglandschap bestudeerd vanuit het perspectief van oudere migranten. De onderzoeksvraag die dit hoofdstuk beantwoordt luidt: *Welke lokale zorgrelaties in de twee steden vergemakkelijken de toegang tot ouderenzorg voor oudere migranten?* Uit de analyse blijkt dat historische relaties met formele zorg, relaties met multiculturele of cultuurspecifieke diensten en informele zorgrelaties, met name binnen lokale minderheidsgemeenschappen, een belangrijke rol spelen bij het vergemakkelijken van de toegang tot ouderenzorg. Oudere migranten die bij aankomst in Nederland positieve ervaringen hadden met zorg- en welzijnsdiensten waren eerder geneigd om ouderenzorg aan te vragen. Voor ouderen met slechte of weinige ervaringen met zorg- en welzijnsdiensten, en voor ouderen die de Nederlandse taal niet machtig waren, waren migrantengemeenschappen en cultuurspecifieke zorgorganisaties een grote ondersteuning in het navigeren in het zorglandschap.

Welke zorgrelaties het belangrijkst waren hing af van individuele factoren van superdiversiteit[38] en de historische, demografische, organisatorische en sociale samenstelling van het lokale zorglandschap. Chinese ouderen in Nijmegen hadden bijvoorbeeld moeite om zorg te vinden, terwijl Chinese ouderen in Den Haag makkelijk

38 De term 'superdiversiteit' verwijst naar het feit dat migrantenpopulaties zeer divers zijn, niet alleen qua landen van herkomst en etniciteit, maar ook qua taal, religie, migratiekanalen, immigratiestatus, woonplaats, geslacht en leeftijd, factoren allemaal die de toegang tot en de behoefte aan openbare diensten beïnvloeden (Vertovec 2007)

hun weg vonden, dankzij een grote gemeenschap op lokaal niveau en de aanwezigheid van diensten in het Kantonees. Etniciteit was dus niet per se de bepalende factor als het ging over welke groepen goede of slechte toegang naar ouderenzorg hadden.

Aanbevelingen voor beleid en praktijk

Het onderzoek laat zien dat toegankelijkheid tot ouderenzorg afhangt van de relationele afstand die iemand ervaart tot deze diensten. Naast de fysieke dimensie (ruimtelijke nabijheid) en de institutionele dimensie (recht op toegang), heeft relationele afstand een sociale dimensie, waaronder vertrouwen en ondersteuning om het zorglandschap te navigeren vallen (Cummins et al. 2007; Green et al. 2014). Professionals en zorgorganisaties kunnen de relationele afstand tussen migrantenouderen en de formele zorg op twee manieren te verkleinen. De eerste benadering, zoals besproken in hoofdstuk 5, richt zich op het verlagen van drempels naar zorgvoorzieningen op zo'n manier dat de sfeer aansluit bij de leefwereld van de oudere migranten die men wil bereiken. Dit wordt gedaan door aanpassingen van materiële aspecten zoals maaltijden, muziek en meubels, zodat deze beter aansluiten bij de leefwereld van de zorgontvanger. Cultuurspecifieke zorg biedt professionals ook ruimte om niet-materiële aspecten van praktijken aan te passen. Door de moedertaal van cliënten te spreken, maar ook door figuurlijke vertaling en herinterpretatie van waarden en normen rondom zorg. Zo werd geobserveerd dat professionals de rolverdeling tussen familie en formele zorg herinterpreteerden door te benadrukken dat het mogelijk maken dat je ouders goede zorg ontvangen net zo passend, of zelfs beter kan zijn als de zorg zelf verlenen.

De tweede benadering, besproken in de hoofdstukken 4 en 6, is gericht op het opbouwen van zorgrelaties met oudere migranten. Professionals deden dit door te netwerken en outreach-activiteiten uit te voeren op plaatsen die al bezocht werden door oudere migranten, zoals moskeeën, activiteiten van zelforganisaties en cultuurspecifieke zorgorganisaties. Om dit 'relationele werk' stads breed uit te voeren, bleken interorganisatorische netwerken instrumenteel te zijn. Deze faciliteerden samenwerking en kennisuitwisseling.

Bovenstaande activiteiten werden al uitgevoerd voor het onderzoek plaatsvond. Echter ontdekte ik ook dat inspanningen om in te spelen op de zorgbehoeftes van migrantenouderen voor een groot deel afhing van individuele professionals. Beleidsmakers kunnen een cruciale rol spelen door hun relationele werk expliciet te ondersteunen in hun beleid en door financiële ondersteuning te bieden, aangezien relationele werk tijdrovend blijkt te zijn (hoofdstuk 5). Een tweede aanbeveling voor beleidsmakers is om de demografische, sociale en organisatorische structuur van het zorglandschap continu in kaart te brengen en te herzien in samenwerking met professionals. Op deze manier wordt het mogelijk te identificeren welke groepen weinig toegang hebben tot diensten op lokaal niveau. Ook wordt het mogelijk om te identificeren welke migratie-gerelateerde identiteiten relevant zijn voor meerdere groepen op lokaal niveau (denk aan religie, arbeidsmigrant zijn of dezelfde taal spreken), en om deze identiteiten te gebruiken om minderheiden te mobiliseren, bijvoorbeeld door het organiseren van ontmoetingsactiviteiten. Ten slotte onderstrepen de bevindingen de noodzaak om de lange termijnimplicaties van beleid op het gebied van integratie, gezondheidszorg, ondersteuning en welzijn in overweging te nemen. Door te investeren in vertrouwensrelaties tussen nieuwe migrantengroepen en zorg- en welzijnsdiensten kunnen beleidsmakers gezondheidsongelijkheden onder toekomstige generaties van migrantenouderen aanpakken.

Conclusies

Het doel van dit proefschrift was om te onderzoeken **hoe responsiviteit voor de behoeftes van oudere migranten in het lokale zorglandschap wordt ontwikkeld in de context van de post-multiculturele en gelokaliseerde verzorgingsstaat.**.
De bevindingen laten zien dat wijkgericht werken en mainstreaming beleidsmakers en professionals op korte termijn de ruimte gaven om in te spelen op de behoeften van oudere migranten. Het proefschrift benadrukt echter dat de strategieën die worden gebruikt om te reageren op de behoeften van de huidige generatie oudere migranten, de responsiviteit op de lange termijn kunnen beperken. Dat komt doordat lokale actoren de behoeften van oudere migranten als een tijdelijk probleem beschouwen, vooral vanwege de lage taalvaardigheid van de huidige generatie arbeidsmigranten. Dit kan een strategische keuze zijn om ervoor te zorgen dat er middelen beschikbaar bleven voor oudere migranten en dat cultuurspecifieke diensten konden worden gecontinueerd. Maar door het probleem als tijdelijk te beschouwen, waren er weinig strategieën om de lokale kennis en netwerken te ontwikkelen die nodig zijn om aan de behoeften van toekomstige generaties oudere migranten te voldoen.

Oudere migranten vormen een groeiende groep, die waarschijnlijk meer, niet minder divers zal worden. Daarom wordt dit proefschrift afgesloten met een oproep aan beleidsmakers en professionals om langdurig te investeren in het opbouwen van lokale kennis binnen het zorglandschap en in het bouwen van relaties tussen zowel verschillende zorgorganisaties als migrantengemeenschappen. Op deze manier kunnen we voor zorgen dat niet alleen de huidige maar ook de toekomstige populatie van migranten ouderen gelijke toegang aan goede zorg hebben.

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At the very start of the fieldwork, our research team had a meeting with Conny van der Aalsvoort who then worked for Swon, now Sterker Sociaal Werk. Little did I know that this meeting would lead to the most important collaboration of the project. Conny, I have learnt so much from following your work and from collaborating with you in the organization stakeholder meetings and webinars. I really admire your ability to build and maintain networks, your advocacy with and for older migrants, and your perseverance in working towards equity of access to services for all.

Thanks to Conny, I became part of the European Network of Intercultural Elderly Care. Doing fieldwork in two cities across multiple sites is challenging, so I am grateful to Jan

Booij and Feruze Sarıkaş for opening doors and sharing their network with me in Nijmegen and The Hague. Carolien Smits, Hatice Bölek and Carlien de Witte, it was a pleasure to work with you on the webinar. Saloua Berdai Chaouni, thanks for inviting me to speak during your learning trajectory for residential care homes and for organising the 2021 BSG session with me. I am also grateful for your willingness to give me feedback not only on my thesis chapter but, more importantly, on my own blindspots when it comes to racism and discrimination. Fatos Ipek Demir – I am similarly grateful for your feedback, for your support during my fieldwork and for all the fun during our trip to Brussels for the learning trajectory. Your words that it is already 'vijf over twaalf' for older migrants echo in my head and push me to always consider how my research can have more impact in the lives of older migrants and their families.

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ABOUT THE AUTHOR

About the author

Hanna Carlsson was born in Enköping, Sweden, on September 29th, 1990. Her ambition to study abroad brought her to University of Saint Andrews, Scotland, where she graduated with a first-class bachelors degree in 2014. A paper based on her bachelor thesis has been published in the journal of *Gender, Place and Culture*. During 2014 she also worked as a research intern at the Scottish Independent Advocacy Alliance. Her work resulted in a research report on the impact of independent advocacy on people with lived experience of mental illness. In 2014, Hanna moved to the Netherlands to study for a Master of Research in Human Geography and Spatial Planning at Utrecht University. Her master thesis, which she presented during the 2016 annual conference of the Association of American Geographers, focused on the urban mobility of visually impaired people in Västerås, Sweden.

In 2017, Hanna was given the opportunity to deepen her expertise in health geography as a PhD candidate in the VIDI project *Caring for Diversity* supervised by Dr. Roos Pijpers, at Radboud University, the department of Geography, Planning and Environment. Hanna's doctoral work on responsiveness to older migrants' care needs in Dutch cities has been published in the *Journal of Social and Cultural Geography*, *Journal of Ethnic and Migration Studies*, *Journal of Health Organisation and Management* and *Journal of Ageing and Society*. For the latter papers she won the OBHC 2020 Liz West Award and the IMR Best Paper award. In 2019, Hanna received the Mohrmann Stipendium, which is awarded to promising women doctoral researchers to stimulate their academic career, which allowed her to spend time at Uppsala University, Sweden and Lancaster University, the UK. To generate social impact through her research, Hanna has provided webinars and workshops to professionals and policy makers in cooperation with colleagues from Pharos (Dutch Centre of Expertise on Health Disparities), Sterker Sociaal Werk (Social Care Organisation, Nijmegen), WWZ (Belgian knowledge institute Welfare, Housing and Care) and Karel de Grote Hogeschool, Antwerpen, Belgium. Hanna is also a member of the professional network ENIEC (European Network of Intercultural Elderly Care). In the future, Hanna will continue to research how European welfare states can respond better to the needs of super-diverse populations as a postdoctoral researcher at Free University Amsterdam and Radboud University Nijmegen.