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ORIGINAL ARTICLE

Caring peripheries: How care practitioners respond to processes of peripheralisation

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Abstract

The centralisation of acute health care is a key policy concern in many countries. Less attention has been given to the side effects of centralisation: peripheralisation, occurring mainly in rural areas and post-industrial towns. In this research, we start filling this gap by exploring how this trend of concentration of health care can contribute to a phenomenon referred to as 'discursive peripheralisation'. This article contributes to the literature on discursive peripheralisation by focusing on how actors, in our case acute care practitioners, cope with or oppose such processes. We draw on empirical data from two healthcare regions in different geographical contexts in Norway and The Netherlands. In these regions, we zoom in on the work of care practitioners and how they, in relation to care organisations and local authorities, aim to organise care for patients in 'the periphery' and how this contributes to more diverse and alternative narratives and practices of health care in these areas. Our findings offer important insights for both rural and regional policy. We conclude that other narratives, for instance, about perceptions of quality of care should be considered to avoid too much

emphasis on the disadvantages faced by peripheral areas, compared to their urban counterparts.

KEYWORDS
cross-country analysis, discursive peripheralisation, healthcare quality, relational approach, rural areas

INTRODUCTION

Peripheral, mostly rural and post-industrial areas, face unique challenges in providing healthcare services due to their lower population densities, geographical distances and limited availability of healthcare resources. As care is increasingly concentrated in metropolitan areas, peripheral areas are pushed to the margins. Some government organisations and media outlets point to 'medical deserts'[1] to describe areas where inhabitants increasingly lack access to health care and remaining care providers have trouble recruiting personnel (Angharad et al., 2019; Chevillard et al., 2018). So far, research mainly focuses on what the concentration of high-end services in metropolitan hospitals means for the quality of care delivered in the urban centre. Less attention is given to the side effects of concentration: peripheralisation, happening in areas 'outside' designated centres where reduction of services and staff is felt (Keim-Klärner, 2021; Milligan & Wiles, 2010; Souza, 2018).

In this research, we start filling this gap by exploring how this trend of concentration of health care can contribute to a phenomenon referred to as 'discursive peripheralisation' (Plüschke-Altof, 2016; Willett & Lang, 2018). Discursive peripheralisation refers to the process of how some geographical areas come to be seen as peripheral depending on their discursive construction and how it is narrated as 'the internal other of the strong core', maintaining and reinforcing existing power differentials (Eriksson, 2008). Such processes are not just about language but also about (symbolic) practices of creating differences between areas. Importantly, this discursive production of peripheries shapes the perceptions and practices within specific areas, such as economic activities, the availability of public services and daily routines of local residents (Willett & Lang, 2018).

This article contributes to the literature on discursive peripheralisation by focusing on how actors cope with or oppose such processes. It does so by shedding light on the agency of local actors within these processes, which can also counteract dominant discourses about peripheral areas. Souza (2018), for instance, claims that actors in these areas can also spark creativity to deal with harsh conditions. In a similar vein, researchers state that attention should be drawn to the agency of actors and how new perspectives for future development may arise, supporting an understanding of peripheral regions as 'spaces of possibility' (Görmar & Lang, 2019; Willett & Lang, 2018). Also in health care, actors and local governments in peripheral areas are exploring viable alternatives for the provision of care (Van de Bovenkamp et al., 2021). They are, for instance, seeking to deliver enhanced care in outpatient clinics, patients' homes or through collaborative partnerships (Lappegard & Hjortdahl, 2013; Magnussen et al., 2007). In this article, we aim to shed light on these initiatives and examine how care practitioners actively shape, oppose and (re)produce peripheralisation in healthcare practice and policy in acute care for older persons in The Netherlands and Norway. Both countries face significant challenges in providing general and acute care for a fast-growing group of older persons, who increasingly live at home as

a result of ageing-in-place policies. Although the two countries differ in geographical context, they face similar problems and mechanisms regarding the provision of acute care services (Wakerman, 2004).

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

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

THEORETICAL FRAMEWORK

The notion of periphery is rarely used neutrally as it suggests underdevelopment and opposition or dependence on a 'core' or centre (Beetz et al., 2008; Kühn, 2014; Souza, 2018). In this article, we pay attention to the production of peripheries, in line with scholars who advance the concept of discursive peripheralisation. These scholars highlight how peripheries are frequently constructed through narratives and images that portray them in unfavourable ways (Eriksson, 2008; Plüschke-Altof, 2016), often formed by a counter-narrative of the hegemonic urban. Meyer et al. (2016), for instance, discuss this phenomenon as stigmatisation, while Eriksson (2008) explores the construction of rural areas in Northern Sweden as an underdeveloped and traditional rural space in contrast to the 'Urban South'. Eriksson (2008) shows how specific traits of parts of the region (in this case, Sweden) can become one with the entire region through negative representations of the region in the news—and how finding alternative ways of representing are significant to deconstruct the dichotomy between north and south Sweden. These studies show how the ways in which peripheries are discursively constructed impact processes of peripheralisation. Negative internal and external images of 'backwarded' or 'lagging behind' areas can contribute to declining economic activities that create a negative spiral, which is difficult to break down (Beetz et al., 2008; Eriksson, 2008; Kühn, 2014). Moreover, the remoteness from decision-making at the centre can lead to a sense of alienation and powerlessness in influencing political decisions. However, dynamics can manifest in diverse ways, as local actors may take proactive measures and attribute new meanings to their area (Görmar & Lang, 2019; Willett, 2020). Negative images of limited opportunities and constrained access can furthermore coincide with more positive narratives of areas as peaceful and rustic (instead of isolation and remoteness) and tight community bonds. Žafran and Kaufmann (2022), for instance, show how the tourism industry contributes to the construction of such positive images and narratives to reframe presentations of regions in Croatia and attract tourists and new in-migrants.

Willett (2020) goes one step further in influencing discursive peripheralisation by challenging negative peripheral discourses. The author does so by approaching peripheral areas as complex adaptive systems. Peripheral areas as complex adaptive systems can be useful to understand the role of knowledge in processes of peripheralisation. Knowledge in 'region–organisms' can flow in narratives and forms of 'truth' about peripheries as well as in more traditional forms of know-how and skills 'produced by the people who live and work within them' (Willett, 2020, p. 87). These traditional forms can play an important role in everyday practices that can contribute to more positive spatial representations. In a similar vein, Görmar and Lang (2019) emphasise studying

these practices in their call to approach peripheries as 'spaces of possibility'. They shift attention to practices of actors coping with and opposing the negative (discursive) production of peripheries. With this article, we respond to this call and focus on care practitioners working in areas where we see discursive peripheralisation happening.

In the case of health care, peripheral areas are often depicted as being less attractive to work or invest in (Bock, 2016; Exworthy & Peckham, 2006). Another often mentioned challenge in Western peripheral regions is the high percentage of older persons living there. They are encouraged to stay at home as long as possible. Previous studies on health care in rural areas reveal how closing facilities often result in longer travel times and reduced access to public services, leading to feelings of unsafety or neglect (Farmer et al., 2012; Perucca et al., 2018; Prior et al., 2010). The replacement and loss of services is linked in multiple ways to the liveability and quality of places (Castleden et al., 2010; Ivanova et al., 2016; Oldenhof et al., 2015; Prior et al., 2010). Studies have shown that citizens do protest loss of care services and that they are not only worried about losing a facility but about losing a complex range of assets: an accessible health-preserving service, human, social and economic resources and a symbol of community resilience (Prior et al., 2010).

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

METHODS

In this article, we focus on acute health care[2] in areas that experience a decline in services. With older persons now living at home longer, acute care is increasingly about addressing situations that are 'out of balance' or that become urgent,[3] instead of life-threatening situations such as a heart attack (Lappegard & Hjortdahl, 2013). This shift in what acute care entails is prompting policy, spatial and medical questions, for example, when to intervene, where to treat the patient and when and how to transport the patient to a healthcare facility. At the beginning of our study, we were particularly interested in the consequences of acute care concentration on older persons care organisations in rural areas. Especially for these organisations, the disappearance of services and shortage of staff can be challenging as the situation of an older person can quickly deteriorate, whilst organisations aim to avoid hospital admission (Schuurmans et al., 2020).

We focused on two regions, one in Norway and one in The Netherlands, where centralisation of services occurred. In these regions, we interviewed care workers and managers in nursing homes and acute care services, such as ambulance services and primary care clinics, who provide acute care for patients in nursing homes and home care. In both regions, the reorganisation of acute care involved shutting down or merging emergency departments from local hospitals and primary care centres, generating frequent local and national media coverage. We acknowledge that these two countries are both relatively wealthy and well-organised, but the geographical differences between them allow us to tease out which patterns recur in assembling acute care in various types of peripheral areas (Marmor et al., 2005).

In order to anonymise data and locations of our study, we use pseudonyms and refer to the Dutch region as 'Weideblik' and the Norwegian region as 'Fjellrike'. In Weideblik, the medical centre is located in the largest city of the region, and there are several regional hospitals dispersed

over the region. Particularly, these hospitals undergo the closing of emergency posts. In some cases, the opening hours of posts are reduced and citizens have to travel to another post at night, causing longer travel times, from half an hour to approximately 45 min to an hour. The financial situation of hospitals, the condition of buildings and the availability of specialists (nurses and physicians) are reasons to concentrate on care (De Smedt & Mehus, 2017). In Weideblik, a few villages, located on an island and at the border of the region, are harder to reach, and in case of severe emergencies, a helicopter is deployed. What is particularly challenging in acute care in this region however are the less severe acute problems, particularly among the older population living in the countryside. Particularly during out-of-office hours, the need for sub-acute care services for older persons is high in this region.

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

Data collection

In Weideblik, our study started in September 2019, as part of a broader research programme on the regionalisation of older persons care (Schuurmans et al., 2020). Our research team tracked four care organisations for older persons as they sought collaboration to alleviate workloads at night and weekends. We collected data during meetings and interviews with nurses, physicians and managers and selected our data by focusing on (sub-)acute care, transition care or beds and out-of-hours services. This led to a selection of interviews ($N = 10$) and observations ($N = 8$). We conducted additional interviews ($N = 8$) with physicians and healthcare co-ordinators and managers working for ambulance and local general practitioners (GPs) services in this area in 2020. We interviewed respondents about (future) closures of acute care facilities and (sub-)acute care initiatives. Alongside the interviews, the second author attended meetings of regional older persons care organisations ($N = 5$) about collaborating out-of-hours in 2019 and 2020. In Fjellrike, we started in September 2020, by interviewing people working in the regional acute care services and responsible for the professionalisation of care in the region. These respondents ($N = 3$) gave insightful information on future prospects of the organisation of care and showed us bottlenecks and good practices. We additionally interviewed healthcare workers and managers ($N = 16$) in four different municipalities, including nurses and GPs operating in primary care centres (covering out-of-hours), ambulance services and first response teams. Alongside the interviews, the first author visited three ambulance stations, a nursing home and a hospital whose emergency department had been closed.

To focus our research, we spoke with care professionals, being nurses, physicians and managers, and how they have an active role in assembling acute care in the region. The position of our respondents in the community was a professional role from exercising their work as healthcare providers. However, some respondents indicated during the interview that they also felt a personal attachment to the community, having lived and worked there for a long time and knowing the patients in the community well. During one of our site visits, at the first response team in Fjellrike, we also spoke with the local council. As they were invited to share with us how they support the initiative, we included this interview in our data analysis.

Data collection was influenced by the SAR-CoV-2 (Covid-19) pandemic; most interviews were conducted online through Zoom, and site visits were limited to a few occasions in accordance with social distancing requirements and other country-specific Covid-19-related rules (Lupton, 2021). Verbal consent was asked and obtained from all interviewees. Transcripts were worked put verbatim and pseudomised. Consent was also obtained for observations. Transcripts and observation reports were stored in a protected environment of the Erasmus University. Ethical permission was obtained from the Institutional Review Board of Erasmus University Rotterdam.

Data analysis

The initial focus of our research was the acute care for older persons, in particular, the target group for whom sub-acute care services (i.e., temporary beds in nursing homes) are important. However, during interviews with respondents, broader issues emerged, which included accessibility for residents (young and old) on the islands. Also, some services were initiated for older persons, yet were also used by other patient groups. In our analysis, we focused on the images and narratives respondents used when talking about the area they worked (and lived) in and the caring and organising practices they engaged in (Tavory & Timmermans, 2014). In these images and narratives, respondents spoke, for instance, about remoteness, distances and facilities that were closing or replaced and described connectivity between places. We also asked about practices to deliver health care and experienced during site visits how they did do so (DeWalt & DeWalt, 2002). The first response team, for instance, demonstrated the cars they converted and the cabinets with emergency materials in the nursing homes. Last, we analysed how respondents talked about caring for peripheries in the broad sense, not only in healthcare practices but also caring for the community and the future and sustainability of the area or caring for know-how. Our analyses resulted in three overarching themes: representation of peripheralisation in acute care, adapting acute care practices and negotiating quality positions. In the following section, we present these themes, with selected excerpts and quotes illustrating the themes that emerged from both the theory and data.

RESULTS

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

Acute care and a dynamic representation of peripheralisation

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

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

In this interview excerpt, peripheralisation is shaped by the replacement or planned replacement of care facilities. The loss of care services and physicians, working at the 'fringes' of the region, are considered to be problematic for the continuity of 24/7 health care. The region Weideblik has seen emergency departments and several primary care units for out-of-hours acute care being closed in the past few years. The low population density of peripheral areas often makes (specialised) acute care expertise financially unsustainable. Moreover, there are concerns regarding quality of care as medical professionals often do not perform many procedures due to a lack of patients with specialised needs. Hospital departments are then relocated to the city, leaving the area with outpatient facilities instead of a 24/7 hospital:

> Hospitals [in this area] become outpatient clinics where health care is available by appointment, 5 days a week. But what about the other times? I mean, rehabilitation and acute care are needed 24/7… this is particularly true for the outlying areas [due to an ageing population and distances]. (Meeting 2, The Netherlands)

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

> Yes.. of course we have the countryside, and we are a small place. Every shop and every official state office, post office, municipality house is important for the inhabitants in [this village], so also the institution (nursing home). But if we take away [supermarket] this place will die. So of course in smaller places, every shop and every gas station and every nursing home is very important. But if you go to [the

> city] and some shops are closing and new shops are coming up, that doesn't matter… (Councillor municipality, Fjellrike)

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

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

> We call it [the island] a sort of mini-society. Care professionals depend on each other more, the GPs, ambulance services, district nurses… you don't want to call the helicopter for every incident. (Ambulance service manager, R21, The Netherlands)

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

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

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

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

These examples illuminate knowledge, in terms of skills and local know-how, as well as inhabitants who are aware of the skills of care practitioners and even support them in urgent situations.

In doing so, inhabitants and practitioners play an active role in keeping health care nearby, despite huge distances and challenging landscapes. Infrastructures evolve over time, however, and in Norway, more and more islands (as well as other remote locations) are now connected by tunnels, roads and digital technologies, such as electronic patient records and electrocardiograms in ambulances. This has shortened response times, connected areas and services and made health care 'less remote'.

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

Adapting care practices to peripheralisation

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

> The first 2 or 3 years, we had 30–35 emergency calls; last year, we had 83! And the main intervention is [response] time… but also the team's competencies [have increased] and they use [these skills] in their home care services. So, a side effect is that nurses do more systematic [clinical] observations…in daily care too. (Municipal healthcare manager, R10, Norway)

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

Setting up new care constellations does not happen overnight. At first, regional ambulance services were hesitant to assign (sub-)acute care to the first response team because nurses are trained differently than ambulance workers. Another challenge was, and remains, the technical infrastructure enabling the regional hospital, ambulance services and first response team to access and share patient information and co-ordinate emergency calls. Although these challenges are not easily overcome, the various parties are now flexible about professional standards and working

to improve information-sharing, for example, by creating a triage system for communicating the first response team's action to the regional services. Besides adapting accreditation and guidelines, creating awareness of the project among the wider public was significant:

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

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

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

> They [GPs] are trained in life-saving procedures. You have to train them with some regularity since emergencies [requiring specific procedures] don't occur very often. Also, GP assistants also undergo basic life support training. So, we're developing a team of people with skills who can consult each other, understand each other's methods and can rely on each other. (Ambulance service manager, R20, The Netherlands)

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

Another finding, is that healthcare facilities are given multiple functions. In both regions, healthcare facilities are adapted so acute care can be performed closer to home. This appears specifically significant for the older generations inhabiting peripheral areas. In Fjellrike, for example, an ambulance boat, previously used mainly for transport, is turning into a place where more acute procedures can be carried out. During one of our site visits, an acute care nurse mentioned that the current boat will be replaced by a catamaran next year. Although the new boat would be slightly slower, it is more stable on the water:

> The new boat gives us more capacity to move specialist or acute care by local general practitioners on board. The doctor will have more space and equipment, and there will be two stretchers instead of one, so they can help more people on the spot or

> perform more procedures before the patient is taken to the hospital. (Ambulance boat nurse, R7, Norway)

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

> The municipalities are under more and more pressure from the national systems and the hospitals. People don't stay in hospitals very long anymore. I often say that they're hardly admitted before they're discharged again, so we need good nurses and doctors in the community because this is where most of long-term sick people are now. (Municipal healthcare manager, R10, Norway)

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

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

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

The examples in this second section demonstrate how acute care provision is generated by creating new places of care (e.g., transition beds), transforming existing places (i.e., the ambulance boat) and creating new professional roles (through the development and sharing of skills and know-how). It shows that areas, and specifically care practitioners and inhabitants, are not completely at the mercy of facilities elsewhere if care is not (more) or hardly available. Actors set up constructions where local know-how is important, for example, navigating in rough landscapes.

Our data moreover show, in line with previous literature (Eriksson, 2008; Willett, 2020) that it is significant to utilise (new) knowledge and ideas to make them sustainable and appreciated among a wider public. Organisational and political support is significant to be embedded in local contexts and recognised as valuable local care services. Yet solutions are also contested because they deviate from common practices and defined (quality) standards. This is what we turn to in the next section.

Adapting what constitutes good quality care in peripheral areas

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

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

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

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

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

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

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

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

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

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

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

DISCUSSION

In this article, we focused on practices in response to processes of peripheralisation in the provision of acute care, centring the agency of actors in the periphery. We used the concept of discursive

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

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

Third, our study shows that the travelling of knowledge and the creation of new connections can evoke a (re)negotiation of what (good) care entails. Care is organised locally in line with geographies, quality logic and local knowledge, such as skills and know-how. (Milligan & Wiles, 2010). Situating care involves infrastructural work, both in relation to the materialities needed to provide care (e.g., a modified ambulance facility or transition beds) or enable the flow of information between people and units (e.g., patient records), in relation to professional identities and roles (e.g., training up municipal nurses) and quality criteria (e.g., adapting national norms to local circumstances; Langstrup, 2013). Local solutions can lead to a multitude of care constellations and a wide variety of healthcare professionals working in different constellations across traditional professional boundaries. This again shows the relational aspect of the caring periphery, yet it also raises questions about accountability for the care provided. It further reveals the negotiations between centres and the peripheries, and between organisations and professionals working in peripheral areas, about quality norms. The fragmentation of acute care provision that results creates complex regulatory environments where it is unclear which service provider can be held responsible for the quality of care in a certain area. There is a tension between the differentiation of services in peripheral areas on the one hand and the move

towards concentration and standardisation of healthcare services on the other. We argue that this tension is not necessarily a bad thing. Instead, it challenges healthcare practitioners as well as regulatory bodies to adapt conventional quality standards and norms to local circumstances. Moreover, it pushes both local care workers and government bodies (e.g., an inspectorate) to debate different quality positions. This requires a more reflexive approach to defining good care (or other public services) within a certain context or region (Castleden et al., 2010; Loon & Zuiderent-Jerak, 2012; Wiig et al., 2020). Good care in the periphery might not be the same as in the centre. 'Ageing-in-place' and care in the community might be more important to patients in the periphery than care provided according to quality norms set in the centre. Re-valuation of good care is not just about care, then, but also about the re-valuation of place.

This study has some limitations. First, some of the data was collected during the Covid-19 pandemic, and social distancing rules affected direct observation and interviews. Wherever possible, we collected data on-site and conducted additional interviews on Zoom. Second, several researchers contributed to the data collection and analysis. This can be both a strength and a limitation, but we ensured trustworthiness by organising analysis meetings and researcher discussions. Third, due to the changing circumstances during data collection, the number of observations and interviews in the two countries differ. The results were not used for comparative purposes, however, but to learn about strategies for maintaining and renewing acute care facilities within those areas across both cases. Fourth, the geographical understanding of peripheralisation and rural health also differed within each country. Northern regions in Norway, for instance, are very different from southern regions in terms of density and geographical distances, making it difficult to generalise the results. The number of municipalities covered could have been higher and would have perhaps produced different or richer results depending on population size and local circumstances (sea, mountains, ferries, fjords, distance to hospitals). By considering two case studies, however, we were able to identify mechanisms and problems associated with the provision of acute services that are transferable to other healthcare contexts and rural regions. We suggest conducting further studies to explore health care in other rural contexts and to include patient or public perceptions. Such studies could also look more strongly at the connection between care and other services (e.g., education, housing).

CONCLUSION

Our findings offer important insights for both rural and regional policies. We show how actors in the periphery oppose, shape or produce peripheralisation processes in their acute care practices. In doing so, they utilise skills and know-how and produce counter-narratives about care in peripheral areas. Zooming in on the work of care practitioners and how they, in relation to care organisations and local authorities, aim to organise care for patients in 'the periphery' contributes to more diverse and alternative narratives of health care in these areas. So far, policymakers usually define the value and quality of healthcare provision in terms of population, distances and quality standards. Research, however, suggests that such framings can be problematic for rural and peripheral areas, where geographical distribution and quality norms are likely to differ from more central places (Castleden et al., 2010; Malatzky & Bourke, 2016; Van de Bovenkamp et al., 2021). This research has shown that alternative narratives, for instance, regarding different perceptions of quality of care, connectivity between care providers and innovation should be considered to ensure equitable development and avoid too much focus on the potential disadvantages faced by these areas, compared to their urban counterparts.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The authors have provided the required data availability statement, and if applicable, included functional and accurate links to said data therein.

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ENDNOTES

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

[2] The term acute care encompasses a wide range of clinical healthcare functions, including emergency medicine, trauma care, prehospital emergency care, acute care surgery, critical care, urgent care and short-term inpatient stabilisation.

[3] For instance, an older person who is temporarily disoriented by a bladder infection or an overburdened informal caregiver who needs relief from daily care tasks

REFERENCES

Angharad, J., Rahman, R.J. & Jiaqing, O. (2019) A crisis in the countryside—barriers to nurse recruitment and retention in rural areas of high-income countries: a qualitative meta-analysis. *Journal of Rural Studies*, 72, 153–163.

Beetz, S., Huning, S. & Plieninger, T. (2008) Landscapes of peripherization in North-Eastern Germany's countryside: new challenges for planning theory and practice. *International Planning Studies*, 13(4), 295–310. https://doi.org/10.1080/13563470802518909

Bock, B.B. (2016) Rural marginalisation and the role of social innovation; a turn towards nexogenous development and rural reconnection. *Sociologia Ruralis*, 56(4), 552–573. https://doi.org/10.1111/soru.12119

Castleden, H., Crooks, V.A. Schuurman, N. & Hanlon, N. (2010) "It's not necessarily the distance on the map…": using place as an analytic tool to elucidate geographic issues central to rural palliative care. *Health & Place*, 16(2), 284–290. https://www.ncbi.nlm.nih.gov/pubmed/20005147

De Smedt, S.E. & Mehus, G. (2017) Sykepleieforskning i rurale områder i Norge; en scoping review. *Nordisk Tidsskrift for Helseforskning*, 13(2), 0–22. https://doi.org/10.7557/14.4238

DeWalt, K.M. & DeWalt, B.R. (2002) *Participant observation: a guide for fieldworkers*. Walnut Creek, CA: AltaMira.

Eriksson, M. (2008) (Re)producing a "peripheral" region – northern Sweden in the news. *Geografiska Annaler: Series B, Human Geography*, 90(4), 369–388. https://doi.org/10.1111/j.1468-0467.2008.00299.x

Exworthy, M. & Peckham, S. (2006) Access choice and travel. *Social Policy & Administration*, 40(3), 267–287.

Farmer, J., Nimegeer, A., Farrington, J.H. & Rodger, G. (2012) Rural citizens' rights to accessible health services: an exploration. *Sociologia Ruralis*, 52(1), 134–144. https://doi.org/10.1111/j.1467-9523.2011.00549.x

Görmar, F. & Lang, T. (2019) Acting peripheries: an introduction. *ACME: An International Journal for Critical Geographies*, 18(2), 486–495.
Chevillard, G., Lucas-Gabrielli, V. & Mousques, J. (2018) "Medical deserts" in France: current state of research and future trends. *L'Espace Géographique*, 47(4), 362–380.
Ivanova, D., Wallenburg, I. & Bal, R. (2016) Care in place: a case study of assembling a carescape. *Sociology of Health & Illness*, 38(8), 1336–1349. https://www.ncbi.nlm.nih.gov/pubmed/27577541
Keim-Klärner, S., Bernard, J., Bischof, S., van Dülmen Klärner, C., & Steinführer, A. (2021) *Analyzing social disadvantage in rural peripheries in Czechia and Eastern Germany*. Johann Heinrich von Thünen-Institut, Thünen Working Paper No. 170. Available from: https://doi.org/10.3220/WP1614067689000
Kilpatrick, S., Cheers, B., Gilles, M. & Taylor, J. (2009) Boundary crossers, communities, and health: exploring the role of rural health professionals. *Health & Place*, 15(1), 284–290. https://www.ncbi.nlm.nih.gov/pubmed/18617433
Kühn, M. (2014) Peripheralization: theoretical concepts explaining socio-spatial inequalities. *European Planning Studies*, 23(2), 367–378. https://doi.org/10.1080/09654313.2013.862518
Langstrup, H. (2013) Chronic care infrastructures and the home. *Sociology of Health & Illness*, 35(7), 1008–1022. https://doi.org/10.1111/1467-9566.12013. https://www.ncbi.nlm.nih.gov/pubmed/23301691
Lappegard, O. & Hjortdahl, P. (2013) The choice of alternatives to acute hospitalization, a descriptive study from Hallingdal, Norway. *BMC Family Practice*, 14, 87.
Loon, E. & Zuiderent-Jerak, T. (2012) Framing reflexivity in quality improvement devices in the care for older people. *Health Care Analysis*, 20, 119–138.
Lupton, D. (2021) *Doing fieldwork in a pandemic*, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4228791
Magnussen, J., Hagen, T.P. & Kaarboe, O.M. (2007) Centralized or decentralized? A case study of Norwegian hospital reform. *Social Science & Medicine*, 64(10), 2129–2137. https://www.ncbi.nlm.nih.gov/pubmed/17368681
Malatzky, C. & Bourke, L. (2016) Re-producing rural health: challenging dominant discourses and the manifestation of power. *Journal of Rural Studies*, 45, 157–164.
Marmor, T., Freeman, R. & Okma, K. (2005) Comparative perspectives and policy learning in the world of health care. *Journal of Comparative Policy Analysis: Research and Practice*, 7(4), 331–348. https://doi.org/10.1080/13876980500319253
Meyer, F., Miggelbrink, J. & Schwarzenberg, T. (2016) Reflecting on the margins: sociospatial stigmatisation among adolescents in a peripheralised region. *Comparative Population Studies*, 41(3-4), 285–320.
Milligan, C. & Wiles, J. (2010) Landscapes of care. *Progress in Human Geography*, 34(6), 736–754.
Nieber, T., Hansen, E.H., Bondevik, G.T., Hunskår, G., Blinkenberg, J., Thesen, J. & Zakariassen, E. (2007) Organization of Norwegian out-of-hours primary health care services. *Tidsskr Nor Lægefore*, 127, 1335–1338
Oldenhof, L., Postma, J. & Bal, R. (2015) Re-placing care: governing healthcare through spatial arrangements. In: *The Oxford handbook of health care management*. Oxford, NY: Oxford Handbooks.
Perucca, G., Piacenza, M. & Turati, G. (2018) Spatial inequality in access to healthcare: evidence from an Italian Alpine region. *Regional Studies*, 53(4), 478–489. https://doi.org/10.1080/00343404.2018.1462481
Plüschke-Altof, B. (2016) Rural as periphery per se? Unravelling the discursive node. *Sociální Studia/Social Studies*, 13(2), 11–28. https://doi.org/10.5817/SOC2016-2-11
Pollitt, C. (2011). Time and place in public administration: two endangered species?" *Acta Wasaensia*, 33–53.
Prior, M., Farmer, J., Godden, D.J. & Taylor, J. (2010) More than health: the added value of health services in remote Scotland and Australia. *Health & Place*, 16(6), 1136–1144. https://www.ncbi.nlm.nih.gov/pubmed/20688555
Raknes, G., Holm Hansen, E. & Steinar, H. (2013) Distance and utilisation of out-of-hours services in a Norwegian urban/rural district: an ecological study. *BMC Health Services Research*, 13, 222.
Schuurmans, J.J., van Pijkeren, N., Bal, R. & Wallenburg, I. (2020) Regionalization in elderly care: what makes up a healthcare region? *Journal of Health Organization Management*. https://doi.org/10.1108/JHOM-08-2020-0333
Souza, P. (2018) *The rural and peripheral in regional development.regional studies association*. New York: Routledge.
Tavory, I. & Timmermans, S. (2014) *Abductive analyses theorizing qualitative research*. Chicago, IL: The University Of Chicago Press.
Van de Bovenkamp, H., Van Pijkeren, N., Ree, E., Aase, I., Johannessen, T., Vollaard, H., Wallenburg, I., Bal, R. & Wiig, S. (2021) Creativity at the margins: quality work in elderly care in peripheral areas. *Health Policy*. 127(2), 66–73. https://doi.org/10.1016/j.healthpol.2022.12.008
Wakerman, J. (2004) Defining remote health. *Australian Journal of Rural Health*, 12, 210–214.

Wiig, S., Aase, K. & Bal, R. (2020) Reflexive spaces: leveraging resilience. *Patient Safety*, 17(8) e1681–e1684.
Willett, J. (2020) Challenging peripheralising discourses: using evolutionary economic geography and, complex systems theory to connect new regional knowledges within the periphery. *Journal of Rural Studies*, 73, 87–96. https://doi.org/10.1016/j.jrurstud.2019.11.016
Willett, J. & Lang, T. (2018) Peripheralisation: a politics of place, affect, perception and representation. *Sociologia Ruralis*, 58(2), 258–275. https://doi.org/10.1111/soru.12161
Žafran, I. & Kaufmann, P.R. (2022) Tourism in a peripheral setting: a case study of farm tourism development in Lika, Croatia. *European Countryside*, 14(1), 140–156. https://doi.org/10.2478/euco-2022-0008
Zerbib, J.-P. (2021) *Medical deserts—a growing problem across Europe*. Brussels, Belgium: European Public Health Alliance, https://epha.org/medical-deserts-a-growing-problem-across-europe/

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