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Healthy ageing for older migrants in Germany – A discourse analysis on health and social care, responsibility, and ethnicity in older age

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CRPD – United Nations Convention on the Rights of Persons with Disabilities

SKAD – Sociology of Knowledge Approach to Discourse

UN – United Nations

Abstract

Research indicates that migrants age in poorer health compared to native populations with time spent in the immigration country, which leads to earlier and increased health risks in old age. The number of people with a migration background is constantly increasing in Germany consisting of 13.5 % of the population above 65 in 2021. Thus, older migrants have been receiving growing attention in ageing and health and social care discourses. This thesis explores how ageing, older age and healthy ageing are conceptualised in discourses on older immigrants, how and when are cultural differences and ethnic belonging made relevant, and how aged care services are constructed in the context of older migrants' representation in the discourses.

These questions are examined in discourses on the ageing and migration nexus in German policy, health promotion and health and social care discourses on the national- and institutional-level at the example of Munich. The data corpus includes 43 documents from health care or aged care organisations, government reports, city or municipal documents and articles from health and care-related magazines published from 2000 until 2019 and interviews with 18 professionals working with aged or social care services in Munich. The discourse analysis was guided by the Sociology of Knowledge Approach to Discourse, which was complemented using grounded theory methods during the coding stage of analysis.

On the macro-level, the attention to ethnicity and cultural difference and the connection of stereotypes of older age and migrant ethnicity create an image of ageing differently and lead to an *othering* of older migrants. Furthermore, the focus remains on one image of migrant culture as more traditional and family-oriented, which homogenises the diverse population of older migrants. Ageing well has historically been placed as a collective responsibility in the private sphere and within migrant communities themselves. However, the discourse on older migrants over the two-decade timeframe displays how the emphasis on ethnic belonging and collective responsibility of migrants shifts towards public responsibility to improve access to services and increased attention to the heterogeneity of migrants. On the meso-level, narrative structures of older migrants reveal how the representation of older migrants affects accessibility in discourses in health and social care in Munich. In this context, opening existing social services is presented as a public responsibility to address the increasing cultural and ethnic diversity of older age in a German context.

Discourse analysis provides a fruitful methodology to explore how knowledge on older migrants and the construction of ageing well for this population group is integrated into public services. Thus, service provision and initiatives to reach older migrants are influenced by constructions of ethnic and ageing differences. To better address migrants in aged care, reflexivity is needed regarding culture and ethnicity, which includes intersectional perspectives and reflecting on German culture and ethnicity instead of creating positions of us versus them. The current Decade of Healthy ageing and its aim of inclusiveness provides an opportunity to investigate and address inequalities for migrants in old age.

Introduction

The United Nation's (UN) Decade of Healthy Ageing 2020-2030 provides a call for action to improve the health and wellbeing of ageing populations worldwide (World Health Organization [WHO], 2020). This framework of healthy ageing builds on previous discussions on what it means to age well and acknowledges the increased awareness of the diversity of ageing populations (Keating, 2022). It shifts the focus from avoiding diseases to "the process of developing and maintaining the functional ability that enables well-being in older age" (WHO, 2020). An integral aspect of healthy ageing is its aim to leave no one behind, which initiates a vision for inclusion for all older people (Keating, 2022). Thus, it is a response to previous proposals such as active or successful ageing, which have been criticised for not sufficiently taking into account the socioeconomic challenges and the diverse realities of wellbeing in older age (Calasanti & King, 2021; Kristiansen et al., 2016). The UN Decade thus provides an opportunity to explore what is needed to realise the vision of inclusivity in older age.

Older migrants constitute one facet of the growing diversity of ageing people and are characterised by varied experiences and motivations to migrate, diversity in countries of origin, and different ages and social capital at the time of migration. The term *super-diversity* describes the heterogeneity of older migrants, which emphasises that migrants do not just differ based on ethnicity or country of origin but based on migration experiences, e. g. legal status, age at arrival, diversity dimension, such as gender, age, socioeconomic status, religion, and individual life courses (Ciobanu, 2019; Vertovec, 2007). The growing research on ageing and migration has highlighted increased socioeconomic and health risks of older migrants in several European countries (Reus-Pons et al., 2017) and specifically Germany (Hoffmann & Romeu Gordo, 2016). Health risks include poor self-rated health or worries about subjective health, problems with activities of daily living, and increased rates of depression compared to the non-migrant ageing population (Carnein et al., 2015; Hoffmann & Romeu Gordo, 2016; Lanari & Bussini, 2012; Solé-Auró & Crimmins, 2008). Older people with a migration background are a continuously increasing population group, constituting 13.5 % of the population above 65 with the majority being first-generation migrants (88 %) in Germany (Statistisches Bundesamt, 2022). Health and social care institutions intend to acknowledge this demographic development and improve the accessibility to services for the increasing number of older people with a migration background. Yet, the health risks older migrants encounter are also impacted by reduced access to and use of health and social care services (Olbermann & Dietzel-Papakyriakou, 1995; Razum & Spallek, 2012). Thus, it is important to review inclusivity in health and social care provision to ensure that healthy ageing becomes a reality for ageing migrants.

The current Decade of Healthy Ageing provides a new perspective on the international discussion in gerontology and policy of how ageing well can be conceptualised for all ageing populations. Discourses on ageing and migration demonstrate how healthy ageing for older migrants is envisioned on a policy- and institutional-level and how this representation translates into service provision and conceptional frameworks. Researchers at the ageing and migration nexus emphasise the need for acknowledging diverse images of old age (Ciobanu, 2019; Enßle & Helbrecht, 2021; Palmberger, 2017), criticise the focus on older

migrants' vulnerabilities and the construction of older migrants as a social problem group (Palmberger, 2017; Torres, 2006) and demonstrate how culture and ethnicity in the context of ageing and migration are presented as traditional and essentialist (Hahn, 2011; Strumpen, 2018). Furthermore, access and utilisation of health and social care services is lower among older migrants due to language barriers, lower health literacy of services in the immigration country, discrimination and limited culturally-sensitive services (Arora et al., 2018; Brockmann & Fisher, 2001; Carlsson, 2022; Ciobanu, 2019; Zeman, 2012). Brandhorst et al. (2021) reviewed migrant aged care in the context of national health and migration policy in Germany and identified the need for a migration emphasis in aged care services. More recently, Carlsson (2022) investigated responsiveness in urban spaces and to diversity and specifically migrants in aged care in the Netherlands.

This thesis builds on discourse research on ageing and migration and studies on health and social care access for older migrants and fills a gap of research in Germany on health care-related discourses of older migrants. The Sociology of Knowledge Approach to Discourse (SKAD) guides this research and provides an analysis of how knowledge on ageing/older age, health and migration translates into service provision (Keller, 2011). By following the Sociology of Knowledge tradition, this work is grounded in theoretical perspectives on how knowledge is produced, reified and discussed in language and communication creating a construction of a collective social reality (Berger & Luckmann, 1966). Discourses, social practices and communication processes that create knowledge are analysed on the macro- and meso-level to understand the development of knowledge construction of healthy ageing and migration over time by looking at a 20-year period (2000-2019). This research methodology combines the German policy, health, and social care perspective with data from municipal-level institutions, with a particular focus on Munich. It is thus both an analysis of how (healthy) ageing, migration, culture, and ethnicity are conceptualised and provides an important basis for creating and implementing precise theoretical frameworks to address an increasingly diverse population.

This thesis explores:

- How and when are cultural differences and ethnic belonging made relevant in discourses on ageing/older age and immigrants? (Paper II)
- How are cultural/ethnic classifications and social responsibility presented in descriptions of services or initiatives for older immigrants? (Paper II, III & IV)
- How are ageing, older age, and healthy ageing conceptualised in discourses on older immigrants in Germany in the fields of health promotion, long-term care, and services for older people? (Paper III)
- How are services constructed based on the knowledge surrounding older immigrants? (Paper IV)

To answer these questions, I conduct a discourse analysis of documents published by health care or aged care organisations, government reports, city or municipal documents, and articles from health and care-related magazines published from 2000 until 2019. Furthermore, the institutional perspective in aged care is investigated through interview data from professionals who provide, consult or develop aged care services in Munich for citizens with a migration background. The interviewed professionals have a portfolio of work that focuses on people above the age of 65 years, who migrated internationally and are now

growing old in Germany. The aim is to link discourses and knowledge construction in institutions and policies on ageing and migration to service provision for older migrants and improve theoretical frameworks on inclusivity and accessibility in aged care. Inclusivity and accessibility to aged care are identified as essential preconditions to ensure healthy ageing for older and ageing migrants.

Healthy ageing

The current UN Decade of Healthy Ageing (2021-2030) places attention on the quality of lives of older people worldwide and introduces a new framework to improve "the lives of older people, their families and the communities in which they live" (WHO, 2020, p. 1). The Decade is a response to globally increasing longevity and the inequities in healthy ageing, which focuses on sustaining functional ability and capabilities that facilitate people to live their lives according to their own values (WHO, 2020). Diversity and inequity act as key considerations to address these areas and provide inclusive access to health services and long-term care. Furthermore, the Decade of Healthy Ageing concentrates on four areas for action (WHO, 2020, p. 6):

- "change how we think, feel and act towards age and ageing;
- ensure that communities foster the abilities of older people;
- deliver person-centred integrated care and primary health services responsive to older people; and
- provide access to long-term care for older people who need it."

The areas for action focus on the national and societal responsibility to address attitudes on ageing and addressing societal ageism, to advance age-friendly environments, to ensure universal health coverage and providing health services that are not discriminatory and do not lead to financial hardship, and to create access to long term care to preserve functional ability and live a dignified life (WHO, 2020). Thus, the Decade of Healthy Ageing presents an opportunity for research and policy to concentrate on the social construction of "environments across life course towards wellbeing" as main components (Keating, 2022, p. 2). On a macro-level, environments are based on societal beliefs, values and cultural norms that shape the contexts of responses to social questions or challenges. Belief systems on migrant integration, ageism and familism influence government initiatives and community actions on ageing and thus relate to how ageing services for older migrants are provided.

Furthermore, the concept of healthy ageing does not just refer to older age but incorporates a life course perspective to consider how societal factors influence health throughout life, which affects quality of life. The social environment and the life course perspective are important components to recognise inequalities in ageing and to address these. Older migrants who have experienced disadvantages and discrimination will continue to experience inequities later in life (Ciobanu et al., 2017). Keating's (2022) research framework on healthy ageing provides important emphasis on the life course perspective and societal environments as social constructions which can help to better understand the ageing circumstances of older migrants. It also provides an opportunity to look at exclusion and marginalisation instead of reiterating the vulnerability of older migrants.

What does it mean to age well?

Healthy ageing as a concept builds and further develops previous theories and approaches to ageing well such as successful and active ageing into a plan of action toward 2030 (Milicevic Kalasic & Kalasic Vidovic, 2018). Healthy ageing follows from outdated concepts such as disengagement theory to more current constructions of ageing well such as active and successful ageing. Disengagement theory by Cumming and Henry (1961) understands ageing as a universal and natural process of withdrawal from society by stepping back from social responsibilities and work. This theory was soon criticised for its negative perspective on ageing, not taking into account older adults' perceptions and heterogeneities and how older people experience ageing (Hochschild, 1975). While this theory has been outdated for several decades, it shows how concepts of disengagement in older age defined the early phases of Social Gerontology and similar perceptions continue to reoccur in discourses on ageing (Boudiny, 2013).

Another common theory is Successful Ageing, which has been continuously discussed and adapted since its early introduction by Havighurst (1961) and especially since the publications and revisions by Rowe and Kahn (1997, 2015). Successful Ageing optimistically focuses on the personal opportunity and responsibility to achieve and maintain physical and mental health in older age to avoid disease and disability and to continue engagement in productive activities. This theory continues to receive criticism due to the neoliberal angle, which constructs ageing as a personal and lifestyle issue. Furthermore, successful ageing neglected the intersecting inequities that people experience and their effect on older age. In the recent adaptation by Rowe and Kahn (2015), social factors gained recognition, however, the biomedical perspective remains the focus of successful ageing. Social inequalities, particularly in terms of ageism, remain insufficiently addressed within this framework (Calasanti & King, 2021).

Healthy ageing evolved out of the previous WHO agenda of active ageing. The theoretical constructions of active ageing shaped European ageing policies and research (Zaidi & Howse, 2017). Different understandings of active ageing exist, which vary from unidimensional concepts that focus on specific aspects, such as productivity or physical activity, to multidimensional approaches which incorporate social activity, social determinants, and societal responsibility. Active ageing, in its broader sense and as defined by the WHO, considers both physical and mental health and social participation to promote health and well-being in older age. Thus, it is based on personal and societal responsibility to maximise opportunities for well-being throughout the life course. Comprehensive approaches to active ageing and the role of societal determinants and the life course perspective have been gaining attention in the last decade (Foster & Walker, 2021). These developments of active ageing respond to criticism of personal responsibility within the active ageing framework, the neglect of social determinants that influence health in older age and the connection of a positive understanding of ageing with activity and good health (Stenner et al., 2011).

However, there is also criticism regarding the aim of the healthy ageing decade. Lloyd-Sherlock et al. (2019) argue that the proposal lacks the integration between health services and long-term care as the goal should be to conceptualise health, long-term care and social

care as a spectrum of needs and responses. Furthermore, Fernández-Ballesteros (2017) remarks that the increased focus on functional ability medicalizes the notion of health; whereas health in its WHO definition as the “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” goes beyond maintaining merely functional ability. These criticisms demonstrate that the call for healthy ageing needs to further strengthen a multidimensional understanding of health and the social environments that can support opportunities to ageing well.

Discourses on ageing

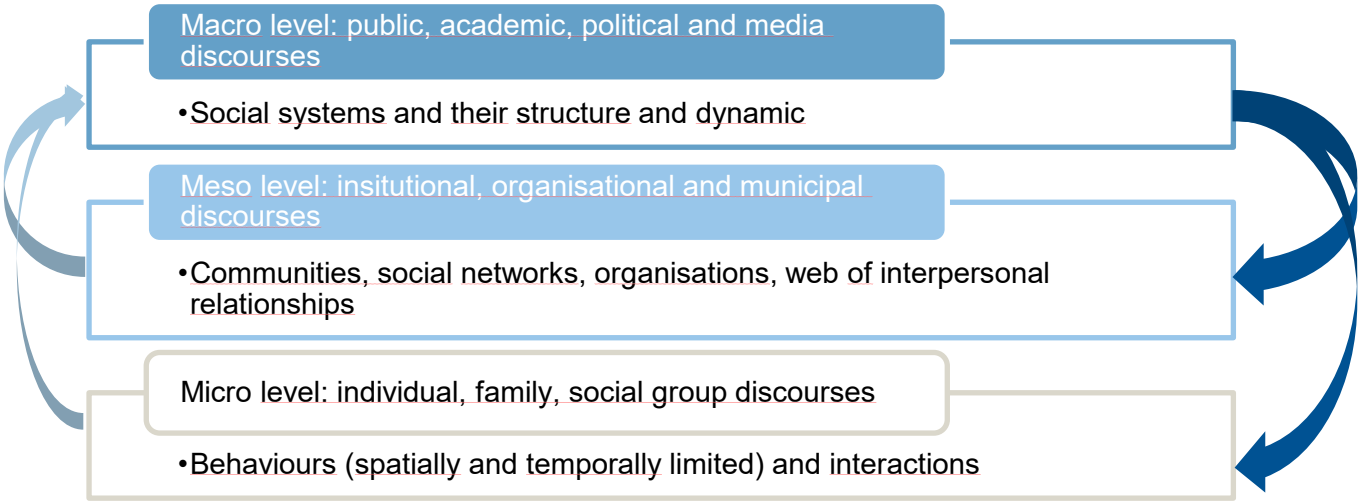

Figure 1 Impact of macro-level ageing discourses on the meso- and micro-level (inspired by Jäger, 2015, p. 84)

What it means to age well is shaped by how society understands ageing and older age and the discourses regarding older people. Discourses take place on the macro- (public discourses, media, policies, advertisement), meso- (institutions, societies, organisations, communities) and the micro-level (personal interactions, family, social groups) (see Figure 1). The public discourse on ageing and older persons is closely linked to the institutional-level. On the one hand, macro-level policies, such as the Decade on Healthy Ageing are translated into practices in institutions and communities (Keating, 2022). Thus, the macro-level influences organisations’ communication on ageing, their services and initiatives for older people. On the other hand, communities, organisations and networks shape national policies and affect the development of macro discourses. Thus, in the context of ageing well the macro- and meso-level are closely related.

Ageing discourses are characterised by a dichotomy of either promoting an active lifestyle and self-responsibility among healthy older adults or by addressing care provisions for and health issues of frail and dependant older people (Angus & Reeve, 2006; Enßle & Helbrecht, 2021; Phelan, 2018). Enßle and Helbrecht argue that images of old age are predominantly shaped the representation of older people on the macro-level through media, policies, and advertisements, whereas diverse images of old age remain in the personal sphere. While the diversity in older age is gaining attention, the two major representations of older age prevail, either as a positive image of active agers or as the negative frail and dependant older age.

These main representations of older people have been shown in discourse analysis in different contexts. While the image of active agers contributing to society is becoming more prominent recently, the vulnerable and passive image of older people remains. Research in Polish and Irish newspapers and magazines demonstrates how older people are homogenised and othered as a separate social group in contrast to the rest of society with stereotypical images of vulnerable old age (Fealy et al., 2012; Wilińska, 2012). Fealy (2012) questions the label and associated constructed identity of old age that is neither natural nor apparent. The discourse analysis of newspaper texts demonstrates how older people are positioned as a distinct demographic group, for example, as “grannies and granddads” and how frailty and vulnerability are linked to the dependency and otherness of older people (Fealy et al., 2012). Weicht (2013) investigates discourses of care in Austria in national daily newspapers and shows how care is presented as a family issue. In this context, older people are characterised by being vulnerable and passive or as active members, when participating and contributing to society. In the German policy context, Denninger and colleagues (2014) investigate how activity is constructed as an individual responsibility and as a moral call to actively contribute to society in retirement in German academic, grey literature, policy and media documents. This discourse of active ageing and the moral duty and individual responsibility to stay active in old age also characterises the organisational discourse in text from Belgian sickness fund agencies (van den Bogaert et al., 2020). Yet, the negative image of older people continues to exist as shown by Makita and colleagues (2021) in their analysis of Twitter communications and posts. Their research demonstrates how vulnerable, disempowered, and homogenous images of old age are (re)produced in social media. Accordingly, Phelan (2018) reviews that ageist perspectives persist, which construct older adults as dependant, vulnerable or helpless, although positive ageing positions coexist in various discourses on old age. She emphasises that the ageist discourse and images of otherness are a part of constructing reality, which produces legitimate knowledge and influences how we think and act towards age.

Social gerontologists have argued for more research on diversity in later life for decades (Calasanti, 1996). This call includes both an increased analysis of different ageing experiences in society and more importantly also an examination of power and social relations in society (Calasanti, 1996; McMullin, 2000). Enßle and Helbrecht (2021) argue that while diversity dimensions, such as gender, ethnicity, and sexuality, among older persons have been increasingly included in ageing research, there is not a conceptional discussion of diversity. Thereby, diversity remains mostly an empty term that lacks a theoretical debate concerning diversity in social gerontology (Enßle & Helbrecht, 2021). It is important to note that this discussion goes beyond looking just at heterogeneity in old age, which describes different ages, levels of functional abilities and the individuality of older persons. Instead diversity “refers to examining *groups* in relation to interlocking structural positions within a society” (Calasanti, 1996, p. 148). Thus, the aim is to integrate both the individual differences in old age and how these relate to structural causes of inequalities and inequities. According to Boudiny (2013), acknowledging diversity on a policy-level means taking a life course perspective on health promotion and accepting the changing meaning of (active) ageing throughout the life course. The growing research on ageing, migration and ethnicity presents one part of the diverse representations of older age and the role of diversity dimensions and power relations for older migrants.

Migration, ageing, and health

In this study, migration describes international movement with the intention to settle long-term in the receiving country. The term *older migrants* can refer to different times and motivations for migration. People migrate in old age, for example, to move to another country in retirement for improved quality of life. Others migrate above the age of 50 to join their children or families. For this study, the focus lies on first-generation migrants who moved either at a young age or before retirement and are now growing old in Germany. Furthermore, circular migration can also be a preference for older migrants, who spend a prolonged time each year in their home country and regularly travel back and forth between receiving and sending countries. While migrants in Germany are on average twelve years younger than the non-migrant German population (Hoffmann & Romeu Gordo, 2016), the population group of people above 65 with a migration background has been continuously increasing (Schimany et al., 2012).

It is important to note that classifications based on migration are related to the socio-political context. In Germany, the term migration background refers to people, who were not, or at least one of their parents was not, born with German citizenship. It is thus closely linked to the person's or their parents' citizenship and can refer to second-generation migrants. Hence, terms such as *immigrant* or *emigrant* highlight nation borders and emphasise the political context of international mobility (Mavroudi & Nagel, 2016, p. 5). Dolberg (2018) and Ehrenkamp (2006) suggest the use of the term *immigrant* to highlight the permanence of migrants, especially in contrast to the commonly used phrased *guest worker* in Germany, and to emphasise the immigration countries' responsibilities in providing welfare services for older immigrants. I use the term older immigrants in three of my articles (Paper I, II and III) that focus more on the policy context in Germany, whereas I used the more common term older migrants here and in Paper IV to highlight the relevance of mobility during the life course and the consequences in older age. Ciobanu (2019) remarks that migrant categorisations of oneself and the majority society can also be disparate. Because of the negative connotation of being classified as a migrant, a person may not identify themself as a migrant but might be categorised as a migrant in society due to their movement to a new country. The term *expat* is one example where the migrant terminology is rejected and a temporary movement within a higher socioeconomic status context is emphasised. Thus, the terminology used to talk about migration also constructs social groups that are differently understood based on the terms used, such as migrant, immigrant, expat, or refugee.

Older migrants are a growing population group in Germany (Baykara-Krumme & Vogel, 2020). The diverse population of older migrants consists of labour migrants, ethnic German resettlers, European and non-European migrants, and refugees (Hoffmann & Romeu Gordo, 2016). The main sending countries of older migrations are European or Mediterranean. Germany has encouraged labour migration since the 1950s and many migrants, who arrived for work in the past decades, decided to stay and are now growing old in Germany. Labour agreements existed from 1956 to 1973 with Portugal, Spain, Italy, former Yugoslavia, Turkey, Morocco, Tunisia and South Korea and family reunification migration continued until the 1980s (Baykara-Krumme & Vogel, 2020; Hoffmann & Romeu Gordo, 2016). Ethnic German resettlers constitute another important migration history who are descendants of Germans and were forced to move or fled during the Second World War to the former Soviet

Union and have been returning to Germany mainly from the 1950s to the 1990s (Hoffmann & Romeu Gordo, 2016). The main sending regions of older migrants for 2013 are shown in Figure 2. It can be expected that the percentage of non-European migrants among the ageing population is continuously increasing. Currently, non-European migrants are still younger on average. In 2021, among African and Asian migrants in Germany, only 3 % were above the age of 65 years (Statistisches Bundesamt, 2022).

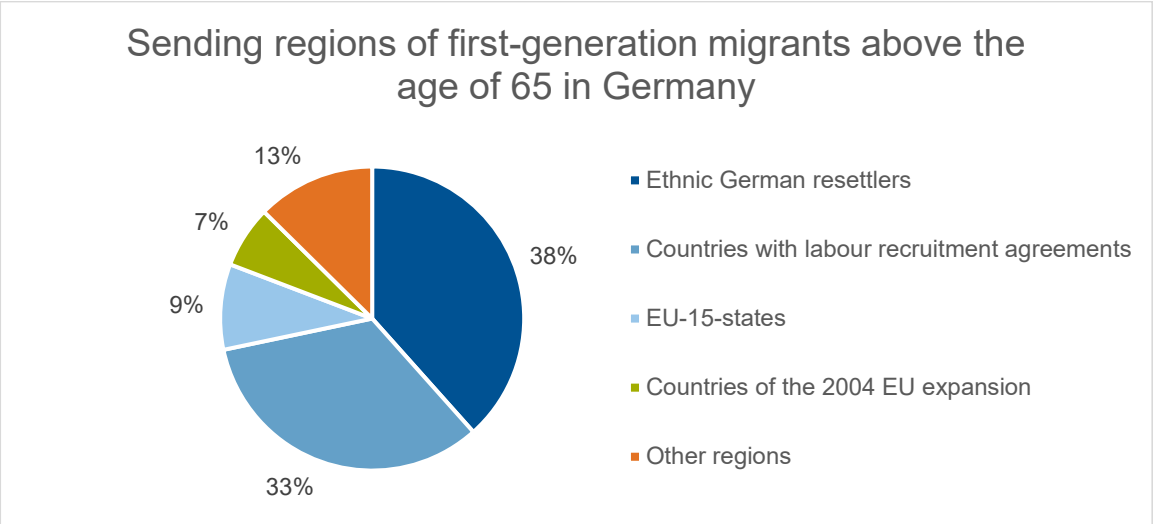

Figure 2: Sending regions of older migrants in Germany in 2013[1] (Hoffmann & Romeu Gordo, 2016)

Super-diversity of older migrants

As stated above, older migrants are a diverse population group with various migration histories, socioeconomic backgrounds, and legal circumstances, having migrated at varying times in their life course due to distinct motivations and from diverse countries of origin. Thus, social gerontologists have argued to consider the diversity of older migrants and move away from homogenising representations of migrant populations (Ciobanu, 2019; Enßle & Helbrecht, 2021; Torres, 2006). The concept of super-diversity, which was introduced in migration studies, provides a more detailed analysis and understanding of older migrants in the context of individual migration processes. Looking at immigration and ethnic diversity in Britain and specifically London, Vertovec argued in 2007 that the demography of migrants has significantly changed and is characterised by super-diversity. Research on migration needs to reflect this diversification regarding the multidimensional aspects that affect migrants. Super-diversity aims to move beyond ethnicity as the primary focus of analysis and to consider the interplay of factors such as immigration statuses, gender, age, migration channel, access to employment, migrants' human capital (e. g. education, work skills), country of origin and language, ethnicity, cultural values, and religion. Ethnicity, hence, needs to be understood in interaction with these variables but not as a main discerning factor of migrants (Vertovec, 2007). This approach seeks to better understand increasing

[1] The term EU-15-states refers to the European Union countries 01/1995 to 05/2004: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, and United Kingdom. The 2004 Eastern enlargement of the EU included the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, the Slovak Republic, and Slovenia.

global migration patterns and the political, legal, and social processes that impact migration status, residence, health, and wellbeing.

Ciobanu (2019) applies the concept of super-diversity to older migrants and demonstrates how re-focusing on the differences of migration experiences can produce a better understanding of social inequality later in life. The age at migration, where a person has lived earlier in life, employment, and legal status contribute to a person's situation in old age, their pension, residency status, health, language abilities, and knowledge about the public systems. The super-diversity approach in the context of older migrants provides two key advantages for the analysis of older migrants. This comprehensive perspective on the various forms of migration-related inequality and discrimination avoids a homogenisation of older migrants as a problem group and creates more nuanced images of the challenges older migrants experience (Ciobanu, 2019). While limited resources and the vulnerable social positions of older migrants need to be recognised, the vulnerability trope should not be unnecessarily exaggerated (King et al., 2017). The super-diversity approach sheds light on sources of inequalities among migrant populations and highlights that migration does not automatically lead to vulnerability (Ciobanu, 2019; Palmberger, 2017). Super-diversity provides a useful perspective to better understand the diversity of older migrants in Germany and the sources of precarity over the life course.

Ethnicity and culture in older age

The approach of super-diversity proposes that a primary focus on ethnicity is not sufficient to understand migration processes. Nevertheless, the social construction of ethnicity is a central classification system in the context of migration and influences how we perceive migrant populations. To be able to understand ethnicity in the context of other social, legal, and political factors as suggested in the context of super-diversity, it is necessary to examine definitions and social constructions of ethnicity. How migrants are categorised and how cultural and ethnic differences are understood translates into approaches for cultural competency and intercultural openness in health and social care (Brandhorst et al., 2021; Carlsson & Pijpers, 2021).

Ethnicity and culture act as classification systems of who is seen as a migrant with cultural differences being highlighted in public discourses on migrants. Ethnicity refers to categorising groups of people, which then turns into naturalised classification systems that have consequences in society. Culture, however, tends to indicate actions, symbols, and values within ethnic groups (Eriksen, 2002). Thus, culture can be defined as a dynamic set of shared, learned, symbolic practices and beliefs . Torres (2019, p. 78) argues that research in social gerontology investigating the intersection of ethnicity and ageing/old age, which aims to inform gerontological policy and practice, is "in dire need of developing their understandings of ethnicity and race" and could benefit from theoretical perspectives from ethnicity scholarship.

The essentialist or primordial perspective was the first approach to delineate ethnicity in the behavioural and social sciences and has mostly been abandoned in ethnicity and race scholarship (Torres, 2019). This perspective understands ethnicity as traits and characteristics of people's background, such as phenotypical traits, first language, nationality, geographic background, and religion. Thus, this classification was primarily seen

as fixed and unchangeable (Eriksen, 2002; Torres, 2019). This position has been thoroughly critiqued as it neglects social transformation processes and attempts a classification that does not reflect the change and variation in ethnicity on a global scale (Cornell & Hartmann, 2006; Eriksen, 2002). Furthermore, the risk of this perspective is the naturalisation and generalisation of assumptions and stereotypes about ethnic groups.

Instead of looking at ethnicity as a fixed, profoundly rooted identification of ethnic belonging, the structuralist or circumstantialist perspective describes the meaning of ethnicity in its social context (Cornell & Hartmann, 2006). The focus is less on the identification itself but on what ethnicity means in circumstances and context, such as the advantages and disadvantages that stem from this categorisation. Thus, from this position ethnicity can be understood in a more fluid and continuously changing meaning as a social position and less as the origins of a person (Cornell & Hartmann, 2006). However, the contextual perspective only provides a limited understanding of how assumptions and attachments about people's backgrounds are produced and shared in discourses (Torres, 2019). Essentialist and circumstantialist perspectives are still common in Social Gerontology and institutional settings. Hahn (2011) and Strumpen (2018) research the role of ethnicity in Social Work and aged care in Germany and argue that different migration experiences and differences regarding care provision should not be essentialised. Preferences regarding aged care are influenced by cultural and religious values but should not turn into an essentialised and static understanding of older migrants' care expectations (Strumpen, 2018).

This research takes a social constructionist approach to ethnicity and culture and asks how and when ethnicity and culture are made relevant and how ethnicity is negotiated and raised in discourses. Ethnicity from a social constructionism perspective refers to the relationship and boundaries between different population groups, their self-ascribed identity and the categorisation of others (Barth, 1969). Thus, the focus is on the boundaries of ethnic groups and how these boundaries discern between fluid assumptions of "us" versus "them" (Barth, 1969). Torres (2015, p. 944) argues that "when ethnicity is understood on the basis of the social constructionist perspective the focus shifts to how ethnicity is made into something significant and when and how it is allowed to play a determinative role in our lives". To summarise, the social constructionist perspective sees ethnicity as something that people do, the structuralist/circumstantialist perspective focuses on what people have or do not have dependant on the context and the essentialist perspective looks at who people are (Torres, 2019). This research particularly focuses on how ethnicity is "done" in discourses and how older migrants are categorised in regard to ethnicity.

Othering and vulnerabilities at the migrant-ageing nexus

The connection of ethnicity, group belonging and the differentiation of an "us" versus "them", also leads to othering based on ethnic identity. Othering categorisations are connected to essentialist perspectives that naturalise or generalise notions and assumptions of difference (Torres, 2015). In the context of ageing and migration, two categorisations come together and form the imagined group of older migrants. Older migrants are both categorised by assumptions of ethnicity, such as religious belief, traditional family values or cultural norms, and by stereotypes of old age, such as disengagement and frailty in old age (Hahn, 2018; King et al., 2017). Thus, the discourses on ageing and older age also affect how we perceive

the group of older migrants and their opportunities and responsibilities for healthy ageing (Dolberg et al., 2018).

Furthermore, the ageing and migration nexus is seen as a combination of vulnerabilities related to migration and older age, which has led to older migrants being perceived as a social problem group. Torres (2006) demonstrates in her research on academic, government and municipal documents that older migrants in Sweden became associated with special needs and being disadvantaged by elderly-care planners and providers. In that way, older migrants are othered as a social problem group that masks the heterogeneity within older migrant populations. In their analysis of representations of ethnicity and migration-related issues concerning elderly care in Swedish newspapers, Lindblom and Torres (2022) note that culture appears differently in discourses of care utilisation among ethnic minorities. The authors summarise that the "[ethnic majority] are represented as individuals who are not determined by their ethnocultural backgrounds, while the latter [ethnic minority] are often described as cultural beings whose language, religion, traditions and customs determine who they are" (Lindblom & Torres, 2022, p. 282). While culture for older Swedes refers to preferences and wishes, such as enjoying art and media, culture for older migrants is presented as needs that ought to be fulfilled in a care setting, such as food, language, or religion. These results show the problematisation of older migrants in Sweden and how culture defines older migrants by essentialising cultural needs in old age.

The health of older immigrants

The health of older migrants is influenced by social determinants of health (e. g. living conditions, healthcare access, environmental hazards, contact with infectious agents), before migration during migration and after migration (Acevedo-Garcia et al., 2012). Research from Western immigration countries has revealed a healthy immigrant effect, which indicates that migrant populations appear to be healthier than the autochthonous population after migration. This effect is often described as a paradox as migrants on average experience more health risk factors such as hazardous working conditions, lower income, and shorter time in education (Kristiansen et al., 2016; Lu & Zhang, 2016). Nevertheless, evidence from higher-income countries supports that migrants show lower overall mortality compared to the non-migrant population (Aldridge et al., 2018). Certainly, this paradox only applies to average comparisons and not to all migrant populations. Selection effects (persons in good health are more likely to migrate) and statistical errors (people with health problems return to the sending country but remain in official statistics) explain some of the difference of mortality differences among migrant and non-migrant populations (Lu & Zhang, 2016).

Yet, with increasing time in the immigration country, the healthy immigrant effect appears to decline (Kristiansen et al., 2016; Lanari & Bussini, 2012; Solé-Auró & Crimmins, 2008). Older immigrants are more likely to report worse self-rated health, chronic conditions, problems with activities of daily living, and depression in older age compared to a non-migrant ageing population (Carnein et al., 2015; Lanari & Bussini, 2012; Loi et al., 2023; Solé-Auró & Crimmins, 2008). This health decline is explained by the social determinants of health migrants experience in the immigration country and is referred to as the "exhausted migrant effect". Physical and psychological stress is caused by a disadvantaged

socioeconomic position, lower income, part-time or short-term contracts, language barriers, low health literacy, discrimination, and uncertainties regarding residency and working circumstances (Carnein et al., 2015; Kristiansen et al., 2016). According to a German study on self-rated health and disability, the exhausted migrant effect, also called the weathering hypothesis, appears to particularly affect migrant women who experience poorer health than their native counterparts (Loi et al., 2023).

Lower self-rated health has been found among older migrant population compared to non-migrant populations in Germany (Hoffmann & Romeu Gordo, 2016; Lanari & Bussini, 2012), France and Sweden (Lanari & Bussini, 2012), and the Netherlands, England and Wales (Reus-Pons et al., 2017). Furthermore, older migrants seem to experience higher rates of depression than the native population in European immigration countries (Aichberger et al., 2010; Lanari & Bussini, 2012). Additionally, limitations in activities of daily living and disability status were found to be more common among Turkish migrants above the age of 50 compared to Germans living in Germany (Carnein et al., 2015). Similar results on activities of daily living and instrumental activities of daily living, needed for independent living such as preparing a hot meal, were found in various European countries among migrants above the age of 50 (Solé-Auró & Crimmins, 2008). These differences point towards an earlier onset of age-related health issues among the older migrant population (Kristiansen et al., 2016).

The reported health issues pose the question of how to realise healthy ageing for older migrants (Bolzman & Kaeser, 2012; Kaeser & Zufferey, 2015; Olbermann, 2013). Firstly, promoting healthy or active ageing requires recognising the diverse realities of ageing well (Kaeser & Zufferey, 2015). Research on the activities of older populations in Switzerland demonstrates the prominent understanding of ageing well, such as active ageing, applies to some older migrants but can marginalise people in situations of vulnerability (Kaeser & Zufferey, 2015). Secondly, healthy ageing requires social inclusion based on a recognition of diversity in older age and encouraging political participation (Olbermann, 2013). Addressing inclusion in public spaces also involves developing access to health and social care. Bolzman and Kaeser (2012) argue to acknowledge the concerns of migrants and their ageing preferences and to support healthy ageing environments which facilitate opportunities for participation and inclusion. Thus, frameworks on ageing well need to be aware of incorporated cultural norms and need to ensure that healthy ageing provides a holistic possibility for diverse life courses of the ageing population.

Access to health and social care for older migrants

Access to health and social care is one central factor to foster healthy ageing for ageing migrants. Health care refers to the treatment of biomedical conditions in outpatient care and inpatient care, summarising all medical services. Social care is the care and support of vulnerable people, usually in the community, for older, sick, and disabled persons. Aged care refers to home care, semi-residential care, residential care, and social care for older populations. In Germany, these services are financed by the health and care social insurance system which is guided by the principles of solidarity, subsidiarity and family responsibility (Brandhorst et al., 2021).

Various barriers exist that influence knowledge, access, and usage of services on the individual, institutional, and structural levels. Hahn (2018) notes that individual aspects (e. g.

language skills, level of education, health literacy), social networks (e. g. social exchange), power structures (e. g. political participation and citizenship, institutional discrimination), and a multiplicity of values among older migrants (e. g. heterogeneity of religious values, ethnicization of differences) influence participation in society. On the individual-level, Strumpen (2018) for example highlights the role of religious aspects of care and service expectations of older Turkish migrants in Germany and emphasises how religious values affect perspectives on ageing. Together these factors influence accessibility and create barriers to accessing aged care services. Thus, major barriers are language, low health literacy, lack of social networks facilitating access and an apprehension of public services due to previous negative experiences (Arora et al., 2018; Brockmann & Fisher, 2001; Hahn, 2018; Kristiansen et al., 2016). These barriers lead to lower usage and quality of health care and rehabilitation programmes (Brzoska et al., 2010; Razum & Spallek, 2012). Similarly, research from Germany, Austria and the Netherlands has shown that knowledge about and utilisation of care facilities, social work and social services is limited among older migrants (Brockmann & Fisher, 2001; Hahn, 2011; Zeman, 2012). On the macro-level, policies of the immigration country also influence the accessibility to aged care services. The transnational lives of older migrants do not correspond with the national policy perspectives that focus on ageing in place (Brandhorst et al., 2021; Strumpen, 2018). Brandhorst and colleagues (2021) thus argue for a “migration turn” in German aged care policies to acknowledge transnational and bi-lateral care networks among ageing populations.

Inclusivity and accessibility to care

The healthy ageing framework posits *inclusive* as one of its guiding principles, which “involves all segments of society, irrespective of their age, gender, ethnicity, ability, location or other social category” (WHO, 2020). Related to inclusivity are the guiding principles of equity and leaving no one behind, which aim to address specific challenges and vulnerability and to create equal opportunity independent of determinants of healthy ageing such as migration, age, gender, place of birth, residence or level of ability (WHO, 2020). Inclusivity for healthy ageing thus means age inclusiveness, participation (of marginalised voices), recognising older people’s diversity, and addressing drivers of inequalities. Creating inclusive health and social care services presents one aspect of the broader discussion of social exclusion and inclusion of older persons (Walsh et al., 2017). Inclusivity in care services is thus one dimension to improve the social inclusion of marginalised old-age populations.

Different discourse strands on inclusions exist: firstly, inclusion in the context of social systems and particularly function systems, secondly inclusion in the context of disability and the UN Convention on the Rights of Persons with Disabilities (CRPD) and thirdly, inclusion in the context of migration (Bundschuh et al., 2021). In the migration context, inclusion differs from integration and assimilation. Assimilation implies an ethnic notion of integration that entails becoming culturally similar to the host society with time (Ehrkamp, 2006; Gustafson & Laksfoss Cardozo, 2017). Integration focuses on equal rights and civic obligations for immigrants and native populations, which can be further distinguished into multiculturalism (acknowledging cultural diversity) and civic integration (civic rights and responsibilities but discounts ethnicity and cultural differences) (Gustafson & Laksfoss Cardozo, 2017).

Furthermore, Ehrkamp (2006) demonstrates how discourses of assimilation and integration overlap in discussions of Turkish immigrants in the German political and media context. Consequently, inclusion addresses the critiques of integration and the duty to assimilate into the majority society (Bundschuh et al., 2021). Instead, inclusion aims to create structural conditions which compensate for disadvantageous social positions and enable participation (Georgi, 2015). Thereby, inclusion incorporates the aspects of participation as put forward in the CRPD and places attention on the intersectional causes of discrimination or barriers (Bundschuh et al., 2021).

Cultural competency and intercultural openness

Cultural competency is a core approach to ensure cultural sensitivity in health and social care to ensure quality of care and accessibility in the context of cultural diversity. Willis and colleagues (2017, p. 693) stress the dimension of cultural reflexivity, “an understanding of one’s own ethnocultural position relative to others, which brings with it a sensitivity to difference” in delivering social care for diverse clients. Regarding cultural reflexivity, the authors suggest incorporating cultural competency in social care involves: “the confidence to ask questions, sensitivity to difference, and a certain level of knowledge about how cultures differ” (Willis et al., 2017, p. 694). Cultural competence thus provides one concept to address cultural, ethnic, religious and language differences in service settings.

In the German context, making public institutions and services accessible to migrants is discussed mainly in regard to intercultural openness (*Interkulturelle Öffnung*). The concept is also applied to health and social care services and addressing cultural differences in long-term care or health promotion. Intercultural openness has been introduced in the 1990s to improve the quality and accessibility of services for the immigrant population in Germany (Penka et al., 2012). Conceptual approaches to intercultural openness range from focusing on acknowledging cultural differences and cultural competency to holistic approaches, which include considering the intersectional relations between diversity dimensions such as gender, age, sexual orientation, physical equipment, and socio-economic situation (Schröer, 2018). Intercultural openness is understood as a cross-sectional task that encourages recognising religious diversity, offering multilingual information distribution, creating contacts with migrant networks and training intercultural teams on cultural competency (Penka et al., 2012). Although this approach should encourage self-reflexivity of one’s own culture, it has been criticised for taking an essentialist perspective on culture and emphasising the cultural differences between immigrants and Germans (Tezcan-Güntekin, 2020). As the concept focuses on the otherness of migrants, it problematises the ethnic-cultural distinction associated with migrants (Khan-Zvornicanin, 2016).

Diversity approaches to improve the access to and quality of services

Diversity approaches have been suggested to move away from the focus on culture and towards recognising all kinds of differences in society, thus lessening the distinction between migrants and non-migrants (Penka et al., 2012). In the context of health and social care, diversity approaches take into account that all clients and users of services differ and thus also display diverse needs and requirements (Brzoska & Razum, 2020). The aim is to design person-centred and diversity-sensitive care that takes diversity into account in terms of

gender, age, sexual orientation, physical ability, ethnicity, and educational background (Tezcan-Güntekin, 2020). Diversity refers not just to heterogeneity in society but relates to the context of difference, addressing inequality and discrimination and being aware of the intersectional relations of diversity dimensions (Enßle & Helbrecht, 2021). Diversity management could thus be an opportunity to establish framework conditions in institutions that promote openness towards the users (Brzoska & Razum, 2020).

However, the benefit of diversity approaches, its holistic perspective on differences, social inequalities, inequities and their interaction, defies a precise definition of the term (Ahmed, 2007). In the context of UK universities, Ahmed (2007, p. 238) discusses how the vagueness of diversity also appeals to practitioners and "secures rather than threatens". Accordingly, Carlsson and Pijpers (2021) acknowledge two main challenges of diversity mainstreaming in Dutch policies for older migrants. Firstly, diversity as a term remains vague, leading to ambiguities in its implementation and limited action on how to attend to inequalities among ethnic minorities. Secondly, the broad term of diversity blurs specific discussions on equity of access and the distinct needs for accessibility, as causes of reduced access, such as cultural factors, are lost under the positively-connotated umbrella term of diversity (Carlsson & Pijpers, 2021).

Nevertheless, diversity approaches provide an opportunity to overcome essentialist understandings of culture and decrease the risk of further othering migrants in the context of accessing health and social care services (Carlsson & Pijpers, 2021; Tezcan-Güntekin, 2020). The health risks of older migrants and their limited access to and use of health and social care services demonstrate the need to acknowledge the growing diversity in aged care. With a precise focus on life course inequalities and inequities as suggested in the super-diversity approach, diversity approaches provide a significant condition towards inclusivity and accessibility in aged care services.

Methodology: taking a discourse perspective on health and social care

Opportunities for healthy ageing, such as accessibility to services, take place in the social environment, which is socially constructed through the beliefs and values of societies (Keating, 2022). Age relations and knowledge systems on older age, migration or ethnicity guide courses of action to address the health and well-being of older people (Keating, 2022). In addition, the construction and reproduction of knowledge on health/illness, healthcare, the role of the individual, and welfare systems shape how health and social care are structured and organised in societies (Lupton, 1992). Discourse analysis offers a valuable framework to examine knowledge constructions on ageing, diversity, and health and how these knowledge patterns translate into service provision (Lupton, 1992; Unger et al., 2018; Yazdannik et al., 2017). Discourse describes sign usages (mainly textual and verbal communication) that result in fairly stable patterns of meaning and knowledge systems, which emerge in a network of social actors, institutional structures and knowledge patterns (Keller, 2012).

Taking a social constructivist perspective in discourse analysis provides a lens on how reality is constructed and organised through social processes (Yazdannik et al., 2017). It also critically questions taken-for-granted knowledge, which might be presented as objective

truth. Instead, knowledge is culturally and historically specific and maintained by social interaction (Burr, 1995/2015). How knowledge is constructed in society also influences the organisation and development of care services for older persons (Phelan, 2018).

For example, how older migrants' culture and ethnicity and their barriers to accessing services are understood will affect how these barriers are addressed. Lindblom and Torres (2022, p. 289) demonstrate in their study on media discourses "that the linguistic categories that daily newspaper reporting on elderly care and migration relies on play a role in how discussions about the sector materialise". The representation of migrants as the most suitable care workers for older migrants places migrant carers in a distinct work niche, which is produced through cultural stereotypes about migrant care (Lindblom & Torres, 2022). Thus, the definitions and implementation of inclusiveness to services are influenced by the discourses on accessibility and barriers. Another example is the discursive shift of older migrants from being described as "hard-to-reach" towards being identified as "seldom-heard". This language shift highlights migrants' position in society, their lack of participation and social exclusion and aims to address this position by making people heard (Ní Shé et al., 2019). Thus, analysing discourse presents a fruitful methodology to examine the relationship between knowledge constructions, social processes and the associated materiality in health and social care.

The Sociology of Knowledge Approach to Discourse

The SKAD research program offers a fitting framework to explore discourses in health contexts by investigating knowledge constructions and patterns, the role of social actors and the relationship between power effects and knowledge (Unger et al., 2018). Thus, this discourse framework explores how social actors construct, produce, and attribute meaning to reality in institutionalised settings that influence how knowledge systems and courses of action are constructed. Furthermore, SKAD offers useful tools (see chapter on data analysis) to investigate how knowledge of older migrants is connected to health/social care system solutions, societal values and public/social responsibilities. This perspective on discourse is based on the hermeneutic Sociology of Knowledge tradition, symbolic interactionism and the Foucauldian focus on power-knowledge constructions (Keller, 2011).

The Sociology of Knowledge perspective is influenced by Berger and Luckmann's work "The Social Construction of Reality" (1966), which underlines the role of language and everyday conversations as a basis of a shared social reality. Knowledge in this context includes all forms of symbolic orderings, from scientific knowledge, ideology or religion to common sense (Keller, 2012). Berger and Luckmann's Sociology of Knowledge approach addresses how human activity can create a world of things (1966, p. 18). The question concentrates on the relationship between the institutions and stocks of knowledge situated in objective reality and the social interaction, identity and socialisation processes that create people's subjective reality. This relation creates a dialectic process, where subjective knowledge is realised and reified through social interactions and becomes an "objective reality" through habituation and legitimisation in institutions.

Furthermore, SKAD integrates Foucauldian thought on power/knowledge systems in social knowledge relations and knowledge politics and its consideration of speakers and actors (Keller, 2011). Discourse thus illustrates the fundamental links between the social

construction of knowledge and power. Power in discourse refers to who has agency, knowledge struggles, voices heard, or voices silent. Therefore, classifications of ethnicity or "social problem groups" in institutional discourses shape the construction of us versus them and influence how health and social care is envisioned for the "other" in society (Lindblom & Torres, 2022; Torres, 2006; Unger et al., 2018). Thus, SKAD offers a suitable methodology to explore discourses on ageing as a migrant and how representations, categorisations, and problematisations of older migrants are linked to health and social care services.

The Sociology of Knowledge thinking is closely linked to symbolic interactionism and how the symbolic meaning of things emerges through individual human interaction (Blumer, 1986). The Sociology of Knowledge provides a methodological framework of how written and verbal communication are part of societal and institutional knowledge stocks and also influence how knowledge is reified and institutionalised. It, thus, provides a helpful notion of how structures and institutions relate to individual actors' agency and how the interplay of both creates society and the associate symbolic orderings (Keller, 2012, 56f).

Data collection: document analysis

The first part of this research builds on a document analysis, which focuses on a macro and meso-level investigation of public, policy and institutional discourses. The data corpus includes 43 institutional, policy and grey literature publications on ageing/older migrants in Germany. The aim was to locate governmental and institutional records accessible to the public and professionals in the German health and social care sector. The search was conducted online using the following search terms: older/ageing (im)migrants, foreigners, or people with a migration background, in combination with keywords such as social care, health care, services, intercultural openness or aged care (Altenhilfe). The search was carried out using general search engines (Google, Google Scholar, Bing) with additional manual searches to identify reports and guidelines published by significant political, welfare, health care or social organisations, grey literature in healthcare or migration-related magazines, or project reports.

Newspaper articles, academic journal articles and publications without a clear focus on older migrants in Germany were excluded from the analysis. Furthermore, only documents published in the year 2000 or later were included in the research. The time frame was chosen as the topic of older foreigners and older people with a migration background gained attention in the 1990s. The interest in the intersection of ageing and migration became prominent in policy publications in the early 2000s, with the Sixth German Family Report in 2000 and the Fifth German Report on Older Persons in 2005 addressing the matter. As summarised in Table 1, the search strategy resulted in a data corpus consisting of policy documents (e. g. reports and public recommendations), publications from organisations and institutions that offer services for older migrants, documents from city councils or municipalities, articles from health-related institutions or magazines, and publications from political foundations. A complete list of the documents included in the analysis is available in the appendix.

Publication type and data sources	Included texts	Publication dates
Federal ministries, government publications Migration/integration reports (5) Ageing reports (3) Family report (1) Guidelines and online information (3)	12	2000-2016
Political foundations, charity organisations Heinrich Böll Foundation, affiliated with the German Green Party (6) Friedrich Ebert Foundation, affiliated with the German Social Democratic Party (2) Arbeiterwohlfahrt (workers' welfare federal association) (2) Stiftung Mitarbeit (foundation for participation) (1)	11	2002-2013
Federal states, district governments and municipal-focused publications State or district governments (4) Local institutions (4) City administrations (3)	11	2004-2019
Magazine and online articles Health-related publications (5) Migration-focused magazine (1)	6	2012-2016
Forums and working groups Forum for culturally sensitive elderly care (1) Working group of the migrant umbrella organisations (1) German institute for retirement provision (1)	3	2009-2018
Total	**43**	**2000-2019**

Table 1: Sources of documents included in the analysis (Göttler, 2023)

Data collection: interview analysis

Setting

The second part of this project concentrates on the institutional sphere in the context of health and social care services in Munich. Munich presents an interesting example to research the discourses on service provision for older migrants. In 2021, 1.5 million citizens from 190 countries lived in the metropolitan area. Among residents, 28.5 % hold foreign citizenship and 16.6 % have a migration background (Statistisches Amt München, 2022b). Among the population above the age of 60, 10.9 % of citizens are German with a migration background, and another 19.2 % are foreigners (Statistisches Amt München, 2022a). The city of Munich implemented a project on the “intercultural openness of long-term care” from 2014-2020 to improve culturally sensitive approaches in health and social care and to acknowledge the increasing population of older migrants. Aged care in the city is organised in 32 municipal service centres for older people, run by welfare organisations that aim to reach older people in their local neighbourhoods.

Sampling and data collection

Interviews were conducted with professionals working in health and social care services, welfare organisations, the city of Munich or aged care services. Purposive and snowball sampling methods were applied to reach a comprehensive sample of actors who worked as service providers or in care management (i. e. coordinating public services or managing aged care institutions) from various welfare or public institutions. The aim was to include professionals both from aged care and migrant-specific institutions. Altogether 25 institutions

were contacted, 17 responded, and 15 agreed to an interview. The organisations that responded but did not participate rejected the interview due to time restraints or limited experience working with ageing migrants. In two cases, the informants wished to be interviewed together with their colleagues to report a holistic perspective about their institutions' work with older migrants. Thus, 18 professionals (13 women and five men) were interviewed in 2019 and 2021. The institutions and organisation of the interviewees are listed in Table 2. One of the contacted organisations concentrates on health and social care for migrant women, which was also the focus of the interview. The interview dates range from 2019 to 2021, as in-person interviews were not possible during the Covid-19 pandemic. Therefore, three interviews were conducted virtually using online video meetings in 2021. Several participants mentioned their long-term experience (more than five years) in health and social care, and about half discussed their own migration background during the interviews.

The interviews followed a problem-centred approach (Witzel, 2000) using a semi-structured interview guide with open-ended questions on the significance of ageing for migrants, forms of support in older age, organisations and networks involved in providing support, and recommendations for actions. The problem-centred interview offers an effective combination of a structured interview guide and the flexibility to encourage a dialogue between the researcher and interviewee that centres on a specific topic. The "problem" – ageing migrants in Munich – is first explored through open-ended, narrative questions and then pursued by more specific enquiries (Döringer, 2021). Furthermore, problem-centred interviews offer a suitable method to gather expert knowledge by investigating personal and professional knowledge through open and follow-up questions (Döringer, 2021). This process also allows interviewees to reflect on the societal aspects and the social field of action related to the problem (Döringer, 2021). After the interviews, impressions during the conversation, emphasised topics, and additional instances not recorded on audio were noted in postscripts. The postscripts were included in the analysis and served as initial interpretations of the interviews, which were recorded as short memos.

Institutional field	Interview partners	Date	Duration	Setting
Health and social care	1	2019-09	36 Min.	In-person
Aged care services	1	2019-10	38 Min.	In-person
Health and social care for migrant women	3	2019-10	81 Min.	In-person
Project on intercultural care	1	2019-10	42 Min.	In-person
Welfare organisation	1	2019-11	51 Min.	In-person
City of Munich	1	2019-11	57 Min.	In-person
City of Munich	1	2019-11	25 Min.	In-person
City of Munich	2	2019-12	44 Min.	In-person
Volunteer project for aged care	1	2021-02	28 Min.	Online
District of Munich	1	2021-04	50 Min.	Online
Migrant community centre	1	2021-05	59 Min.	In-person
Welfare organisation	1	2021-06	35 Min.	Online
Aged care services	1	2021-07	48 Min.	In-person
Aged care services	1	2021-09	47 Min.	In-person
Welfare organisation	1	2021-08	45 Min	In-person

Table 2: Institutions and organisations contacted for interviews

Ethical aspects

All participants were informed about the project and the handling and storage of the collected data. Written informed consent was obtained from each participant. The Ethics Committee of the Technical University of Munich waived the requirement of ethics approval for this study.

Data analysis: Combining SKAD and Grounded Theory

Keller understands SKAD as a research program which can be combined with interpretative research methods and discourse analysis tools. Grounded Theory offers practical methodological steps for data collection and analysis by applying theoretical sampling, maximal and minimal contrasting and coding techniques (Keller, 2012). Theoretical sampling informed data collection by investigating the borders and structure of the discourse and merging data selection with the analysis process and theory development. The maximal and minimal contrasting strategy influences the data collection to capture a holistic assessment of the discourse and provides starting points for the iterative analysis to compare and contrast (Keller, 2011). Data collection and analysis based on maximal contrasting means to identify discourse elements that represent the range of the discourse. Thereby, different positions and speakers in the discourse are explored and compared in the analysis. Minimal contrasting aims to look for similarities and repetitions to deepen and sharpen the concepts in the analysis.

In this research, Strauss and Corbin's (1990) approach is applied to coding, constant comparison, asking generative questions and memo writing for the analysis of the data corpus. For the document analysis of this research, it was not possible to conduct a line-by-line analysis of all documents, instead, sections were carefully chosen for fine-grained analysis (Keller, 2011). Open coding of the data presented the first step of the coding process, which was followed by axial coding to relate codes into stronger categories. Finally, selective coding connects categories to develop the final analysis and to tie categories into storylines and phenomenal structures (Strauss & Corbin, 1990). While the coding steps are mainly influenced by Strauss and Corbin's work, it is necessary to acknowledge the role of the researcher in co-constructing the data and the researcher's position in interpreting the meaning of data as suggested in the constructivist approach to grounded theory (Charmaz, 2006). The process of coding and contrasting discursive events is complemented by memo writing, which captures interpretations and hypotheses of codes.

The findings and concepts of both analyses were shared in a grounded theory working group to discuss alternative interpretations. The working group regularly coded and analysed extracts of documents and interviews together to discuss individual interpretations, categories, and patterns in the data. Furthermore, colleagues' suggestions helped to deepen the data analysis further[2].

[2] As suggested in the constructivist approach by Charmaz (2006), I believe that the researcher co-constructs research and influences the research process. Thus, I aimed to reflect on my positionality and my role as a researcher throughout this project. As a younger, white, and native German, I approach the topic of ageing and migration as an outsider. Professionals with a migration experience were included in the interviews to incorporate migrant voices in my research. Due to their employment

SKAD suggests discursive analytical concepts to investigate knowledge patterns and discursive structures. The analysis focuses on subject positions, classifications, and phenomenal and narrative structures (Keller, 2018, 33f). These tools were chosen to analyse knowledge and social positions related to older migrants (subject positions), to investigate the concepts of ethnicity and culture (classifications and categories), to explore how older migrants are situated in past and present societal stories of progress (narrative structures) and to link subject positions to the context of care access and solutions and responsibilities related to service provision (phenomenal structures).

Subject positions

Actors in discourse interact as speakers and statement producers and contribute to discourse but can also be addressees of the statement practice (Keller, 2012, p. 62). Subject positions refer to the representation and positioning of social actors, which can have positive or negative connotations. For example, Torres demonstrates how older migrants can be positioned as a social problem group that differs from the rest of the ageing population and has specific needs (Torres, 2006). Thus, the subject positions of older migrants indicate how their actions, needs, challenges, resources, and social responsibilities are understood in the public and institutional discourse.

Classifications and categories

Classification processes expose social typification and their formalisation and institutionalisation (Keller, 2018). Discourse analysis offers a lens to assess how classification systems are formed and reproduced critically and to question naturalised or essentialised explanations of classifications. For example, ethnicity might be linked to biological or innate differences between people, and ethnic classifications may vary depending on the context. Thus, examining classifications in discourse can uncover how these systems are introduced and perpetuated and how they are used, given meaning or related to social orders/hierarchies (Unger et al., 2018). Categorisations refer to identifying, sorting, and naming entities. Classifications describe how specific categories are connected and the systems they form (Unger et al., 2018, p. 171). As demonstrated in the context of ethnicity, categorisation takes place both in the form of self-ascription and categorising the other. Unger and colleagues (2018, p. 172) note that “categories and classifications derive from existing social structures and power hierarchies, and at the same time, they unfold power effects and thus contribute to the sociality they are embedded in”. Therefore, categories such as old/older, migrant, or ethnic are related to existing power constellations in society and carry elements of ageism and ethnic discrimination. The role of categories and classification is explored in the second and fourth papers of this project.

Phenomenal structure

Phenomenons of interest display discursive attributions at certain points in time in the sociocultural and historical moment. Phenomenal structures provide snapshots of how causal relations, responsibilities, subject positions, values, courses of action and othering

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in the German public system, conducting the interviews in German did not present a problem for the participants and did not exclude any potential interviewees.

form dimensions of a topic. Competing discourses can lead to disparate phenomenal structures within a discursive field. These patterns of causation, evaluation and solutions are explored in the second, third and fourth papers (Keller, 2012, 2018).

Narrative structures

Interpretations, subject positions, and aspects of the phenomenal structure are linked and structured into logical orders that create storylines. Narrative structures help to explore how cases, actors, histories or stories of progress or futures are presented. These narrations aim to address the audience and offer an ordering of the world into a communicable form (Keller, 2012). Narrative structures of older migrants are explored in the fourth paper, which looks at the story of what being a migrant in Germany has entailed and how storylines influence healthy ageing and accessibility to services at present.

Results

Paper I – Healthy immigrant later in life?

Goettler, Andrea (2020): What Happens to the Healthy Immigrant Later in Life? – The Health of (Forced) Migrants Through the Life Course. In Katharina Crepaz, Ulrich Becker, Elisabeth Wacker (Eds.): Health in Diversity – Diversity in Health. 1st ed. Wiesbaden: Springer Fachmedien, pp. 103–119. (Peer-reviewed book chapter)

This book chapter reviews research on migration and health and discusses what we know about immigrants' and refugees' health after migration, with a focus on prevention and health promotion in older age in Germany.

Health risks, such as exposure to infectious diseases, environmental hazards, or violence, can affect the health of forced or voluntary migrants before and during migration and have a long-lasting impact on people's health. Although migrants, on average, experience more socioeconomic challenges than the non-migration population, their mortality appears to be lower compared to the population in the receiving country. This effect has been partially explained by selection biases and statistical errors but remains a paradox regarding the experienced health risks and health outcomes. For forced migrants, research on health status after migration is limited, and the results paint a very heterogeneous picture. Infectious diseases and mental health problems appear more common among refugees compared to the non-migrant population. However, studies on mortality remain unclear, with one study pointing towards a mortality benefit for refugees. The health advantage after migration seems to decline with time spent in the receiving country leading to the poorer health status of older migrants and refugees compared to the non-migrant population. Older migrants report lower self-rated health, higher rates of depression, and limitations in terms of functionality and activities of daily living in various European immigration countries. While health data for older refugees is still limited, similar social determinants of health after migration, such as legal uncertainties and socioeconomic challenges, also apply to ageing refugee populations and provide a risk for healthy ageing.

Language differences, costs, cultural preferences, or limited health literacy are barriers to accessing prevention and health promotion services, which need to be addressed in health and social care services. In addition, the accessibility of prevention and health promotion for migrants is still seen as a side issue and not a central concern. This could be improved by focusing on cultural competency, strengthening existing support structures, following a settings-based approach, and creating connections between social networks and service providers. Even though migrants seem to experience a health advantage after migration, detrimental social determinants of health after migration lead to increased health risks in later life compared to the non-migrant population. Thus, the health issues older migrants currently experience in Germany should raise awareness for healthy ageing opportunities for future (forced) migrant populations.

What Happens to the Healthy Immigrant Later in Life? – The Health of (Forced) Migrants Through the Life Course

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Keywords: Immigrant Health, Life Course, Forced Migration, Labour Immigrants

Abstract

Studies on immigrant health continuously provide evidence for the "healthy migrant effect" and discuss the associated "healthy migrant paradox". This contribution reviews the relationship of health and migration and considers the role of social determinants of health associated with labour and forced migration over the life course. Studies among older labour immigrants in Germany show the long-term effects of health risks in the receiving country. While older immigrants' health is increasingly addressed through prevention, health promotion and care services, improvements for the recognition of long-term socioeconomic barriers to health are still needed. To conclude, the relationship of health and migration is linked to future health risks of current forced immigrants in Europe.

Contents

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1 Introduction

The relationship between health and migration has often been viewed from two different perspectives. On one hand, evidence for healthy immigrants especially shortly after arrival is presented; on the other hand, diseases and health problems are highlighted, particularly with reference to forced migrants (Beiser 2005). However, the health of migrants is influenced by socioeconomic and environmental factors before, during, and after migration, and by the specific reasons for migration and associated risk factors. The positive view on immigrant health refers to the "healthy immigrant effect", the phenomenon that immigrants seem to experience lower mortality compared to the native population. This effect has been shown in several international studies (Lariscy et al. 2015). These results are surprising because socioeconomic status tends to be lower in immigrant populations, which is associated with more health risks (Kristiansen et al. 2016; Ronellenfitsch et al. 2006). Hence, the "healthy immigrant effect" has also been termed the "healthy immigrant paradox". However, this positive picture of healthy migrants is not supported in the literature on forced migrants and refugees. Here, infectious diseases and psychological conditions are emphasised at the time of arrival in the host country (Pavli and Maltezou 2017). Overall, the focus often remains on the time shortly after arrival in the immigration country.

This chapter will bring the issue of immigrant health into a life course perspective with an emphasis on health in older age. Immigrant health will be discussed for both voluntary and forced migrant populations. Looking at older labour immigrants in Germany provides an example of how social determinants of health impact healthy life expectancy when growing old in the receiving country.

2 Healthy Immigrants?

The "healthy immigrant effect" or the "healthy immigrant paradox" refers to the results of international studies that show that immigrant populations seem to be in better health than the autochthonous population. Several studies from North America (Lariscy et al. 2015; Markides and Eschbach 2011; Singh and Hiatt 2006) and Europe (Brzoska et al. 2015; Anson 2004; Ronellenfitsch et al. 2006; Uitenbroek and Verhoeff 2002) have shown lower all-cause mortality risks among immigrant populations. This can be seen as a paradox as immigrants often face higher risk factors, which include poverty, lower education, and precarious working conditions (Lu and Zhang 2016; Kristiansen et al. 2016). However, it is important to note that not all migrant populations experience lower mortality rates after migration. To better understand this phenomenon, it is im-

portant to consider migration-related factors and processes that influence mortality statistics.

2.1 Migration of the Fittest

One explanation focuses on selection effects of migration that influence health differences in the host country. It is assumed that good health facilitates migration whereas sickness or disability constrain people's mobility. Migrants might thus be in better health than the average population of their origin country. Migration is, therefore, a self-selection of healthy people who find it easier to move internationally. This effect is usually described as the "migration of the fittest" (Lu and Zhang 2016). Furthermore, migration is in most cases associated with the labour market, which favours young and healthy individuals (Lu and Zhang 2016). In the case of labour immigrants in Europe, health selection also took place in the arrival countries to ensure the immigration of healthy workers (Bolzman et al. 2004). In addition to physical health, migrating requires resilience to cope with stress caused by uncertainties and unexpected challenges. Individuals who are psychologically and physically more resilient might thus find it easier to migrate internationally (Acevedo-Garcia et al. 2012; Lu and Zhang 2016).

Health as a prerequisite for migration becomes even more valuable in the context of forced migration. Therefore, selection effects might also take place in forced migrant populations. Yet, given the dangerous journeys forced migrants experience together with the vulnerabilities associated with seeking refuge, the combination of selection and health risk effects during forced migration are complex (Abubakar et al. 2018; Norredam et al. 2012). Health threats such as physical and psychological stress during migration and insecurities at arrival are common and severe (Norredam et al. 2012). While health is an important factor for the decision and opportunity to migrate, the health selection effect only indicates health benefits at the time of migration but does not consider health risks during and after migration.

2.2 Salmon Bias Hypothesis: Unhealthy Return Migration

Later in life return migration provides a further explanation for migrant mortality benefits. This so-called "salmon bias" gets its name from the migration of the salmon fish that returns to its place of birth before spawning and subsequently dying. According to the salmon bias or the "unhealthy return migration" hypothesis, people are likely to return to their home country when faced with health deterioration later in life. This explanation particularly concentrates on statistical errors, which occur when people return to their home country but remain in official statistics. They consequently become "statistically immortal"

as their death is only registered in the return country (Abraído-Lanza et al. 1999). Their healthier counterparts, on the other hand, might be more likely to stay than individuals faced with health problems. Yet, the evidence is not clear, it seems, as this hypothesis cannot entirely explain lower mortality rates among migrants. In longitudinal studies, for example, it has been shown that the beneficial mortality effect remains even when the return bias is controlled for (Abraído-Lanza et al. 1999). Thus, uncertainty regarding the healthy migrant paradox remains and selection effects do not seem to suffice as an explanation (Lu and Zhang 2016; Razum 2006a).

2.3 Healthy Forced Migrants?

Does the healthy migrant effect that has been discovered in many international studies also refer to the health of forced migrants? Here the evidence is contradictory. While some research shows that refugees are overall in good health, other studies highlight infectious or mental health risks. Interestingly, there seems to be a higher awareness of the refugee's health status, creating two contradictory pictures: that of the healthy immigrant and that of the sick refugee (Beiser 2005; Abubakar et al. 2018).

While there is a higher prevalence of infectious diseases and mental illness, the overall health status of refugees at arrival is very heterogeneous depending on the receiving country and the health risks experienced during migration (Pavli and Maltezou 2017). In a Danish study, all-cause and cause-specific mortality rates from cancer and cardiovascular disease were lower in refugees compared to native Danes (Norredam et al. 2012). Yet, representative data is not always available on forced migrants (Frank et al., 2017). In Germany, analysing the results of initial examinations on arrival provides some indications but no complete picture of health conditions at arrival. These examinations have shown that refugees show a higher prevalence of tuberculosis, Hepatitis B and other infectious diseases (Frank et al. 2017). Higher prevalence regarding mental health conditions has been reported but results vary based on different studies (Frank et al., 2017). Mental health is more vulnerable because of the specific life contexts that have led to leaving the home country and seeking refuge (Pavli and Maltezou 2017; Abubakar et al. 2018).

3 The Social Determinants of Migration

Studies on immigrant health frequently focus on cultural explanation, specifically the relevance of "acculturation" and neglect commonly accepted frameworks to understand health such as the social determinants of health (Viruell-Fuentes et al. 2012; Acevedo-Garcia et al. 2012). However, environmental, sociocultural,

and economic aspects in the sending and the receiving country influence individuals' health over the life course. How these transnational factors affect health depends on the age at migration, socioeconomic status and time of exposure in different living contexts. Acevedo-Garcia and colleagues (2012) suggest a framework which considers determinants of health cross-nationally and across the life course. According to this framework, health is influenced by factors in the sending country before migration, which influence the decision to migrate and health during migration, by factors during migration and by factors in the receiving country after migration. Age at migration plays a significant role within this framework. Migrating during childhood or after the age of 40 have both been shown to be associated with socioeconomic and health risks (Gustafsson et al. 2019; Acevedo-Garcia et al. 2012).

As for the *sending country*, determinants of health include socioeconomic factors, health distribution and epidemics, exposure to infectious diseases and environmental hazards, which in the case of forced migration are highly unfavourable due to conflict, violence, poverty or environmental catastrophes (Acevedo-Garcia et al., 2012). Furthermore, disadvantageous socioeconomic situations before migration can have long-lasting health effects. Exposure to health risks in sending countries can manifest later in the receiving country (Razum 2006b; Razum and Spallek 2012). Later-in-life cancer cases, for example, have been associated with early-in-life infectious diseases (Razum and Spallek 2012). Especially in the case of forced migration, the push factors in the sending countries, such as violence/war, political crisis or lack of public health infrastructure, relate directly to health risks. Nevertheless, health selection effects influence migration intentions and opportunities. Thus, both voluntary and forced migrants may constitute a healthier or more resilient population compared to the average population of the sending country.

Risk factors *during migration* are predominantly relevant for forced migrants who experience high-risk journeys as undocumented migrants. First points of arrival, for example in refugee settlements, pose a considerable risk factor due to highly populated accommodations and associated infectious diseases (Pavli and Maltezou 2017; Abubakar et al. 2018).

Health determinants in the *receiving country* include the same factors as in the sending country: socioeconomic determinants, health distribution, epidemics, exposure to infectious diseases and environmental hazards (Acevedo-Garcia et al. 2012). The immigrant-receiving context is related, primarily, to social status, working and living conditions and the quality of health services. Discrimination or uncertainty and psychological strain in the receiving country act as severe stressors (Acevedo-Garcia et al., 2012; Viruell-Fuentes, Miranda, & Abdulrahim, 2012). Furthermore, economic factors in the receiving countries such as poor housing and working conditions as well as barriers to health care access

and social exclusion can lead to worse health outcomes (Warnes et al. 2004). Access to healthcare services can be especially difficult depending on the socioeconomic situation, health literacy barriers or legal status (Kristiansen et al. 2016).

When looking at the difference between sending and receiving countries and associated health risk behaviours such as smoking and quality of food, it needs to be recognised that immigrant health behaviours are flexible. Health behaviours can change over time, remain similar to the sending country or assimilate with the culture of the receiving destination. Additionally, social factors play an important role. A better socioeconomic situation and environmental benefits in the receiving country might come with a loss of social support due to a separation from family and social networks in the sending country (Spallek et al. 2016).

4 Health of Older (Forced) Immigrants

Immigrants are predominantly a younger population at the time of migration. However, the diversity of older migrants also includes people who migrate later in life. For example, Warnes and Williams (2004) describe "retirement migration" as an increasing phenomenon of people migrating, for example, to Southern Europe from other European countries, or to Florida in the case of the United States after retirement. While migration takes place at all ages, this chapter focuses on what happens over time in the receiving country and on the health aspects of reaching older age in the host country.

4.1 Exhausted Migrants Later in Life

As discussed by numerous studies, it seems as if a health benefit for immigrants exists with regard to lower mortality. However, this is not the case when looking at the older migrant population. While the majority of research indicates lower mortality among immigrants, the healthy immigrant effect seems to decrease with the length of stay in the receiving country (Anson 2004; Kristiansen et al. 2016; Lanari and Bussini 2012; Solé-Auró and Crimmins 2008). This has been described as the "exhausted migrant effect" (Bolzman et al. 2004). After arriving in good health but working under strenuous conditions, migrants have lost their initial health advantage due to physical and psychological stress throughout the life course. These health stressors start with uncertainties after arrival related to residency and working permission. Physically strenuous working conditions in high-risk sectors follow together with short-term or part-time contracts. In addition, psychological burdens such as discrimination can be common. Over time, these health stressors result in worse health outcomes later in

life. Studies on older migrants in Europe continuously report worse self-rated health, chronic conditions, problems with activities of daily living, and depression compared to the non-migrant older population (Solé-Auró and Crimmins 2008; Lanari and Bussini 2012; Carnein et al. 2015).

Some studies show that not just younger migrants after arrival experience lower mortality benefits; also, older migrants experience lower all-cause mortality compared to older native populations (Reus-Pons et al. 2017; Carnein et al. 2015; Lariscy et al. 2015). The mortality difference, however, diminishes with age and time spent in the receiving country. Other researchers have looked beyond all-cause mortality to assess morbidity and quality of life among older migrants. Reus-Pons and colleagues (2017) demonstrate that healthy life expectancy is lower among older migrants in the Netherlands, Belgium and England and Wales compared to the older non-migrant population. The reason for lower healthy life expectancy, despite mortality advantages, is lower self-rated health (Reus-Pons et al. 2017). Lower self-rated health has been shown in several studies comparing older migrants to non-migrant populations (Lanari and Bussini 2012; Evandrou et al. 2016; Hoffmann and Romeu Gordo 2016). Additionally, higher rates of depression are reported by older migrants (Lanari and Bussini 2012; Aichberger et al. 2010). Other studies point to limitations in terms of functionality, activities of daily living and disability status among older migrants in Europe (Evandrou et al. 2016; Carnein et al. 2015).

It seems that the potential health benefit or selection effect declines over the life course leading to worse health outcomes over the age of 65 years. This poses the question whether the health disadvantages are related to migration-associated health risks or specific socioeconomic risks of the current older generation in Europe. Many of the older immigrants in European countries arrived as labour migrants and experienced socioeconomic disadvantages in the receiving countries.

4.2 The Health of Older Forced Migrants

Similarly to the term "older migrants", the group of older forced migrants and refugees includes people who are forced to migrate to another country at an older age and those who grew old in exile (Bolzman 2014). The population of migrants being forced to move later in life is statistically small but does make up a small percentage of the forced migrant or refugee population. In Germany, persons older than 60 years filed 1.2 per cent of all first asylum applications in 2017 (BAMF 2018). In 2011, it was estimated that 3 per cent of all refugees were 60 years and older (Bolzman 2014).

Alternatively, "older refugees" also refers to people that grow old in exile. Although forced migrants share social and economic difficulties with other

migrant populations, the challenges are intensified due to insecurities related to the migrant status (Becker and Ferrara 2019). Lower socioeconomic status, as well as traumatic migration experiences, among forced migrants can have a negative impact on health over the life course (Bolzman 2014). For example, Bolzman and colleagues (2012) show that forced migrants from former Yugoslavia who lived in precarious legal statuses experienced poorer health indicators than immigrants from Italy or Spain. Even at younger ages, this group of forced immigrants had more physical and mental health problems than the older migrant population from Italy and Spain (Bolzman et al. 2012). Looking at life expectancies, Kohls (2012, p. 218) remarks that undefined precarious or limited rights of residence can lead to higher mortality due to stress and associated unemployment. Overall, the data on forced migration and health is still limited or very recent but it is likely that the health challenges of older migrants also apply to older forced migrants.

5 Older Immigrants in Germany and Health

Migrant populations are loosely defined by a migration event in the life course; this inevitably leads to a very heterogeneous group of people. The same is true for older migrants in Germany who come from a range of countries and have migrated to Germany at different times in their lives and due to different reasons (Baykara-Krumme et al. 2012). However, in this mixed group of people, it is possible to identify shared migration histories. One shared characteristic is that the great majority, 97.5 per cent, of immigrants above 64 years are first-generation immigrants who moved to Germany in their lifetime (Schimany and Baykara-Krumme 2012). About 40% have a foreign nationality; the remaining majority are German citizens. The number of older migrants has been increasing significantly in the last decade and is likely to rise in the future as the percentage of immigrants is higher in younger age groups (Schimany and Baykara-Krumme 2012). One group that can be identified in terms of shared migration histories is that of former guest labour migrants in Germany. Recruitment agreements were in place from 1955-1973 with Italy, Spain, Greece, Turkey, Morocco, Portugal, Tunisia, Yugoslavia and South Korea. Among the people who migrated to Germany themselves, immigrants from countries with recruitment agreements make up a third of all immigrants older than 65 years (Hoffmann and Romeu Gordo 2016). The majority of them moved to Germany before 1973. After 1973, when the labour agreements were suspended, spouses and other family members migrated to Germany to reunite their families. Another group of shared migration histories characterises the group of repatriates. The terms ‘late repatriates’ or ‘late re-settlers’ refers to ethnic Germans who resettled to Germany after the fall of the Soviet Union. This group makes up 38 per cent of older people above 65

years with migration experience. Other migrants predominantly come from other EU countries as well as other global regions (Hoffmann and Romeu Gordo 2016).

5.1 Health Determinants of Older Labour Immigrants

The group of older labour immigrants is particularly interesting as people have stayed in the receiving country for several decades and are now reaching older age. The specific socioeconomic situations of labour migration demonstrate the relationship between health and migration over the life course. While some decided to return home, others have found a compromise of moving between countries and some are staying in Germany for their time in retirement (Strumpen 2018). The focus of the labour agreements was on manual labour employment for a restricted period; yet, a large percentage of labour migrants ended up staying in Germany. Integration policies were limited as labour migration was thought to be a short-term occurrence which, however, had long-lasting effects. For instance, due to the lack of focus on language classes, communication barriers remain until today (Ciobanu et al. 2016). Manual and physically intensive work and lower-skilled employment led to lower income and a higher risk of poverty. Moreover, higher unemployment rates, part-time working contracts, and early pension due to sickness pose additional economic risks (Brzoska et al. 2010; Schimany et al. 2012; Bolzman et al. 2004; Ciobanu et al. 2016). For example, work accidents are more frequent among immigrants and especially Turkish immigrants compared to native German workers due to employment in higher-risk occupations in the industrial sector (Brzoska et al. 2010). Brzoska and colleagues (2010) also found a higher risk of early retirement for health reasons among immigrants in the period from 2001 to 2006.

Former labour migrants, their reasons to migrate and the related consequences differ considerably from current forced migration processes (Becker and Ferrara 2019). Yet, there are some similarities, which should raise awareness of future health risks among current forced migrants. Labour migrants were not expected to stay permanently in Germany and integration services were thus limited (Schimany and Baykara-Krumme 2012). Likewise, forced migrants are often stuck in a short-term perspective, which has a negative effect on psychological health. Uncertain residence status and insecurities regarding work permits, housing and residency will have a negative impact on health, not just with a view to the period after arrival but also as regards the long-term health perspective (Kohls 2012).

5.2 Health Situation of Older Labour Immigrants in Germany

These socioeconomic disadvantages have a significant effect on health later in life. Data on older migrants is still limited although this field has been gaining rapid attention in the last decade.

Despite common health risks, Kohls (2012) shows that mortality is lower among labour migrants and late repatriates until the age of 60 years, after which mortality rates increase. Furthermore, immigrants who stayed longer in Germany demonstrated fewer health benefits associated with migration than immigrants with a shorter time after arrival (Kohls 2012, p. 217). As described above, Carnein and colleagues (2015) argue that lower mortality needs to be understood together with morbidity by considering healthy life expectancy. Turkish women and men experienced more years with health limitations despite similar or longer life expectancy than Germans. Health disadvantages were measured using the Global Activity Limitations Indicator, which measures the effect of health conditions or disabilities influencing people's everyday lives (Carnein et al. 2015). Klaus and Baykara-Krumme (2017) present that labour migrants indicate the highest risk for functional limitations among migrant populations or people without a migration background. Studies on psychological health found a higher risk of depressive symptoms, which are only partially explained by differences in socioeconomic status (Klaus and Baykara-Krumme 2017; Lanari and Bussini 2012). Besides, older migrants report more worries regarding their own health and rate their health subjectively lower. Worries regarding own health were stronger among older labour immigrants than late repatriates or older people without a migration background (Hoffmann and Romeu Gordo 2016). Lower subjective health compared to the non-migrant population was shown in a number of studies (Özcan and Seifert 2006; Baykara-Krumme and Hoff 2006; Razum et al. 2008). Subjective health generally corresponds with other "objective" health measures across different populations and cultures (Razum et al. 2008). Lower subjective health thus reflects other health problems relating to functional limitations and mental conditions. Furthermore, detrimental living and working conditions such as work in the industrial sector, lower payment, times of unemployment and part-time working contracts can have a negative effect on functional as well as subjective health. Some studies have shown that worse health outcomes persist even when controlling for socioeconomic status. This is, for example, the case when considering health care access and medical rehabilitation, where negative outcomes of medical rehabilitation remained even when considering lower socioeconomic status (Brzoska et al. 2010). Yet, in other studies, for example, on subjective health, health differences between migrant and non-migrant population were associated with socioeconomic differ-

ences (Baykara-Krumme and Hoff 2006). It seems that disadvantages at least partially remain even under consideration of socioeconomic status.

6 Addressing Immigrant Health in Older Age

The health risks of older (forced) migrants and the diversity of the ageing population has led to an increased awareness of immigrants or ethnic minorities in older age. In the last two decades, internationally and in Germany, studies on older migrants, their health and socioeconomic situations have gained attention in research and politics. Thus, quality and accessibility of care and prevention and health promotion are now being increasingly discussed in regard to older migrant populations.

6.1 Prevention and Health Promotion

As health risks and lack of access seem prevalent among older immigrants, the demand for prevention and health promotion has been emphasised for this population group. Researchers ask what barriers exist and how prevention and health promotion attend to the needs of older immigrants. To overcome these barriers, language differences, costs, cultural preferences or lack of knowledge on such services need to be addressed. Furthermore, it is important to recognise both sociocultural factors as well as economic, environmental influences without highlighting cultural or ethnic differences.

Another limitation regarding health promotion of older immigrants was shown in a project on primary prevention and health promotion for older immigrants in Germany (Olbermann et al. 2011). Experts in this field report that older migrants are not a core area in communal work, but are generally seen as a side issue. Therefore, only limited capacities are available. To address these limitations, research in this field has highlighted several points of improvement: providing culturally sensitive services, strengthening existing resources, creating connections between social groups/networks and contact persons and following a settings-based approach. The aim is to situate services in the community to facilitate easy access through decreasing distances and building on existing contacts (Olbermann et al. 2011).

6.2 Care and Health Services

Despite prevention and health promotion initiatives, the ageing of society will result in an increased demand for care. Especially as the literature indicates various health risks in old age, it is important to assess how sickness and disability among older immigrants are currently addressed.

The role of cultural backgrounds and ethnicity on healthcare has been the main focus to understand barriers to health or long-term care access (Arora et al. 2018). For example, social connections, including family members, play an important role in healthcare access and act as facilitators for gaining knowledge about healthcare services. In the literature on long-term care, there is a strong focus on the importance of family for care in immigrant populations. Often references to traditional family structures are emphasised and presented as the main reason why care predominantly takes place in the family (Strumpen 2018; Arora et al. 2018). Care is thus often associated with family resources or other forms of informal support. On the one hand, the family is the preferred option to provide care in a culturally sensitive and private manner. On the other hand, it is acknowledged that the care provided by family members puts stress on the carer and leads to a certain dependence on the family. Furthermore, older migrants rely predominantly on their social capital such as family, friends and social networks to access health services, which are not always available.

While the support from family and informal support systems is crucial to older immigrant populations, it is also essential to recognise economic factors that influence the sociocultural circumstances. Language skills, literacy, education and social responsibilities are greatly influenced by socioeconomic status and need to be taken into account. Especially, as older immigrants endure more socioeconomic risks such as higher poverty rates, it is important to remain critical when the focus is put predominantly on informal solutions to care.

7 Discussion and Conclusion

Despite initial health advantages through selection effects, health in older age is marked by health disadvantages in migrant populations. While younger or newly arrived immigrants display lower mortality rates than native populations, older immigrants experience more health risks in regard to activities of everyday life, mental and subjective health. This is due to long-term socioeconomic stress factors for health that are often experienced in the receiving country. The example of labour immigrants in Germany demonstrates how socioeconomic factors, such as precarious and physically strenuous working conditions, can influence health later in life. It is thus important to look beyond mortality rates at specific points in time and, instead, to consider quality of life and healthy life expectancy over the life course. This perspective should keep in mind the determinants of health before, during and after migration and recognise long-term health stressors in the receiving country.

The presented socioeconomic risks for older labour migrants in Germany should raise awareness of the future health of current (forced) migrants. Short-term perspectives on health and integration have been linked to increased health

risks in both labour immigrant populations and forced migration. It is therefore important to acknowledge a long-term perspective that does not neglect the future of (forced) migrants independently of the country of residence. Research and data on the health of forced immigrants in Europe is currently still sparse but will become an important topic in the future. Health determinants need to be identified in order to be able to consider health processes without simply categorising into “healthy”, “sick” or “exhausted” migrants.

Lastly, examination of older immigrant health will continue to gain relevance with a view to the increasing percentage of immigrants in the older populations in Germany. Long-term care in older age is one of the main challenges of an ageing society. This includes the provision of access to care for migrant populations, especially as older migrants are an increasing group in many European countries. A critical perspective is needed that recognises sociocultural factors but looks beyond cultural differences to improve prevention, health promotion and long-term care in the future.

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Paper II – Ethnic belonging, traditional cultures, and intercultural access

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Ethnicity and culture play a central role in the discourse on ageing for older migrants. Academic, media, and policy discourses have been shown to homogenise older migrants as an easily identifiable social group, as a social problem group and to perpetuate stereotypes about "traditional" migrant cultures. Different definitions and theoretical perspectives of ethnicity and culture exist that either define ethnicity as fixed traits based on language, culture, and biological heritage (essentialist perspective), as an attribute that displays positive to negative connotations depending on the context (structuralist perspectives), or as a self-ascription and ascription by others that highlight the imagined boundaries between groups of people (social constructivist perspective). This article examines ethnicity and culture from a social constructivist perspective to investigate the construction of cultural values and ethnic belonging of older immigrants in Germany and othering mechanisms in organisational, institutional, and political communications in Germany over a timeframe of two decades.

This study examines 43 publications from health care or aged care organisations, government reports, city or municipal documents and articles from health and care-related magazines published from 2000 until 2019. The discourse analysis is guided by the Sociology of Knowledge Approach to Discourse and focuses on cultural and ethnic classifications and categorisation of older migrants and how ageing and older age are constructed in this context. The results show that ageing for migrants is understood to take place earlier due to health and sociocultural differences compared to the non-migrant population. While the diversity of older migrants is recognised in the analysed publications, there is a tendency in earlier texts to homogenise migrant culture as Southern, traditional, and family-oriented in comparison to the individual and more modern society of Germany. Older migrants are predominantly described in the context of communities and neighbourhoods in their specific sociospatial contexts and the context of family and intergenerational support. Furthermore, negative stereotypes of old age, such as a natural disengagement from society, become linked with associations of ethnicity and culture and thereby emphasise the vulnerability and exclusion of older migrants. More recent documents show a shift to an increased recognition of intercultural and diversity approaches that emphasises socioeconomic aspects instead of cultural difference.

The ageing discourse in Germany essentialises migrant culture as traditional and produces an image of distinct ethnic communities. However, to create culturally sensitive institutions and policies, it is essential to recognise the dynamic nature of culture and the social construction of ethnicity. The concept of super-diversity offers a useful framework for considering the diversity of historical, legal, political, and socioeconomic aspects of migration and their relevance in old age and specifically for creating culturally sensitive institutions and policies.

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Ethnic belonging, traditional cultures and intercultural access: the discursive construction of older immigrants' ethnicity and culture

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ABSTRACT

Older people with a migration background are a continuously increasing population group in Germany. This increase has led to a heightened awareness of the socioeconomic situation, access to health care and social services available for older immigrants in politics, research and health care institutions. Previous research indicates that generalisations about older immigrants, e.g. as a social problem group, are common in academic research and policy publications. Furthermore, the focus on ethnicity seems to homogenise older immigrants under their ethnic difference, instead of acknowledging cultural and ethnic diversity. This discourse analysis investigates 43 publications from health care or older age-related organisations, government reports, city council or municipal documents and articles from health and care-related magazines published in Germany between 2000 and 2019. The methodology is guided by a sociology of knowledge approach to discourse to examine knowledge constructions of ageing/older age, older immigrants and cultural/ethnic classifications. I demonstrate how ethnicity and culture of older immigrants are stereotyped and portrayed as traditional and family-oriented and support is presented as situated in informal private networks. At the same time, a general consensus is that intercultural approaches should be encouraged as important strategies to improve access to health care and social services.

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Background

Diversity in older age is gaining attention in research and policy with a predominant focus on migration background and ethnicity in later life. This focus stems from the increasing number of older migrants, generally defined as 65 years and older, among ageing populations in European countries (Warnes et al. 2004). Certainly, older populations with a migration background are just as diverse as non-migrant agers: the term 'older migrants' encompasses people having migrated at an early age and growing old in the destination country, those who recently moved to their destination country, those who migrated after retirement, and second- or third-generation migrants (Warnes et al. 2004). In particular, older migrants growing old in the destination

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country have become a focal point of political, social work and health care institutions in the last two decades (Warnes et al. 2004; Ciobanu 2019). In Germany, researchers and the government shifted their attention to older immigrants[1] in the late 1990s (Naegele, Olbermann, and Dietzel-Papakyriakou 1997). Despite the range of migration trajectories, the interest has been on immigrants with shared migration histories, especially former labour migrants[2] and ethnic German resettlers.[3] In 2013, around 22% of persons with a migration background above the age of 65 were from EU15 member states (excluding countries with labour agreements), around 18% from Middle and Eastern European states or the former Soviet Union (who returned to Germany as resettlers), around 17% from former labour agreement states (primarily Turkey, Italy, Greece and Croatia), and 8% from countries of the EU Eastern enlargement since 2004 (Hoffmann and Romeu Gordo 2016, 66). Research is limited for those older immigrants, who migrated from other Western or European states (e.g. Canada, USA, Sweden, Switzerland), from Africa, Asia, Latin America, or the Near and Middle East or where data is lacking regarding the country of origin (Klaus and Baykara-Krumme 2017).

While ethnicity has received increased attention in policy and research, this attention seems to have homogenised older immigrants because of a dominant focus on ethnic difference to the autochthonous population. Social gerontologists have pointed out that the emphasis on culture and ethnic belonging has constructed older immigrants as 'the other', highlighting vulnerabilities, and identifying the culture of immigrants largely according to familial and traditional values (Torres 2006; Hahn 2011). Furthermore, based on Swedish policy and research documents, Torres demonstrates how older migrants' ethnicity is presented primarily from an essentialist perspective as a fixed and static attribute (Torres 2006, 2015). These results suggest that older immigrants are 'problematised' through cultural assumptions and generalisations and that these discourses likely affect the health care, and social services developed for ageing immigrants.

Given the critique of stereotypical representations of older immigrants, this study investigates discursive constructions of ethnicity and culture in organisational, institutional, and political communications in Germany. Accordingly, this study asks: how and when are cultural differences and ethnic belonging made relevant and what is the content of these categorisations in discourses on older immigrants? How are cultural/ethnic classifications presented in descriptions of services or initiatives for older immigrants? The methodology follows a sociology of knowledge approach to discourse (SKAD) to examine knowledge constructions of ageing/older age, older immigrants and cultural/ethnic classifications. This discourse analysis spanning over the last two decades enables an exploration of images of older immigrants as being traditional, family-oriented and self-supporting, as well as an exploration of a discursive shift towards intercultural approaches in the services and institutions for older people. The results of this study centre on immigrants above 65 years, especially former labour migrants and ethnic German resettlers, who migrated before retirement and are now growing old in Germany (Hoffmann and Romeu Gordo 2016). How the terms culture and ethnicity are used and understood in the discourse demonstrates how differences are created and reified in the older population based on migration background. The resulting Othering language leads to a homogenisation of older immigrants and an essentialisation of culture and ethnicity, which should be confronted in research and practice, especially given current developments, to implement culturally-sensitive elderly care services in Germany (Aşkın 2018).

Defining culture and ethnicity

Examining how and when culture and ethnicity appear as defining and classifying characteristics can signify how differences in and between groups are understood and reproduced in public discourse. While the use of ethnicity and culture often overlaps in everyday language as well as in the discourses on older migrants, defining the difference between those concepts is necessary as it allows for a closer look at attributes (culture) versus group construction (ethnicity) (Eriksen 2002). The social constructivist framework provides a valuable perspective to investigate the discursive construction of knowledge systems that connect cultural and ethnic categories with health or policy discourses, as classifications and the organisation of knowledge arise out of historical, sociocultural, ideological contexts and work practices of speakers and actors (Scott, Odukoya, and Unger 2014).

While many different definitions of culture exist, social constructivist perspectives converge on culture as shared, learned, symbolic and subject to change (Nanda and Warms 2019, 55). Therefore, culture is a dynamic construct, constantly subjected to changes and existing across national and social boundaries. It reveals what is emphasised about specific ethnic groups and what becomes part of the construction of ethnic difference. While culture is an essential concept to understand the lived realities of older immigrants in Germany, this study concentrates on the construction of ethnicity at the intersection of migration and age, as studying ethnicity provides a lens for analysing categorisations of people and the social processes creating these categorisations.

Defining the concept of ethnicity is important to avoid using ethnic identity in the same manner as culture, race or migration background. Different research paradigms have informed various definitions of ethnicity with the essentialist, structuralist, and social constructivist perspectives having particularly influenced academic discussions of ethnicity (Torres 2015). First, the essentialist or primordial perspective assumes pre-existing, biological (i.e. body shape, skin colour, eye colour) and fixed traits such as language, culture and biological heritage (Beer 1988). Ethnicity is thus understood as a fundamental characteristic, describing what we are (Torres 2015). This primordial understanding of ethnicity as an essentialist trait neglects change and social transformation processes (Eriksen 2002). The risk of this perspective is that traits or characteristics are seen as static and natural, which can lead to the normalisation of assumptions and stereotypes.

Second, the structuralist perspective describes the relevance of ethnicity based on societal structures. It has also been called the circumstantialist perspective, as ethnicity can have a positive or negative connotation, depending on the context. Accordingly, ethnicity is seen as an attribute, something people have, which can be emphasised or not (Torres 2015). This perspective is a dynamic understanding of ethnicity that includes a socio-historical context on the structures affecting society (Cornell and Hartmann 2006). Thus, the structuralist view provides a more fluid concept, but can only explain the importance of ethnicity based on the determining structures (Torres 2015).

Third, to understand the categorisation process behind ethnic identity, the social constructivist approach is most fruitful for discussing my research question as it enables exploring the construction of ethnic groups at their boundaries to other groups. This allows for an examination of when and for whom ethnicity or cultural difference

becomes relevant. Ethnicity focuses on the relationship, communications and imagined boundaries between people (Barth 1969; Eriksen 2002). According to Eriksen, 'ethnicity is a relationship between two or several groups, not a property of a group; it exists between and not within groups. (Culture, of course, may perfectly exist within groups.)' (Eriksen 2002, 58). Using this definition of ethnicity provides the opportunity to investigate power relations between ethnic groups. According to Barth (1969), ethnicity is a concept shaped by its boundaries with other identities and depends on the definition of both its own members and those of other ethnicities. This definition suggests that ethnicity is not only formed by past communities but also by migration itself and the current socio-cultural context. People with certain ethnic identities self-categorise and categorise others in relation to themselves, through 'self-ascription and ascription by others' (Barth 1969, 13). Therefore, the social constructivist perspective is particularly relevant in the context of older migrants as ethnicity and ageing is negotiated in a social context (Torres 2015). This approach can therefore demonstrate how and when ethnicity is constructed, what is accepted by others and what is accepted within each ethnic group.

Ethnicity and ageing in academic and policy discourses

Ethnic categorisation manifests both differences and similarities between people and creates discrete social groups whose members appear internally homogenous (Brubaker 2004). According to Brubaker (2004, 51), there is a tendency to reify ethnic groups with specific attributes and to describe ethnicity-associated encounters as the conflicts of ethnic groups in everyday conversations, media, politics and academic writing. Even in academic research, assumptions of older age and ethnic background come together creating the 'other group' of older migrants. The negative view of old age, which emphasises deficits and biological decline, often results in an attention to vulnerabilities (Palmberger 2017). In the literature on older migrants, essentialist understandings of older age concentrating on biological and functional aspects of ageing are still common, which generally have been declared outdated in Social Gerontology (Powell 2001). For example, the concept of 'ethnic withdrawal in older age' is commonly mentioned in research on older migrants (Naegele, Olbermann, and Dietzel-Papakyriakou 1997; Baykara-Krumme et al. 2012), which neglects the critique on functionalist ageing theories such as disengagement theory and dynamic and fluid aspects of ethnicity. Strumpen (2018) in her research on Turkish migrants in Germany remarks that previous research findings now can and should be read from a critical perspective. She summarises that 'the aim should be to arrive at detailed analyses, to overcome the period of reproducing the same catchphrases (e.g. marginalised, family-oriented, preference of same-gender care, ethnic withdrawal, and food preferences and rules) from the last 20 years' (Strumpen 2018, 83). Phrases, such as 'ethnic withdrawal in old age', appear only in the context of migration background; the relevance of withdrawing to or being defined by one's culture and ethnicity is seldom discussed in regard to the ageing majority society (Lindblom and Torres 2021). This phrase also demonstrates the coming together of common stereotypes at the intersection of ageing (perceived as a withdrawal or disengagement) and ethnicity (perceived as increasing with passivity and related to the family sphere).

Ethnicity, ethnic boundaries and the differences between migrants and non-migrants develop on various discourse levels: from academic discourses to everyday interactions. With reference to Swedish policy and applied research reports, Torres notes that older migrants in Sweden have often been portrayed as one 'easily identifiable' social group with little recognition of in-group diversity (Torres 2006). Homogenisation and highlighting of difference have subsequently led to this group being characterised as 'the other'. Through research and policy concentrating on socioeconomic disadvantages, needs and vulnerabilities as permanent attributes, older immigrants became constructed as a social problem (Torres 2006). Furthermore, Palmberger remarks that despite the vulnerabilities experienced by older migrants, 'concentrating only on vulnerabilities prevents us from drawing a more differentiated picture that does justice to the diverse migrant groups with their different migration histories, present experiences and outlooks' (Palmberger 2017, 236). In addition, Hahn (2011) remarks in her research in the social work sector in Germany that older immigrants are perceived as the ethnic 'other' compared to the older 'native' population, which includes a focus on different religious values, family norms and preferences regarding health and care in older age. As previous research shows (Torres 2006; Hahn 2011; Palmberger 2017; Strumpen 2018), emphasising difference in terms of culture, ethnicity and socioeconomic factors invokes the 'otherness' of migrants, which is further enhanced in older age. Therefore, Phelan (2018, 561) reminds us that 'in everyday discourse, there are power relations that exist and which appear neutral, tacit and unproblematic but promote inequalities'. Thus, there is a connection of power and knowledge in ethnicity categorisation and ageing communications, which displays how prevailing social inequalities are transmitted and (re)produced in discourses on older immigrants.

Diversity in ageing

Given the critique about generalisations and essentialisation of migrant populations, calls have emerged to acknowledge the diversity of (older) migrants and to move away from an overemphasis of ethnic difference (Vertovec 2007; Ciobanu 2019). Palmberger (2017), in her research on older Turkish immigrants in Austria, stresses that the diversity of older people and migrants is largely not acknowledged (Palmberger 2017). Likewise, Enßle and Helbrecht (2020) aim to address this absence of diverse images of old age in their research on older immigrants in Berlin. This call to advance gerontological theory builds on Vertovec's concept of super-diversity (Ciobanu 2019; Enßle and Helbrecht 2020). Vertovec (2007) argues at the example of London that diversity in a migration context goes beyond ethnicity and country of origin and includes an increasing multiplication and interplay of relevant variables such as language, religion, cultural values, regional identity, migration channel, legal status, education and employment. Acknowledging diversity as a multidimensional concept provides a better understanding of new patterns of migration and the political, legal and social processes influencing immigrants (Vertovec 2007). The aim should thus be to look beyond ethnic diversity and instead acknowledge the variety of migration experiences, socio-economic characteristics and life course differences (Vertovec 2007).

Methodology

Sociology of knowledge approach to discourse

In line with the SKAD framework, this study defines discourses as 'performative statement practices and symbolic orderings, which constitute reality orders and also produce power effects in a conflict-ridden network of social actors, institutional dispositifs, and knowledge stocks' (Keller 2012, 59). Hence, discourse is created through continuous statements and interactions that produce a relatively stable knowledge system (Keller 2011). Social actors constitute shared knowledge through interactions, which shape the social realities of the actors involved. By circulation and transmission of categories or classifications, these knowledge systems become institutionalised into 'objective realities' (Berger and Luckmann 1966). The SKAD research programme combines sociology of knowledge theory, symbolic interactionism and the foundations of Foucault's approaches to discourse (Keller 2011). Sociology of knowledge is conceptually grounded in Berger and Luckmann's notions on the 'social construction of reality', the construction and (re)production of knowledge through social acts (Berger and Luckmann 1966). Thus, SKAD offers an approach to investigate knowledge creation and institutionalisation through social relations. Furthermore, Foucault's observations on discourse add the dimension and relevance of power and pre-existing societal structures for the meaning of legitimisation processes, speaker positions, and agency (Keller 2011). Foucault's work on discourses emphasises the connection of power and knowledge and the power relations of social actors formed in discourses (Foucault 1972). This institutionalisation of social relations, categories/classification and resources, which are marked by power and agency exist in society's hierarchical structures. Hence, the focus lies on (collective) voices of different agency as well as silent positions within discourse arenas.

The construction of older immigrants is particularly interesting in the political and institutional context on the macro/meso level. Here, the creation of vulnerabilities and ethnic difference influences the discourses on services available for this population group. Therefore, this study investigates discursive constructions of culture and ethnicity and their effect on intercultural approaches within services for the older population. SKAD provides a valuable methodological approach to examine the knowledge production and process of categorisations concerning older immigrants and the meaning and consequences attached to this ascribed knowledge.

Data corpus and analysis

This research is part of a larger study on older immigrants in Germany in the health, care and welfare discourses (Göttler 2020) with this paper focusing on the use and social construction of ethnicity and culture. In Germany, academic research on ageing and migration is increasing, yet, non-academic publications on ageing and migration are still limited. As research on older immigrants gained attention in the 1990s, older foreigners and older people with a migration background became a new concern in political reports. One of the first government reports to pick up the topic was the Sixth German Family Report in 2000 and later the Fifth German Report on Older People in 2005. With the rising awareness outside of the migration discourse, older immigrants

became a more frequent theme in health and care-related organisations and municipal publications in the early 2000s. Thus, the document search covers publications from 2000 to 2019. For the data collection, the aim was to identify documents in the political and institutional arenas which are accessible to the public and professionals working in the fields of migration and ageing in Germany. Online searches were carried out using various search terms that address older/ageing (im)migrants, foreigners or people with a migration background together with keywords such as care, health, intercultural opening, elderly support (*Altenhilfe*), or health insurance. To concentrate on the political and institutional arena in Germany, exclusion criteria comprised newspaper articles, academic research articles and publications without a clear focus on older immigrants in Germany. The search strategy included political publications (such as reports and official recommendations), publications of organisations and institutions offering services to older immigrants, documents by city councils or municipalities, articles by health-related institutions or magazines and publications by political foundations (see Table 1).

For the data analysis, interpretative methods from grounded theory were applied (Strauss and Corbin 1990) to generate concepts, specifically coding the text and writing memos, both by hand and using the computer-assisted qualitative data analysis software MAXQDA, depending on the stage of analysis. As the documents are written in German, the analysis, memo writing and initial notes were done in German and later translated to English. Using the minimum and maximum contrasting method, the aim was to identify subject positions, processes of sense-making, phenomenal structures and communication processes by different speaker positions (Keller 2011). The concept of phenomenal structures provides an access point to analysing meaning constructions of issues presented and the associated causes, solutions, responsibilities, other-positions, etc. (Keller 2012, 68–69).

Table 1. Sources of documents included in this study.

Federal ministries, government publications	12
Migration/integration reports (5)	
Ageing reports (3)	
Family report (1)	
Guidelines and online information (3)	
Political foundations, charity organisations	11
Heinrich Böll Foundation, affiliated with the Green Party of Germany (6)	
Friedrich Ebert Foundation, affiliated with the Social Democratic Party of Germany (2)	
Arbeiterwohlfahrt (workers' welfare federal association) (2)	
Stiftung Mitarbeit (foundation for participation) (1)	
Federal states, district governments and municipal focused-publications	11
State or district governments (4)	
Local institutions (4)	
City administrations (3)	
Magazine and online articles	6
Health-related publications (5)	
Migration-focused magazine (1)	
Forums and working groups	3
Forum for culturally sensitive elderly care (1)	
Working group of the migrant umbrella organisations (1)	
German institute for retirement provision (1)	
Total	43

Results

The data corpus comprises 43 documents published by political bodies, foundations, charities, municipalities and health- or migration-related magazines (Table 1). Several of the documents, while all being grey literature and publicly available, are close to academic research discourses and demonstrate an overlap of research and public discourses in the field of ageing, migration and health.

The documents included in the analysis mainly refer to immigrants who arrived as (young) adults and grew old in Germany. Some of the reports published until 2005 specifically discuss older 'foreigners', later documents relate to older people with a migration background.[4] While this includes second-generation immigrants, the focus is almost exclusively on first-generation immigrants, with particular attention on two main migration movements. Firstly, former labour migrants who moved to Germany during labour agreements between the 1950s to 1970s, especially from Turkey, Italy, former Yugoslavia and Greece. Secondly, ethnic German resettlers who moved to Germany from the former Soviet Union after 1992. Immigrants from non-European or non-Mediterranean regions and refugees are rarely mentioned.

The results centre on the core themes of the discourse analysis: (1) older immigrants age differently, (2) older immigrants are not permanent residents, (3) homogenisation of older immigrants, (4) immigrants belong to ethnic communities, (5) familial cohesion constitutes a core value, and (6) intercultural approaches are necessary to improve services.

Ageing differently

Earlier reports refer to a population above 60, whereas, from around 2010, people with a migration background aged 65 and older make up the target population of most reports. Investigating the population of older immigrants also includes an analysis of how ageing is understood, how older age is categorised and what attributes are associated with growing old. Old age is differently understood depending on the context as chronological (starting at 60–65 years), functional (according to age-related health issues) or sociocultural age (as a life phase). In some texts, immigrants are described to age earlier from a sociocultural, psychological or functional perspective than the non-migrant population. Early functional ageing is explained by the early onset of health problems among immigrants in Germany, as for example 'migrant workers are affected by age-related diseases to a greater extent and earlier than German senior citizens' (Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration 2012: 156). Sociocultural age is described to occur earlier due to life events such as marriage and having (grand)children taking place at an earlier stage.

> However, the psycho-social age occurs much earlier than chronological age, especially in the case of migrant workers, as they align their life phases with their own cultural age passages such as earlier marriage and earlier grandparenthood. (Deutscher Bundestag 2000, 117)[5]

The quote underlines how the psycho-social age of migrant workers differs from chronological age, which is based on the majority population. Hence, ageing and older age for immigrants seem to be influenced not just by socioeconomic or health-related

determinants but also by their culture. Throughout the themes presented here, there is continuous attention on cultural aspects, which further emphasises the connection of age and culture and the notion of older immigrants ageing differently.

Residency and returning

The possibility and relevance of return and circular migration patterns are frequently discussed in the data. Particularly concerning former labour migrants, return migration is suggested as a migration goal or preferable future option. While this is constructed as a likely option in the early 2000s, it has become less probable with more time after retirement spent in Germany. As the commonly used phrase 'guest worker' implies, returning to the country of origin is perceived as the expected retirement objective for Germany's labour migrants. Indeed, returning is put forward as the favoured option and desire of labour migrants. The 6th family report differentiates: 'In contrast to the migrant workers, who are often return-oriented, late repatriates came to Germany to settle here forever' (Deutscher Bundestag 2000, 117). The fact that many older immigrants ended up staying in Germany is seen as a surprise and as a situation that neither the public services nor older immigrants are prepared for, with many organisations and government reports calling for better preparedness. Even in 2016, a health report from Berlin-Brandenburg criticises that 'the system of care provision is still not sufficiently prepared for the (growing) group of people with a migration background' (Gesundheit Berlin-Brandenburg e. V. 2016, 10). Besides, circular migration between the country of origin and destination is reported as both a potential resource to make the most out of two places and as a challenge to continuously pursue activities (such as maintaining voluntary work) in Germany. The attention on the temporality of residency and circular migration highlights the connections to both sending and destination country.

Between heterogeneity and homogeneity

Immigrants are often described as a heterogeneous group with various cultural and social backgrounds. Yet, this diversity is not further explained beyond a short note on immigrant heterogeneity. With the focus on two main immigration movements, the majority of immigrants are summarised into two distinct groups: 'those of the labour migrants on the one hand and the late repatriates on the other' (Gesundheit Berlin-Brandenburg e. V. 2016, 5). The emphasis on these two main migrant trajectories neglects the vast variety of immigrants who migrated from other regions or for various reasons and are growing old in Germany. Furthermore, other aspects of migrant diversity, such as age at migration, time spent in the immigration country, socioeconomic background (besides low-resource circumstances), gender identity, sexual orientation or disability, are seldom considered. In addition, cultural diversity gets lost within ethnic difference as the central distinguishing factor in relation to the autochthonous population. This emphasis on foreign cultural values of immigrants creates the image of one migrant culture. Consequently, ageing, living situations and care preferences are grouped as immigrant-specific and culturally different.

This construction of cultural homogeneity conveys the collective image of older immigrants. Due to the focus on former guest workers, the culture of immigrants is often summarised as southern/Mediterranean (*südländisch*). Additionally, migrant culture is repeatedly described as 'traditional' or 'traditionally oriented', especially concerning family structures and gender roles. Concentrating on traditional characteristics, biographical differences and migration backgrounds strengthens the image of traditional migrant lifestyles.

> In addition, traditional values and role models of agrarian societies from the Mediterranean region, from which most of the older immigrants come, cannot be maintained in the long term in an individualised society such as Germany.[…] The declining commitment of native values and norms in the children's generation leads to a change in relationships of authority and family ties, resulting in increased tensions between the generations. (Tempel and Mohammadzadeh 2004, 30–31)

In contrast to the traditional or here 'agrarian' culture of immigrants, German society is presented as 'modern' and 'individualistic'. This contrast arises in the disparity between first-generation immigrants, defined by traditional/Mediterranean culture, and their children, defined by modern and individualistic values. German culture, thereby, remains elusive and only appears as a contrast to the culture of immigrants.

Traditional values seem to be enhanced in descriptions of immigrant women, who are generally seen to be situated more in the private, family sphere. Presented as a cultural characteristic the 'traditional women's role, which can be influenced by religion and in which the possibility, of making wishes or demands is interpreted as an unknown or unseemly behaviour' (Innere Mission München 2005, 8). Furthermore, the existing 'traditional gender roles' highlight care and support responsibilities of women in the family and the social networks.

> For certain nationalities, however, [self-organisations] are clearly dominated by the male members and are shaped according to their needs. Older women deviate into their own, mostly informal areas. (BMFSFJ 2005, 436)

It is important to remember that the focus remains on immigrants who have been living in Germany for several decades. Yet, voluntary services, as well as care homes, are discussed as unknown to some migrants as these are not common in the country of origin. In this comparison of origin and destination country, there seems to be a certain timelessness that neglects the time immigrants have spent in Germany. In particular, labour immigrants are described as still 'standing a bit with one leg in their home country' (Camino 2014, 32). Consequently, immigrant culture becomes essentialised as a static trait without change until the next generation. Moreover, the cultural change of the younger migrant generation is continuously depicted as a source of conflict between the generations.

Immigrants are further homogenised in the context of a shared emigration country. This is particularly the case for Turkish immigrants, who constitute the largest group of immigrants in Germany. Correspondingly, religion in a migration context often refers to Islamic beliefs with examples from Turkish people in Germany. Again, traditional values, family cohesion and care roles of women are mentioned as cultural aspects of all Turkish immigrants:

> The family is consistently mentioned as the first and strongest guarantee for a safe, satisfactory and successful life for both sexes in old age in Islamic statements. It also holds the key position in the expectation of old age of Turkish immigrants in Germany. (BMFSFJ 2010, 56)

Cultural or social differences of immigrants disappear behind a shared migration background and assumed shared religious values. In this way, the culture and religious beliefs are also homogenised in the description of Turkish immigrants, analogously to the homogenisation of 'immigrant culture'.

Belonging in ethnic communities

These cultural values are presented to be situated not just in individuals and families but also within networks, groups and communities. Ethnic belonging is constructed through a shared migration history, a shared country of origin or family connections in social networks. The clear boundaries of such imagined groups are created by referring to 'ethnic colonies', 'ethnic communities' or 'ethnic neighbourhoods' giving the impression of geographically definable groups. Depending on how contained these structures seem relates to ideas of exclusion and hence (lack of) integration. Thus, closed-off terminology such as 'ethnic colonies' emphasises the segregation of such communities. In this image of closed environments, group size plays an important role in visibility, which further increases the emphasis on Turkish residents as the largest immigrant group.

> Immigrants from Turkey are the only group of nationalities that, due to their large numbers, are able to form quasi-self-sufficient ethnic colonies and are increasingly segregating in their own care structures. (BMFSFJ 2005, 397)

A key aspect of ethnic belonging is the similarity of people of the same ethnicity. Thus, the imagination of homogenous ethnic communities exists regardless of the diversity within these communities. The similarity of people within ethnic networks is further highlighted by a focus on the family as the main social contact of immigrants. The family and the social networks are thus presented as indistinguishable as shown in the following quote:

> The commitment of individuals, which goes beyond the boundaries of the family, also develops in the sociospatial context of the ethnic colonies, in which many migrant families live. A sharp distinction is, given the extensive family networks, hardly possible. (BMFSFJ 2005, 435)

This conflation of the family and the social sphere further results in a perception of closed communities and highlights a similarity – or even familiarity – of ethnic group members.

Ethnic withdrawal in older age

As demonstrated in the first theme on 'ageing differently', the data shows a connection between ageing and sociocultural aspects, with culture and ethnicity gaining additional relevance in older age. As the quotes of two federal ministers summarise: 'Especially in old age, cultural customs and religious values play a central role for many people' (Baden-Württemberg.de 2014). Thus, ethnicity is understood to become more significant with older age, which is described as a withdrawal from the public to one's ethnic

background. In general, it is not specified for whom the phase of ethnic withdrawal is applicable. This is shown by the following quote: '[…], however, in some cultures - as noted here only marginally - there is also a tradition of withdrawal in old age' (May 2010, 4). Indeed, the specific ethnicities or countries of origins are omitted and thus withdrawing to one's ethnicity or cultural customs remains a vague concept.

Furthermore, the social construction of older age paired with assumptions on frailty and disengagement interlinks with the social construction of ethnicity. The link between biological ageing and culture essentialises cultural values as a fixed personal trait and ageing as a decline or withdrawal from society.

> In our opinion, it is also important to understand the retreat to the ethnic enclave as a coping strategy for growing old abroad, because it offers the freedom to live and age according to one's own ideas and cultural traditions. (Arbeiterwohlfahrt Landesverband Berlin e.V. 2004, 4)

Ethnic withdrawal is thus understood as a 'coping strategy', as a solution to the difficulties of growing old. The subsequent theme demonstrates how the ethnic community is presented to be situated in the informal and familial sphere; therefore, a withdrawal in older life also presents a shift from the public to the informal domain.

Family cohesion and support

Throughout the data, the family plays a major role with the majority of the documents presenting family members as the main point of social contact. Family is frequently referred to as an extended household with more than one generation living together and children in the second generation. The close relationship between parents and children is characterised by intergenerational support. Mutual family support includes caring for each other: the parents for their grandchildren and the children for their ageing parents. As already mentioned, the culture of immigrants is generally seen as more 'traditional'. These traditional values include the preference of care being done by family members at home, which is almost always emphasised in discussions on long-term care. The cultural/traditional reasons are presented as the main reason for this preference. Care within the family is presented as the norm and the optimal choice for older immigrants and society. Due to the people available within an extended family, family carers are constructed as an obvious solution:

> Amazingly, migrant families are less likely to receive benefits in kind of long-term care insurance. Likewise, they rarely seek professional support for care. Almost all of the immigrants in need of care are looked after by their own relatives at home. The reason for this: strong family cohesion, but also financial hardships that make care in a nursing or retirement home difficult. Migrants have more children than the general population on average. Relatives can thus take better care of each other. (Zerche 2018)

Besides cultural aspects, monetary advantages and discrimination experiences with public services are mentioned as reasons for why care is preferred to take place within the family. These additional factors are always brought up secondary to the assumed ideal of a traditional family. Thus, children as carers are presented as a cultural value without real alternatives. While immigrants are presented as traditional, their children are seen as more modern and individualistic with both sons and daughters working. The traditional

family structure changes only because the younger generation may move away from the extended family. Unfulfilled care duties are thus seen as problematic within the family as parents have high expectations of their children to fulfil their filial duties.

> If the children withdraw from expectations, they violate cultural norms. Depending on the [social] environment and degree of acculturation of the migrant milieu, this can, not only result in personal feelings of guilt, but also feelings of shame in front of the wider family or the ethnic community and possibly sanctions. (Heinrich-Böll-Stiftung 2012, 24)

However, there is also recognition of the challenges of caring at home, the psychological, physiological burden and time invested in this task. Considerations on improving care through public services generally combine familial support and ambulatory care.

From culturally sensitive to diversity approaches

I have shown that information on older immigrants emphasises their cultural difference. This cultural difference is understood as a barrier to access health and long-term care services, which are used less frequently by older immigrants. The SKAD framework guiding this analysis offers the examination of problem-solution-responsibility constructions to explore what solutions are presented and what is expected by speakers in the discourse. In more recent documents, the 'problematisation' of cultural aspects shifts to a recognition of socioeconomic factors that older immigrants experience. This included an appeal to avoid generalisation and ethnicization and instead to acknowledge the role of financial insecurity and social background for social and health issues in older age.

> At the same time, it is crucial not to expose older migrants to generalized, ethnicizing and therefore discriminatory treatment. Essentially, the intercultural opening is about perceiving and taking people as individuals with their own needs and life stories seriously. (Die Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration 2010: 309)

Furthermore, this included a new commitment to integrating intercultural approaches in the development and organisation of social and health services. The intercultural opening (*interkulturelle Öffnung*) involves the provision of information in several languages, recognising religious norms and offering Mediterranean or religious food preferences. Yet, despite the emphasis on intercultural frameworks, the focus here remains on the culture of former labour immigrants from Mediterranean regions, their languages, foods and religions. In addition to the call for intercultural approaches, an increased recognition of diversity approaches is put forward. However, intercultural and diversity management initiatives seem to overlap to a large extent and diversity policies are not further theorised beyond the provision of culturally-sensitive services. Thus, the development from migrant-specific services to culturally sensitive approaches and diversity measures partly involves an increased recognition of socioeconomic circumstances, but primarily centres on culture and ethnicity.

Discussion

This discourse analysis of policy and grey literature publication on older immigrants in Germany investigates the construction of ethnicity and culture categorisations. While the

heterogeneity and diversity of countries of origin are recognised, the attention remains on former labour immigrants who migrated to Germany in the 60s and 70s. This focus results in a homogenisation of older immigrants who are characterised collectively by traditional and familial values. Consequently, a picture of one migrant culture emerges which neglects the simultaneous recognition of diversity. In this traditional image of 'migrant culture', intergenerational support within the family plays a core role, leading to a predominant emphasis on familial responsibility, especially regarding long-term care. These discourses change over time towards an opening of existing structures both formal and informal, towards the connection of ethnic communities with public institutions and to intercultural approaches in social work and health care.

The collective other and essentialised perspectives of culture

The results of this discourse analysis reflect public discourses on older age, which construct older people as the collective other (Fealy et al. 2012; Phelan 2018). For example, newspaper coverage on older people has been shown to collectively refer to older people as a homogenous and dependant demographic outside of the majority society (Fealy et al. 2012). These stereotypical representations have been argued to shape public opinions, reinforce ageism and visualise power relations in society (Phelan 2018). De-individualising discursive constructions have also been observed regarding older immigrants, as the results by Torres (2006) show regarding the homogenisation and Othering of older migrants in Sweden. In line with previous studies, the results presented here suggest that an emphasis on ethnicity and culture creates a discrete group of older immigrants in Germany. Members of this group become homogenised through discourses that focus on shared similarities: migration background, cultural difference, socioeconomic difficulties and health risks. The results indicate that older immigrants are continuously referred to as collective groups, as 'ethnic colonies', 'ethnic communities', 'ethnic neighbourhoods' or 'extended families'. The individual becomes almost invisible within informal networks or geographical spaces. Instead, older immigrants appear as self-supporting groups, which encourages a public understanding of older immigrants as secluded and not integrated into society.

As differentiated above, ethnicity creates and shapes the boundaries of group belonging (Eriksen 2002). Within these clear borders of migrant ethnicities culture appears static and without changes since the move to Germany. In many cases, cultural values are related to the country of origin, mostly concerning the 'home country' without further clarification. In comparisons of the culture and society 'in the home country' and 'in Germany', it is left unclear whether the authors refer to the country of origin at a point in time before migration or to the current situation. This further increases a sense of timelessness of both the culture and country of origin. Such an understanding of culture characterises the essentialist perspective, which comprehends culture as something people are, a trait that does not change over time. Essentialised understandings become especially evident through the concept of ethnic withdrawal, where disengagement in older age is linked to ethnicity and both 'traits' reinforce each other. The link between ethnicity and ageing becomes apparent in several themes in the data and indicates how these characteristics and their connotations (i.e. vulnerability, disengagement, exclusion) join in the discourses on older immigrants.

Descriptions of migrant culture as traditional and family-oriented are not specific to older immigrants. Sökefeld (2004) observes that Turkish culture is homogenised and essentialised in German discourses, which emphase the similarity of all Turkish migrants. Furthermore, Turkish culture is seen as rural, traditional and static, especially concerning the role of women as oppressed and dependant (Sökefeld 2004). Similarly, the descriptions of older immigrants produce an image of timeless traditional values similar to what we expect or assume from traditional rural life. This image particularly affects expectations of care and the role of the family. Intergenerational care and mutual social support are generally seen as traditional and connected to gender roles that underscore women as carers in German society (Kunstmann 2010). This perspective persists in society but is enhanced in discourses on immigrants due to the emphasis on their presumed traditional values (Brotman 2003). In Germany, care at home is continuously valued more than institutional care and assumptions that everyone can provide care are a common theme in the media (Krüger 2016). In the context of older ethnic women in Canada, Brotman (2003, 21) argues, the idea that care in the family is possible and achievable may result in the belief that older ethnic women are 'taken care of' and do not require public support. As a consequence, this assumption might impede the development of care services for older immigrants (Brotman 2003). In recent years, the challenges of caring for family members have received more attention, which decreases the expectation of familial care (Aşkın 2018). Yet, discourses on older immigrants show that despite recognition of the challenges of familial care, privately organised long-term care is continuously constructed as the norm and cultural responsibility for families with a migration background.

From intercultural to diversity approaches

My analysis follows a discourse shift over time towards more recognition of the heterogeneity of immigrants. The same discourse shift is also visible in gerontological research, which calls for a recognition of diversity in later life (Ciobanu 2019; Enßle and Helbrecht 2020). Understanding older immigrants from a super-diversity perspective provides a 'lens to further de-essentialize ethnic and cultural differences, casting light on the underlying concurrent processes of societal differentiation, individual identification and group (dis)alignment' (Boccagni 2015, 611). While Vertovec (2007) refers to the diversity of migration patterns in London, the relevance of his concept remains valuable in other contexts, when we consider recent global migration patterns and the growing percentage of older migrants throughout Europe. In this way, it offers the advantage to better understand the variety of the causes of social inequality and to shed light on the needs of immigrants to inform local authorities and public service providers (Vertovec 2007; Ciobanu 2019).

With the growing awareness of cultural diversity in old age, culturally sensitive or intercultural strategies are increasingly discussed regarding care and health services to address demographic changes (Razum and Spallek 2014; Brzoska, Yilmaz-Aslan, and Probst 2018). Yet, migrant-specific or culturally sensitive approaches have been criticised for neglecting other diversity dimensions such as gender, sexual orientation, education or religion (Razum and Spallek 2014; Brzoska, Yilmaz-Aslan, and Probst 2018). According to my results, intercultural approaches pose a prominent topic, which suggests a

direction towards recognising the diversity of older immigrants. However, this shift does not replace the emphasis on cultural difference, generalisations and homogenisations of people with a minority cultural background. In the early phase of theorising intercultural approaches, Domenig (1999) already urges that an 'uncritical adoption of [transcultural nursing care] without theoretical and historical background information produces in practice a stereotyped image of migrants and a cultural rating of social and individual aspects instead of mutual understanding'. Therefore, it is crucial that culturally sensitive approaches in health care address the dynamic, interactive and fluid aspects of culture to avoid the adoption of stereotypes in the health care sector.

Limitations

While discussions about older immigrants have been gaining attention over the last decades, suitable texts to be included in the study were limited and some authors, sources or citations appear repeatedly and in reference to each other. Hence, the data corpus remains close to scientific research and academic discourse and partly overlaps with academic publications, despite the focus on grey literature for the public audience. Thus, this analysis can only refer to a niche discourse at the intersection of ageing and migration in the political and organisational arena in Germany. It does not provide any material on the discourses within organisations or about everyday discourses with older immigrants on a micro-level. However, the proximity of the political, institutional and scientific discourse further stresses that the results of this paper are also relevant for improving age, care and health-related services and academic research on older migrants.

Conclusion

This study investigates political and organisational health care and welfare discourses in the context of ageing and migration. The discovered ageing discourses range from essentialised perspectives, which describe older immigrants as ethnically separate and culturally traditional, to the necessity of integrating intercultural structures in public services. The focus on former labour immigrants specifically seems to have led to a generalisation of migrant culture and ethnicity, which can be summarised as family-oriented, traditional and secluded in informal ethnic structures. This study applied a sociology of knowledge perspective to examine how knowledge constructions about the culture and ethnicity of immigrants create the image of a shared cultural background, emphasising ethnic belonging and thus, producing a distinct group of older immigrants separate from the modern and individualistic non-migrant population. Since these generalised assumptions appear in the care and welfare context, the effect of such stereotyping on the development of public health and care services for older immigrants calls to be further investigated and addressed in Social Gerontology. In particular, the growing emphasis on intercultural approaches is insufficient if stereotypical images of immigrant culture and ethnicity continue to coexist. The concept of super-diversity, thereby, provides a valuable framework to consider the diversity of socioeconomic, historical, cultural, legal and political aspects immigrants experience throughout their lifespan and especially in older age. Furthermore, acknowledging the dynamic nature of culture

and the social construction of ethnicity is essential to creating culturally sensitive institutions and policies.

Notes

1. While the term 'older immigrants' emphasises the nation-state borders of migration, I use this term in the German context to acknowledge the permanence of immigrants, especially in contrast to the frequently used phrase 'guest worker' (Dolberg, Sigurðardóttir, and Trummer 2018, 178; Ehrkamp 2006, 1673). The term older migrants is used when not referring specifically to older immigrants in Germany.
2. The majority of labour immigrants (*Gastarbeiter_innen*) arrived in Germany during times of labour agreements (from 1955 to 1973) from Italy, Spain, Greece, Turkey, Morocco, South Korea, Portugal, Tunisia and former Yugoslavia.
3. Ethnic German resettlers or late repatriates (*Spätaussiedler_innen*) are defined as ethnic Germans who emigrated from countries of the former Soviet Union to Germany in the early 1990s.
4. The German Federal Statistical Office states that a 'person has a migrant background if they themselves or at least one parent did not acquire German citizenship by birth' (Statistisches Bundesamt (Destatis) 2019: 4).
5. All quotes were translated into German by the author. As translations carry an interpretation of the translator, a second (German-native speaker) and third researcher (English-native speaker) reviewed the quotes and disagreements were discussed.

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Paper III – Activity and social responsibility

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The discourse on active ageing is associated with a positive image of older age, the opportunity to stay active in retirement and the benefits of activity for ageing healthily. This theoretical perspective on ageing and older age and the use of active ageing as a policy tool received criticism for emphasising individual responsibility to ensure good health in old age and the expectation to contribute to society through productive actions. These criticisms question the applicability of active ageing for low-resource and vulnerable populations. While older migrants represent a diverse population from various socioeconomic and cultural backgrounds, financial challenges and health risks are increased in the older migrant population in Germany. This paper explores how active ageing is conceptualised in the context of ageing migrants in Germany and investigates the knowledge constructions of (individual) responsibility, informal support, and public initiatives in the discourse of ageing well for older migrants.

This discourse analysis investigates public texts from health, political, ageing or migration-related organisations or institutions over two decades from 2000 until 2019. The data corpus includes 43 publications from health care or older age-related organisations, government reports, city council or municipal documents, and articles from health and care-related magazines. The analysis concentrates on subject positions and the phenomenological structure of ageing well for older migrants. The aim is to examine discourses on meanings of ageing and health, specified problems and causes, individual and collective responsibilities and how these translate into the health care context and health and welfare services.

The subject positions and phenomenal structures depict a shift over the analysed timeframe and a change in the construction of ageing well for older migrants. While in earlier texts social responsibilities of older immigrants are presented as a resource for self-supporting ethnic networks, in more recent documents, the social responsibilities of older immigrants are described as a resource for society. There is a continuous emphasis on informal and collective support structures among migrants, which highlights the collective responsibility of older migrants for active ageing. Furthermore, the need to connect migrant networks, migrant organisations, and public health and social care services is emphasised, and migrants are proposed as bridging agents between public services and migrant groups. On the one hand, activity and active ageing seem to be situated in the collective support structures of migrants. Yet, on the other hand, the analysis also shows a direction towards the increasing responsibility of municipal responsibility to promote and ensure active ageing for its population.

Unlike the discourse on active ageing in the non-migrant population, which emphasises individual responsibility, active ageing in the context of migration focuses on collectivity and stresses the cultural preferences of ageing well. With the increasing diversity of the ageing population, cultural biases within the framework of ageing well need to be addressed and adjusted to ensure diversity-sensitive and inclusive opportunities for staying healthy in older age.

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Research Article

Activity and Social Responsibility in the Discourse on Health Care, Long-Term Care and Welfare Services for Older Immigrants

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Ageing well has been associated with the responsibility to age actively, successfully, or healthily in public and research discourses. This connection of individual responsibility with ageing has been criticised in Social Gerontology for neglecting the access to social, economic, and health resources. This paper investigates (individual) responsibility, informal support, and public initiatives in discourses on older immigrants in Germany. The research framework employs a sociology of knowledge approach to discourse, which guided the discourse analysis of German policy reports, guidelines and handbooks on ageing and migration from 2000 to 2019 (43 documents in total). The results reveal that besides public initiatives concerning long-term care, health promotion, and social services, informal solutions through social networks are frequently emphasised in the data. The focus, thereby, is on long-term care, which is presented as a responsibility of the extended family. Thus, resources are situated in the family, social networks, and ethnic group, which should be opened and connected with public services; however, the focus is shifting from older immigrants towards local municipalities. This study provides a discourse perspective on the construction of resources and challenges for older immigrants concerning health, care, and social services and offers an assessment of the cultural and integrating/excluding qualities in active ageing discourses.

1. Introduction

Demographic change has led to increasing longevity and changes in the age structures on a global scale. These trends also affect the age distribution of migrant populations and have led to an increase in older migrants in Europe [1, 2]. A common response to this demographic change has been the promotion of active ageing to ensure healthy and independent older lives [3]. However, to develop active ageing and its potential, the concept must include the diversity of the ageing population, which is particularly important given the criticism and developments of ageing policies and discourses. Active ageing has been widely discussed and criticised for the connection of a positive image of old age with activity and health, the individual responsibility to stay active and healthy, and the neglect of socioeconomic and environmental factors [4]. Following these criticisms, it is important to evaluate active ageing regarding minority and low-resource populations, where structural determinants define ageing well [5]. While research has addressed the meanings and potentials of active ageing for older migrants [6, 7], the connection between migration and ageing discourses and the resulting construction of active ageing has not been investigated yet. Older immigrants are a growing population group in Germany, who constitute 12% of the population above 65 in 2019 [8] and who experience more health risks and financial insecurities compared to the autochthonous population [9]. While the term immigrant emphasises the nation-state borders of migration, I will specifically refer to older immigrants in the context of Germany to highlight the permanence of immigrants, especially in contrast to the commonly used phrased "guest worker" in Germany [11, 12], and to highlight the immigration state's responsibilities in welfare services for older immigrants. I will use the term migrant when not specifically referring to older immigrants in Germany. This paper explores (individual) responsibility, informal support, and public initiatives in the context of ageing immigrants in Germany

and how active ageing is conceptualised regarding migration background.

The discourse on active ageing impacts our understanding of ageing and older age [10]. Hence, the discourse on older age is marked by an emphasis on individual responsibility, an expectation to stay active and healthy and to provide a valuable contribution to society in old age. This understanding of older age also affects welfare services and the construction of support structures for the older population. Thus, this study analyses the discourse on older immigrants in Germany in health promotion, long-term care, social services, and the welfare sector. The discourse analysis is carried out using the sociology of knowledge approach to discourse (SKAD) to examine how active ageing is conceptualised regarding migrants. The discourse arena comprises the macro- and meso-level examining policy documents, reports of health or care institutions, migrant organisations and political foundations, and articles from health- or migrant-related magazines. The focus, thereby, is on social and health-related public services, especially health promotion initiatives, ambulatory and stationary long-term care, social service centres for older people, and welfare services. This research provides a novel analysis of the active ageing discourse at the intersection of ageing and migration. The results display that active ageing is a dynamic framework that is constructed differently in the context of migration in Germany.

2. Discourses on Ageing Well

Society's expectations of ageing and older age are under constant negotiation and have significantly changed over the past decades. Old age as frail, sick, and dependant has been at least partially replaced by the idea of active and socially engaged older age. Yet, Angus and Reeves [13] remark that despite the emphasis on the healthy, independent, and self-responsible older individual, the contrasting image of dependant older age persists at the same time. Furthermore, the promotion of activity, health, and social participation in older age is shaped by an emphasis on the challenges of the demographic change [10, 14]. With lengthening life expectancies, the sustainability of pension schemes came under threat, which has led to a redefinition of retirement age as a time of activity, productivity, and opportunity. The policy objective to retain individual independence through better health and social involvement addresses both individual well-being as well as collective welfare [15]. This led to the promotion of a positive image of ageing, which is described in various ways, ranging from successful, productive, active, or healthy ageing. While these concepts overlap to a large extent, they also highlight different components: successful ageing predominantly focuses on physical functioning, productive ageing on economic contributions, whereas active and healthy ageing is more broadly understood [5]. Healthy ageing is the current main approach of the WHO, emphasised in the current Decade of Healthy Ageing 2020-2030 and defined as "developing and maintaining the functional ability that enables well-being in older age" ([16], 3). Active ageing is the concept most widely used, ranging from unidimensional approaches to definitions, which include behavioural and structural aspects, similar to healthy ageing. It is also the most prominent wording in age-related policies and presents a more holistic approach, which considers the life course and structural determinants of health [17].

Active ageing has first been introduced in the 1990s through the promotion of health and activity [17]. Since then, European states have adopted active ageing policies as a response to preceding age-discriminating descriptions of frail and passive old age [17]. It is rooted in two different discourses that have become increasingly interlinked. Based on the broader definition of the WHO, active ageing (or healthy ageing since 2015) emphasises general well-being, with a focus on physical and mental health and social participation [18]. However, other definitions have centred on the productivity aspects of retirement [10, 17, 19]. The connection of these different policies has led to productivity and social participation becoming the main tools for achieving improved well-being [20]. Although active ageing aims to improve the image of older populations from frail and passive to active and healthy, this call for activity has received substantial critique [4, 5, 10, 21]. First, through an emphasis on activity and productivity, a positive image of older age is always connected with activity and health as indicators. This poses the questions of what counts as an activity, especially, as active ageing discourse mainly emphasises actions valuable for the general society [5, 22, 23]. Second, highlighting the value for society comes with the responsibility and imperative for the individual to do their best in older age. To contribute to society, in form of productivity or social participation, is conceptualised as a necessity for an ageing population [10]. Thirdly, active ageing has been criticised for taking for granted financial, social, and health resources. Older people in low-resource situations are thus at risk of further marginalisation by not complying with the normative standard of ageing actively [23, 24]. This focus on health, responsibility, and resources has led to a dismissal of vulnerable populations in the active ageing context.

As a response to the overshadowing discourse on what older age should look like, there exists a vast amount of research on older people's experience-based perspectives on what ageing well means to them. In general, older people value a diversity of components emphasising physical, mental, social function, independence, and well-being as well as (social) engagement, positive attitude, family, adaptation, financial security, personal growth, and spirituality [25–27]. All studies confirm that ageing well—to use a general term—is multidimensional, complex, and culturally specific.

2.1. Ageing Discourses in the Context of Older Migrants. The determinants of health influencing ageing processes resemble across populations, yet migration has been linked to health risks in older age [28]. Despite generally good health during or after migrations, the health of migrants seems to decrease with time spent in the destination country [29]. Often health risks are caused by disadvantageous socioeconomic positions, language barriers, low health literacy, psychological vulnerability, and discrimination. Therefore, older migrants on average experience worse health outcomes and an earlier

onset of age-related diseases [28]. Health risks are increasingly recognised in the policy context of active ageing, which aims to address the heterogenous life course aspects of older migrants [30, 31]. Bolzman and Kaeser [6] investigate the gap between the normative concept of active ageing both in its productive and holistic understanding and the reality of older migrants among the older Spanish and Italian population in Switzerland. They summarise that it is important to provide the societal foundations to create opportunities for participation and integration, but also to recognise direct concerns of migrants and "ensure their rights to age in the way they want" ([6], 41). In Germany, older immigrants are characterised by opportunities and challenges to active ageing [7, 32]. On the one hand, families, ethnic communities and networks are presented as an important resource to self-support in older age. On the other hand, lack of health access, health literacy, and political participation act as barriers to an active and healthy environment for older immigrants [7]. Furthermore, Strumpen [33] concludes in her research on older Turkish immigrants in Germany that the idea of active ageing needs to be understood as a cultural phenomenon, which does not accurately represent older immigrants' expectations and thus presents a gap between policy, research, and older migrants' preferences.

Despite cultural and socioeconomic differences between the majority society and the population with a migration background, it is important not to overemphasise differences and to construct older migrants as "Others" in society. Thus, Torres [34] reminds us that socioeconomic challenges should not exemplify migrants as a social problem group. Moreover, the recognition of "foreign" cultural differences and cultural preferences should include an acknowledgement of own cultural biases and expectations. Therefore, in addition to describing cultural aspects of older immigrants, there must be a recognition of the German majority culture. Ageing is culturally specific and active ageing frameworks cannot be considered without cultural influences, which can exclude or neglect the needs of minority populations.

2.2. Individual Responsibility in Older Age. Active ageing is just one discourse strand in the wider ageing discourse. While this concept does not summarise the entirety of ageing discourses, it provides an insight into the discursive constructions of ageing, older age, and responsibility over time. Active ageing as a policy tool highlights the ideal perspective of how to support a healthy and active ageing population, looking both at the responsibility of the individual and society [5]. The discourse encompasses a shift from a problem perspective to the potentials in older age, by highlighting older people as an important resource for society and by emphasising ageing (actively) as an individual responsibility. The emphasis on activity stems from a long tradition of associating passivity and dependency as a weakness and ageing as a time of deficiency unless activity and independence can be sustained for as long as possible. Thus, the responsibility to keep active is the responsibility to keep independent [35]. Rüegger [35] questions the association of passivity and dependence as a weakness; instead, he argues that both autonomy and activity, as well as passivity and dependence, are normal human phenomena and that life continuously takes place between these poles. In the neoliberal context of active ageing, the strive for autonomy and independence is predominantly framed as an individual one, with collective and comprehensive public commitments taking a secondary role [3, 4].

2.3. Discourses on Health Services/Access. Examining discourses on ageing in the health care context offers an opportunity to analyse knowledge claims on meanings of ageing and health, perceived problems and their causes, responsibilities in society, and power effects, which translate into real health, care, and welfare practices. Discourse, as theorised by Foucault, describes a social system and social practice which creates knowledge and meaning, producing social facts [36]. These knowledge constructions become embedded in as well as performed by institutions, media, and social bodies. In the case of active ageing, the associated meaning of ageing well has been proclaimed by political institutions, media discussions, and research to produce a knowledge system where activity and independence in older age are positively connected with health and societal potential [37]. Furthermore, active ageing emphasises the self-governance of the individual, who is responsible to keep active, healthy, and independent [10, 37]. Discourses, therefore, affect individual and societal responsibility and the services available. Besides, the individual responsibility to stay healthy requires access to health-promoting resources, which is not equally available and has been shown to be lacking for migrant citizens [28].

3. Methodology

The study follows a sociology of knowledge approach to discourse analysis. This research framework combines theoretical aspects of the sociology of knowledge tradition and the microperspective of symbolic interactionism with Foucauldian perspectives on power and knowledge [38]. These theoretical foundations allow the researcher to analyse the actors' role in discourses and the (re)performance of discourses while being aware of the structures and power relationships in a discursive field. Using these interpretative sociological lenses provides a toolbox for analysing discursive constructions of knowledge on older immigrants. This study particularly aims to investigate how problems, their solutions, and associated consequences are raised in the literature and have changed over time. The discourse on older immigrants takes place on different societal levels spanning from everyday conversations to media, political, and academic arenas [39]. In this field of ageing, migration, and care, institutional actors such as political, healthcare, or ageing- and migration-related organisations engage in a specialist discourse, which is closely associated with academic discussions. Accordingly, discursive events are situated in the meso-/macroarena of political and organisational actors, which overlap with the scientific articulations and actors in this specialised field.

3.1. Data Collection and Sampling. Since 1995, the governmental report on foreigners in Germany addresses specifically the situation of older foreigners. Since 2000, the

relationship between migration and ageing became a recurrent topic in government reports on families, the ageing population and migration/integration [40–42]. This surge of interest is also reflected in the scientific literature [43, 44]. However, some researchers have explored the topic of older age among the migrant population in Germany before the year 2000 [45]. Due to the rising interest in this topic in the last two decades, the literature search spans from the year 2000 onwards up to December 2019. The data collection followed the SKAD approach to include maximum and minimum contrasting documents. First, political reports were collected going through government reports published on the topics of ageing, migration, family, and voluntary work. Second, the search strategy included political reports, guidelines, and reports from political, public, religious, healthcare, or social organisations active in the fields of ageing and migrations. Thirdly, the data corpus was completed by other grey literature from healthcare or migration-related magazines or project reports. The online searches were performed using search terms that address older/ageing (im)migrants, foreigners, or people with a migration background together with keywords such as care, health, intercultural opening, elderly support (*Altenhilfe*), or health insurance. It has to be noted that the term "older (im)migrants" represents a heterogeneous population from numerous countries of origin, having migrated at different points of time at different ages and for a variety of reasons. Therefore, the search strategy on "older migrants", "elders with a migration background", and "ageing and migration" includes different definitions of who constitutes "older immigrants in Germany".

The search strategy led to 43 documents for analysis. The data corpus consists of government reports (12); reports and articles by political foundations or charity and welfare organisations on the topic of social support, health care, and long-term care (12); federal state, municipal, and city government publications (10); texts by migration and health-related magazines (6); and documents by forums and working groups (3). All texts included in the analysis are publicly available online and written for an informed but not just academic audience.

3.2. Analysis. The project examines the discursive constructions at the intersection of ageing/older age and migration, including associated challenges and potentials as well as public or institutional services. Subject and speaker positions are identified to highlight different roles and practices within the discourse. The concept of phenomenal structures helps to examine themes by investigating associated elements such as problem constructions, responsibilities, course of actions, consequence, value implications, and the positioning of social actors [38]. The method of analysis draws upon grounded theory strategies; this includes creating codes to discover themes, constant comparison of codes and interpretations, and memo writing [46]. Furthermore, the grounded theory approach was used together with SKAD tools such as examining at a minimum and maximum contrasting examples using both fine and larger analysis techniques to assess the data corpus. Coding was carried out using the MAXQDA software or done by hand for detailed analyses.

4. Results

Older immigrants, in the documents analysed in this study, are predominantly described to be above 60-65 and to have lived in Germany for several decades. Documents from 2000 to 2005 focus more specifically on older foreigners. This definition changes to include older people with a migration background and mostly a personal migration experience after 2005. Largely, it is recognised that older immigrants are a heterogeneous group from various countries of origin with different life circumstances and social responsibilities. However, the attention mainly centres on two main migration movements, first, the former guest workers and, second, late repatriates (ethnic German resettlers). With the emphasis on former guest workers, the culture of immigrants is generalised as Southern, family-oriented, and traditional. Thus, despite the acknowledgement of the diversity of immigrants, a homogenous description of migrant communities and preferences is presented. Therefore, the results pertain to older immigrants in general with some discourse strands referring specifically to former guest workers.

4.1. Subject Positions and Phenomenal Structure. Over the span of two decades, two major subject positions emerge that can be associated in their phenomenal structures. Table 1 depicts values, perceived problems and their causation, and associated informal and public/municipal responsibilities related to these positions. Undeniably, utterances also fall between these positions and discourse events can refer to both positionings. Nevertheless, these subject positions present two key viewpoints on older immigrants. The traditional position is somewhat more common in earlier documents and the municipality position more frequent in more recent publications. The results presented in the following demonstrate the shift from more traditional to integrated perspectives on older immigrants, which is partially reflected in the time of publication.

4.2. Active in Private–Passive in Public. Older immigrants appear to be more passive in society with few remarks on leisure time activities, political participation, and voluntary work. Accordingly, ageing is depicted as an ethnic withdrawal from society. Also, integration is described as "particularly difficult at an advanced age" and the motivation of integration is assumed "to disappear in old age" ([47], 20). The passivity of older immigrants is further marked out by existing language deficits, which obstruct participation in society [48]. By contrast, activity is predominantly associated with commitments in the informal sphere, specifically, care work within the extended family. Furthermore, the emphasis is frequently on social groups, such as the family or ethnic community, but seldom on the individual. Therefore, the individual older immigrant appears passive while the community is praised for its self-support. For instance, the "German Report on Ageing" ([48], XIII) approves how "families—partly supported by outpatient care services—do a great job in caring for their relatives." These forms of activity are seen as great potentials, which need to be recognised more to move away from negative stereotypes ([49], 27).

Table 1: Phenomenal structure and subject potions of older immigrants.

Interpretative pattern	Social responsibilities of older immigrants are a resource for self-supporting ethnic networks	Social responsibilities of older immigrants are a resource for society
Subject position	(i) Older immigrants are traditional and family-oriented; therefore, activity and social engagement take place in extended families and within extensive ethnic networks. (ii) Because of cultural differences, older immigrants age differently.	(i) Older immigrants are a heterogeneous group (culturally, ethnically, economically), often having experienced socioeconomically challenging and discriminatory living conditions. (ii) Their social networks include the (extended) family, migrant organisation, and the municipality.
Values	(i) Family values are based on intergenerational cohesion, i.e., care in the family is best; recognition for delivering care within the families. (i) Traditional or cultural values provide as a sense of belonging ("identity anchor" ([47], 5))	(i) Promoting responsibility for and participation in the community. (ii) Achieving independent living in old age. (iii) Overcoming a deficit perspective on older migrants and strengthening potentials.
Perceived problems and causation	(i) Increased health risks compared to the nonmigrant older population due to low-paid and high-risk employment, short time in employment, and financial insecurity. (ii) Changing family structures challenge the provision of care by family members.	
	(i) Migration leads to disadvantaging living situations (migration as a risk factor, e.g., due to psychosocial stress). (ii) Lack of knowledge on services and authorities in the health and social sector as well as language barriers. (iii) Previous expectation that older immigrants will migrate back to the country of origin in old age. (iv) Ethnic networks are not accessible, segregated from society.	(i) Older immigrants live predominantly in discriminatory and low-resource socioeconomic circumstances. (ii) Municipalities and their health and social services are not adapted to cater for older immigrants; care, health promotion and social services are underutilised. (iii) Experiences with discrimination in public service institutions. (iv) Lack of accessibility of existing social/health structures due to language barriers, limited integration, and information deficits.
Older immigrants' responsibilities	(i) Family is a central resource for support and care. (ii) Important services are carried out in the (ethnic) communities. (iii) Older immigrants need to familiarise themselves with state services.	(i) Social involvement in the municipalities is expected. (ii) Migrant organisations need to be opened and accessible to society. (iii) Immigrants can fulfill bridging positions between ethnic/private networks, migrant organisations, and municipal services.
Public/municipal responsibilities	(i) Support of family and extrafamily networks and expansion of support services. (ii) Assistance for long-term care in families with outpatient care. (iii) Developing intercultural or culturally sensitive approaches in health, care, and welfare services.	(i) Improving access to public/municipal services (i.e., health promotion, ambulatory, and stationary long-term care). (ii) Developing intercultural approaches in institutions such as culturally sensitive care; avoiding parallel structures of migrant/nonmigrant clientele. (iii) Better networking of existing actors, resources, and services; connecting private and public services; recognising informal work of older immigrants; and providing support for independent living.

For example, circular migration between sending and receiving country represents a migrant-specific resource that allows an active lifestyle in old age, keeping in touch with relationships in both countries and leading to higher life satisfaction [50]. These associations of being active within the family and the close social circle and passive in the public sphere is further emphasised for older immigrant women. Women are frequently associated with the household, the ethnic community, and their social responsibilities within these social structures.

The social networks in the ethnic colony can have many functions, e.g. in the field of lay medical systems and the reciprocal support of women, which is important for the care of the elderly in families. ([41], 499) (All quotes were translated by the author and were discussed with another German and English-speaking researcher to ensure a close translation of the original texts.)

As the quote shows, the emphasis is on the role of the lay medical knowledge and the cooperation between women in the informal sphere. On one hand, activity is emphasised and promoted as a valuable resource for independence. On the other hand, activity is presented as restricted and segregated from society, distinct to the private realm of older immigrants, which generates an image of passivity. In line with general discourses on active ageing, being active presents the prerequisite of independent ageing, which is

constructed as the overarching aim. Therefore, the goal is to support activity and social responsibility to ensure autonomous, independent, and self-supported ageing as a solution.

4.3. Collective "Ethnic" Responsibility. In the family, the close social circle, and "ethnic" networks of older immigrants, activity and support are constructed as a collective "ethnic" responsibility. Above all, the (extended) family or family associations (*Familienverbände)* ([40], 121) play an essential role in the discourses on older immigrants. Cultural values are seldom related to a specific cultural background or region of origin but generally describe the perceived cultural difference of immigrants to German society. These cultural aspects, associated with a migration background in older age, highlight the value of familial cohesion, intergenerational support, and the significance of the extended family. This includes the expectations on relatives that care preferably takes place within the family. Solidarity and intergenerational support among the migrant community is introduced as a cultural and traditional value. Moreover, it is explained that immigrants do not want "to be a burden" ([51], 4) of society and have high expectations of support structures within their communities [52]. Older immigrants live predominantly in larger family households due to cultural and financial reasons, which facilitates familial support. The importance of family support is a dominant discourse theme appearing in most documents. By stating the cultural significance of familial support, the expectation and responsibility for migrant relatives to care for each other becomes accentuated by discourse actors, i.e., political institutions, health and welfare organisations, and migrant organisations. This emphasis on self-supporting values stresses the obligation of older immigrant to care for each other, as it is shown in the following quote from conference proceedings of a symposium on migration and ageing:

These people grew up in a different culture, where elderly people can expect help but where no demands are made. They grew up in a culture of informal help and family solidarity. Official services and institutions are foreign to them. That means that this is a radical change for them. ([52], 47)

Though, it is recognised that despite the efforts within families, additional support may be required as there may be a risk of overburdening the family by providing long-term care for relatives [53, 54]. Therefore, reports conclude that there needs to be additional care assistance, for example, in form of outpatient care, to sustain the collective support within private networks.

Beyond the family, an additional emphasis lies in the informal structures of older immigrants. The potentials and resources of immigrants are found in networks, ethnic communities, and neighbourhoods, which are characterised by high informal engagement, self-support, and help networks [49]. Yet, these forms of social activity are depicted as informal and private and not as formal voluntary work. Voluntary work or social engagement (*Ehrenamt*) is described as a foreign concept for older immigrants:

In many countries of origin, societal structures are also much less developed than in Germany, and there are sometimes few equivalents in other languages for the German term 'Ehrenamt'. The idea of getting involved in formal (association) structures for people with whom there are no family or neighbourly ties is, therefore, a strange idea, especially for the first generation of immigrants. ([55], para. 8).

Thereby, the difference between informal activity and voluntary work in associations is frequently noted, but it remains undefined what counts as informal support and what as societal participation. Moreover, migrant organisations are portrayed as another form of an informal social resource. These are presented as outside of traditional German voluntary work. Though migrant organisations are embedded in official structures, they appear as being informal and separate from German voluntary organisations. The emphasis on family cohesion and the informal ("ethnic") structures of older immigrants leads to a presentation of migrant communities being distant and separate from the majority society. The continuous focus on informal, ethnic, cultural, or family-related therefore constructs a line between the collective support of older immigrants and other services that exist outside in the public sphere.

4.4. Opening Private Support Systems and Connecting Existing Structures. As shown by the emphasis on the collective support structures of migrants, it appears that there is a boundary between informal structures and public engagement. However, the discourse also depicts a shift towards opening informal networks to make social engagement public and, thus, more widely accessible, especially in later documents. This change is also demonstrated in the description of informal structures. The nature of these networks is constructed differently over time from descriptions of segregated "neighbourhoods" or "ethnic colonies" to more openly described "communities" and "structures." This also includes a shift from acknowledging familial and neighbourhood networks to a call for supporting the cooperation of local communities with public services. Overall, ethnic networks represent private and inaccessible resources, whereas institutional or publicly organised support is presented as cultureless and open for all members of society. Consequently, the promotion of migrant organisations and networks is increasingly encouraged with the aim to connect these to the public sphere.

The aim is to open existing informal structures, connect them with public services, and bring them from private, inaccessible spheres to the public. As a result, existing support structures need to be recognised and constructed as open and accessible. While self-supporting resources exist, they are not sufficient. Thus, opening and bridging the informal with migrant organisations and public services becomes a strong effort.

At the same time, the extensive informal support networks of older immigrants need to receive more attention. The existing assistance services and support systems should be opened for these forms of self-organization. ([48], 91)

Besides, the connection of structures includes linking existing welfare services such as actors in senior citizen work, geriatric care, integration work, and migrant organisations. The aim is to connect the topics of older age and migration and to improve cooperation among actors, institutions, and

welfare amenities as thus far services have seldom overlapped. Even for migrant organisations, ageing is an underaddressed issue that is still gaining importance. This opening of the informal includes bridging the communities of older immigrants with existing municipal services. To achieve this, migrant organisations play an important role to bridge migrant communities with general society with the use of migrant representatives. Through emphasising the image of the bridge from the immigrant community to the German majority society, migrant communities, again, appear as detached from the general public. In addition, immigrants are characterised by being difficult to contact and to welcome in existing services. Therefore, persons with a migration background themselves need to act as a link between migrant and nonmigrant [47, 49, 56, 57]. Here, it is the migrant background that is the unifying feature, not the cultural similarities. Thus, it seems as understanding the socioeconomic situation may be more relevant than overcoming cultural differences. On the one hand, the connection of services aims to further support immigrants; on the other hand, it also emphasises the expectation that older people contribute to society, not just in private but also in the public sphere.

4.5. Shifting Responsibility to the Municipality. In more recent documents, the importance of the municipality appears as a space for interaction and bridging various actors in the field of migration, ageing, and health/care. Migrant structures should be opened to be accessible for the municipality, and the connection of existing services is suggested on a municipal level. The municipality becomes the community, which refers to all citizens as an inclusive entity independent of migrant background. Social issues are, therefore, municipal issues and not migrant-specific problems. This includes the promotion of more culturally sensitive and intercultural approaches in prevention, health promotion, and long-term care as an ongoing process within municipal services. However, with the focus on the municipal community, the responsibility of addressing these challenges lies in the entire community. The focus on the municipality, therefore, comes with a shift from the social responsibility of immigrants to the responsibility of the local community. This responsibility produces the image of the municipality as a social actor taking responsibility and solving its problems:

In order to improve the living situation of senior citizens with a migrant background, it is important that municipalities take demographic change into account when developing their intercultural concept and that their services check their relevance for migrants of senior age and expand them if necessary. ([58], 13)

Thereby, it remains elusive what and who the municipality represents. The image of the municipality refers to the local community and the social responsibility of people living in this community. Thus, the responsibility remains close to older immigrants. This emphasis on the local also demonstrates that the challenges of older immigrants are due to the services and support available in the local community and are more distantly related to issues on a national level. The shift to the municipality represents an inclusive local society and the coming together of various welfare services. However, a public or national responsibility on providing services for the older generation remains vague.

5. Discussion

This discourse analysis investigates ageing and specifically the active ageing discourses in the political and institutional arenas at the intersection of ageing and migration. The discourse on older immigrants includes elements of the active ageing discourse, including a call for individual responsibility and volunteer work. Yet, in the context of older immigrants, the focus lies not on the individual but social groups, i.e., ethnic communities, families, and migrant networks. These social groups are expected to support each other but also to make existing social structures accessible and to connect with public services. Moreover, the discourse has shifted increasingly to the responsibilities of, and reciprocal support within, the municipality. Consequently, two opposing subject positions of older immigrants emerge: first, the traditional, family-oriented immigrant and, second, immigrants as municipal citizens and "bridging agents" connecting existing services.

The paper analyses the German discourse on ageing and migration, which is influenced by the German healthcare and welfare service landscape. The study demonstrates how stereotypical representations of immigrants become included in the active ageing framework and therefore shape the opportunities for ageing immigrants. Thus, the presented connection of migrant discourses and their effect on ageing initiatives is an example of active ageing discourses in Europe and highlights the challenges of creating inclusive active ageing policies. Furthermore, the results display how knowledge around immigrants and knowledge on ageing influence each other and how these systems of knowledge become reconstructed within the active ageing frameworks.

5.1. Between Activity and Passivity. In the discourse on older immigrants, activity is communicated differently than in the general discourse on (active) ageing. Activity and passivity are understood in the context of culture, ethnicity, and public accessibility. Activity in the informal and "ethnic" community does not, thereby, gain the same praise as being formally involved in social engagement. Instead, self-support in the migrant community appears inaccessible. There is, however, one exception: care activity in the family is continuously praised as a cultural value and responsibility. What is considered an activity is an ongoing question regarding active ageing. In the data, what counts as active or passive seems to be measured on its value for society. As Foster and Walker [3] remark in this issue, narrow definitions of activity pose a threat as they reduce the variety of actions to productivity (such as paid work). Furthermore, Minkler and Holstein [59] underline that pleas for civic engagements should not undermine private acts of sustenance and nurture by highlighting the potential of volunteering and social engagement for society's social structures. Hence, activity should not be defined by its value for the majority society but should encompass "all meaningful pursuits which contribute to

individual well-being" ([3], 6), which is particularly important with increasing diversity in older age. As Strumpen ([33], 315-316.) remarks in her research on older Turkish immigrants in Germany, active ageing should be understood as a cultural phenomenon and as a manifestation of the ageing culture in Germany. Therefore, active ageing is not without cultural preconceptions which influence how activity and ageing well are conceptualised and promoted [34, 60]. Recognising active ageing's cultural biases provides a necessary foundation to develop cultural sensitivity within active ageing and other ageing concepts.

5.2. Active Ageing as a Form of Integration. Ideally, active ageing should function as an inclusive framework to enhance age-related integration throughout the life course, leading to an inclusive environment to facilitate participation in the community in older age [61]. At the same time, older people are expected to be engaged and active for as long as possible and therefore remain integrated in public life [4]. For former guest workers in Germany, integration measures were limited for decades because their stay was expected to be temporary [62]. This lack of integration raised barriers for immigrants to access services, and these barriers persist due to language difficulties, discrimination experiences, and information deficits [62–64]. Accordingly, opening existing public services, linking organisations, and migrant-specific initiatives could serve as an important step towards establishing an inclusive environment. Creating inclusive structures in older age holds the potential to create both age and culturally sensitive services for older immigrants. With regard to former guest workers, older age is constructed as a second chance for integration missed earlier in life. However, integration should not be framed as an individual responsibility; instead, it needs to be addressed on a macro level going beyond the local, municipal districts [65].

5.3. From Ageing as 'the Other' to Municipal Responsibility. The SKAD approach, by examining knowledge constructions and subject positions, enables exploring the positioning of older immigrants, which demonstrates the role of Othering language in the discourse. In the first subject position, which centres on older immigrants as traditional, family-oriented, and situated in ethnic networks, older immigrants are constructed as a distinct social group who appear as the Other in contrast to older nonmigrants. Similarly, Torres [34] observes that older migrants in Sweden are othered but considered a social problem group in the discourse on elderly care and policy. In the German context, Hahn [65] discusses how the ethnicity and culture of older immigrants have been a defining feature since the start of the discourse on ageing and migration in Germany. This perception of difference and Otherness, highlighting "us" versus "them," continues in social work and manifests on the city district level [65]. Thus, the focus on ethnicity and cultural difference conceptualises ageing with a migration background as inherently different. That is precisely why the shift to responsibility within the municipality is a curious trend as it positions older immigrants as part of the municipality. This diverts the focus from "ethnic networks" to the local community. The discourse, however, remains elusive on the definition of the municipality and who it entails. Ultimately, the shift to opening and connecting existing services in the municipality underscores a recognition of environmental and public structures, yet it also places the responsibility to contribute and stay active with the citizens.

5.4. Health in the Active Ageing Paradigm. The discourse on older immigrants in Germany demonstrates the ongoing dynamic on conceptualisations of ageing and ageing well. The relationship between activity and health is one aspect of the active ageing discourse that is under discussion; depending on the definition of ageing well, good health can be a means and a goal of active ageing [66]. A Health Science perspective can be beneficial, first, to recognise the effect of the life course on health and activity later in life [3] and, second, to consider the role of social determinants of health and environmental factors [66]. This perspective is particularly important in the context of migration, where integration measures have been limited and accessibility to existing services is lacking [11, 62]. While health risks in the past have been extensively explained with socioeconomic determinants in the data, strategies to develop health promotion in older age remain a side topic. How active ageing policies can promote health needs to be discussed on an institutional, political level to not rashly rely on an undertheorised connection between activity with health and well-being [67]. Instead, official action and welfare services must be clear and not appear as agents eluding responsibility, as the municipality is presented in the discourse. Supporting structures must be developed to promote an active and healthy lifestyle throughout the life course and specifically for the older population.

5.5. Limitations. The data collection only included online available publications, which limits the scope of the discursive events. With the increase in digitalisation, the search strategy might have led to more recent publications and fewer documents from the early 2000s, which could limit the variety of texts included. However, both government documents and organisation reports are published throughout the entire period and were included in the data corpus. Another limitation is that various speakers use different terminology to refer to older immigrants, which refer to different age groups and, in some cases, focus specifically on older foreigners, former guest workers, or Southern European immigrants. While this paper sought to address this lack of clarity, generalisations in the discourse and the associated knowledge constructions of age, migration background, and terminology, the term "older immigrants" in the documents analysed here and therefore in the results remains inadequately defined.

6. Conclusions

This paper demonstrates how active ageing is conceptualised in the context of older immigrants in Germany. The emphasis on informal and collective support structures leads to understanding active ageing as a collective responsibility for older immigrants, with families expected to provide long-

term care for their members. Furthermore, there is a discourse shift to solutions in the municipalities, where existing health care, long-term care, migration, and age-related services can connect and provide a holistic support structure for older immigrants. Older immigrants would therefore become engaged active citizens in their municipality. Thus, the active ageing discourse at the ageing and migration nexus focuses on collectivity instead of individual responsibility and emphasises the cultural and ethnic differences regarding ageing preferences. Rather than highlighting the difference between older immigrants and constructing immigrants as the "Other" older population, cultural biases need to be acknowledged in the active ageing framework. Demographic change will include an increase in the diversity in the experience of ageing, due to the manifold reasons for migration, the multiplicity of countries of origin, gender, sexual orientation, and dis/ability. The inherent ageism in ageing discourses has been extensively criticised in Social Gerontology, yet additional forms of discrimination and Othering need to be addressed by developing diversity-sensitive and inclusive ageing frameworks. In so doing, active ageing can play a significant role in realising the social inclusion of older immigrants.

Data Availability

The discourse analysis data used to support the findings of this study are available from the corresponding author upon request.

Conflicts of Interest

The author declares that there is no conflict of interest regarding the publication of this paper.

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Supplementary Materials

The supplementary data provides the list of documents included in the data corpus by publication type. *(Supplementary Materials)*

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Paper IV – Accessibility and care service provision

Goettler, Andrea; Willis, Rosalind: Aged care services as facilitators of delayed inclusion – An analysis of institutional discourses on service provision for older migrants in Germany. Submitted to BMC Health Services Research on 31.01.2023.

Accessibility to health and social care services is an essential prerequisite to healthy ageing. Research from European immigration countries has shown that older migrants experience limited access to public services due to language, financial and cultural barriers and restricted knowledge about health and social care services. Health and social care institutions are recognising the increasing number of ageing migrants and are taking steps to accommodate cultural diversity in service provision. This process is also evident in Munich, where 45 % of residents have a migration background and the percentage of older migrants is growing. This study investigates institutional discourses regarding the accessibility to health and social care services for older migrants. The focus is on service provision from the perspectives of professionals who provide, consult, or develop aged care services in Munich for citizens with a migration background. This paper aims to demonstrate how older migrants, their challenges, opportunities for ageing well and forms of support are constructed in the institutional discourse and how their representation relates to the accessibility to service provision.

Eighteen professionals working in or with health and social care services were interviewed on the significance of ageing for migrants, forms of support in older age, organisations and networks involved in providing support, social networks, and recommendations for actions. Following the SKAD research programme, the results explore narrative and phenomenal structures (causal relations, link to responsibilities, causes of action, values, and self-positioning) in the data. Looking at narrative structures reveals that informants understand migrants in the context of the structural barriers they experience over the life course, such as limited knowledge of public systems and shorter time in formal employment with subsequent low retirement income. Thus, older migrants are associated with cultural, financial, and language differences and socioeconomic challenges, which were particularly faced by labour migrants. Therefore, improving access to health and social care services is seen as a public responsibility to recognise the increasing diversity among older adults and provide low-threshold access to these services.

The discourse perspective reveals how opportunities for action are presented and which actors and measures contribute to improving the care arrangement for older migrants at the institutional-level. The paper discusses the theoretical frameworks of intercultural openness and diversity mainstreaming and their application to improve inclusivity and establish cultural competency in health and social care services for older migrants. The focus on addressing the sources of inequities and intersectionality provides a foundation for a diverse and equitable approach to healthy ageing.

Author contribution: I collected and analysed the data and drafted the manuscript. Rosalind Willis edited the manuscripts and provided comments on the analysis and final draft of the paper.

Aged care services as facilitators of delayed inclusion – An analysis of institutional discourses on service provision for older migrants in Germany

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Abstract

Background: Migration within and to Europe in the past decades has led to a growing diversity and a rising proportion of migrants in the older population. Germany has encouraged labour migration since the 1960s and many migrants who arrived for work in the past decades decided to stay and are now growing old in Germany. Health and social care institutions intend to acknowledge this change and adapt to the cultural diversity in aged care. This process can also be observed in the city of Munich, which is characterised by a high percentage of citizens with a migration background and an increasing population of older migrants.

Methods: This study examines discourses on older migrants and their access to health and social care in Germany, associated challenges and proposed solutions. Problem-centred interviews were carried out with 18 professionals from public, welfare and charity organisations who develop, organise or provide aged care services for older migrants. The analysis examines the narratives of migrant representations, constructions of healthy ageng and phenomenal structures of services provision following the sociology of knowledge approach to discourse (SKAD) research programme.

Results: The discourses on older migrants in public and social care institutions demonstrate how being defined as a migrant is related to cultural, socioeconomic and language difference and particularly stresses the structural challenges labour migrants experienced throughout and after employment. Thus, improving accessibility to health and social care is presented as a public responsibility, which aims to recognise the increasing diversity in older age and to create low threshold access to these services.

Conclusions: Recognising the increasing diversity in older age by implementing diversity sensitive frameworks and improving accessibility to health and social care services could provide an opportunity for (delayed) inclusion in public services for older migrants.

Keywords

Healthy ageing, older migrants, discourse, diversity, care services, culture

Background

Building on the United Nation's Sustainable Development Goals, one of the guiding principles of the Decade of Healthy Ageing 2020-2030 is the objective to leave no one behind by building structures and services that address marginalised members of society [1]. The principle of leaving no one behind is an opportunity to consider inequality and inequity in ageing and to explore the role of health and social care services to address these inequalities. Thus, the current Decade of Healthy Ageing is a stimulus to improve ageing environments for older migrants who on average experience limited or insufficient access to health and social care services in European countries [2–4]. Research has shown that older migrants in Europe [2, 3, 5, 6] and Germany [4, 7–9] experience limited accessibility health and social care services. In particular, first-generation labour migrants, who arrived as former guest workers and received inadequate integration services and experienced discrimination during their time in Germany, are not adequately reached [7, 9, 10]. To ensure that services can be accessed by all older migrants, policymakers and social care organisations recognise that both culturally sensitive and diversity approaches are necessary to improve health and social care for older migrants [11, 12]. However, both approaches are broadly defined and especially initiatives of 'intercultural openness' of aged care in Germany have been critiqued to be largely underdefined without a clear theoretical framework [13, 14].

This study uses interview data to explore institutional discourses on identifying ageing migrants, how their representation is related to service provision, strategies to improve access and recommendations for actions in the health and social care sector in Germany. While the interviews were conducted with professionals in the social care sector, the discourses are closely linked to health care and to creating opportunities for healthy ageing for older migrants. The analysis focuses on current challenges and areas of action in social care for older migrants and examines the discursive construction of these statements regarding problem interpretations, causal relationships, proposed solutions and responsibilities from a sociology of knowledge perspective. Furthermore, this paper explores how institutional concepts to acknowledge cultural competency and social inequity, such as intercultural openness and diversity frameworks, help to improve access to care services for migrants.

Older migrants in Germany

The term "older migrants" refers to a diverse population that migrated internationally and is now ageing or spending older age for a prolonged period in the receiving country. In academic and public discourses, the focus on older age is not a strict age-specific description but often refers to people aged 65 or over, pensioners or people who start to experience increased age-associated health issues. In Germany in 2021, 13.5% of people 65 years and over had a migration background, of which most (87.9%) are first-generation migrants [15]. The majority of older migrants in Germany moved from European or other Mediterranean countries. Some are ethnic German resettlers, who fled or were forced to move to the former Soviet Union during the Second World War and who have been returning from Central and Eastern European states to Germany since the 1950s [16]. Many resettlers returned in the 1990s and are now growing old in Germany. Other migrants arrived due to

labour agreements from 1956 to 1973 with Italy, Spain, Greece, Turkey, Morocco, Portugal, Tunisia, former Yugoslavia and South Korea with subsequent family reunification migration until the 1980s [10, 16]. In addition, labour migrants from other Western and Eastern European countries, especially since the 2004 enlargement of the European Union, constitute a minority of older migrants [16]. Migrants from other continents are still younger on average. For example in 2021, only 3 % of those from African or Asian countries living in Germany were older than 65 years [17]. The percentage of older migrants among the population above 65 has been rising in the last decade and is expected to further increase in the future [18]. It can be expected that this change will also lead to a greater diversity of countries of origin among older migrants.

Older migrants and healthcare

Many migrants who moved for work, notably former guest workers, experienced socioeconomic challenges in Germany due to employment in low-paid jobs, shorter time in formal employment and low pensions [16]. In addition, integration programmes shortly after arriving, such as language courses, were limited or lacking as the assumption was that migrants would temporarily work in Germany and eventually return to their country of birth [4]. This exclusion in connection with common essentialist and static understandings of culture in Germany also resulted in marginalisation and discrimination of migrants, which further hindered access to public services [4]. Once Germany started to identify as a country of immigration, integration become more prominent in the political discourse, with the expectation that migrants assimilate and integrate into German organisations [4]. Socioeconomic disadvantages, past manual labour or hazardous employment and social exclusion also affect wellbeing and health in older age. Thus, older migrants experience more health risks in older age, such as poor self-rated health, problems with activities of daily living, and higher rates of depression compared to the non-migrant older population [19–22]. In Germany, research has shown that migrants, 50 years and older, worry more than the German-born population about their health [16]. Furthermore, access, quality and usage of health care and rehabilitation services for older migrants are unsatisfactory compared to the non-migrant ageing population [8, 22]. For both health and social care, language barriers are identified as key aspects that obstruct access to services in European countries [3, 6]. Overall, socioeconomic disadvantages in combination with discrimination and social exclusion negatively impact the health of older migrants in Germany.

Access to social care services for older migrants

This research explores discourses on service provision for migrants and how access and quality of services could improve older migrants' opportunities for healthy ageing. Primarily, this study looks at services for older citizens, such as old-age support (*Altenhilfe*), residential care, (psychosocial) counselling, social work or health promotion services offered by public, private, voluntary or welfare organisations (*Wohlfahrtsverbände*). Some of these services are closely linked with or aim to provide better access into the healthcare sector. Research from Austria, Germany and the Netherlands has shown that access to social care services is often inadequate for older migrant or ethnic minority populations [4, 6, 7, 23–25]. In Germany, a study from 1995 demonstrated that older migrants have less knowledge about care facilities, outpatient care, or residential and nursing care homes, use these less often

and are less inclined to use them than the non-migrant population [9]. Limited literacy about the service sector due to language and information barriers, social discrimination, foreign citizenship and lack of political participation, mistrust of services and othering of migrants are put forward as key reasons for reduced access to participation and access to services in Germany [7, 24] and other immigration countries [23, 25]. Due to these challenges as well as the growing number of older migrants, there has been an increasing focus on initiatives to improve service access.

Various concepts have been introduced to address cultural differences in social care which focus on aspects of dealing with cultural sensitivity, cultural practices and the intersectionality of diversity dimensions [26]. In the German context, different terms have been suggested to move away from services that cater mainly to German(-speaking) clients. The main term is “intercultural openness” (*Interkulturelle Öffnung*) alongside culturally sensitive or transcultural approaches [12]. Intercultural openness refers to a policy agenda to improve the accessibility and quality of social care services, social work or public institutions for migrants since the 1990s [27]. The intercultural openness of aged care services presents a broad and flexible process that aims to make existing services more accessible by providing multilingual information material, networking with migrant communities, training intercultural teams, recognising religious diversity and educating staff on cultural competence [13, 27]. The process should incorporate recognition and acceptance of difference, taking a self-reflexive position on one’s own culture, reflecting on the relationship between majority and minority populations and considering the interactions between different aspects of life (e.g. gender, generations, age, sexual orientation, physical ability, socioeconomic situation) [14]. However, the focus remains on an often essentialised understanding of culture in terms of ethnic background, religion and language, which emphasises cultural differences between migrants and non-migrants [4, 12, 28].

Diversity management or mainstreaming frameworks have been discussed more recently as complementary or alternative frameworks in response to the shortcomings of the intercultural openness approach in health and social care services [12, 14, 29]. Diversity approaches have a historical basis in US social justice movement but have been increasingly linked to an economic opportunistic perspective on how to use diversity as a resource to optimise team productivity and quality outcome [29]. Diversity strategies consider diversity dimensions, i. e. differences that lead to inequalities and discrimination in social contexts, such as race, disability, gender, religion, sexual orientation and age, as well as socioeconomic and educational background [29]. These differences are understood as part of diverse societies with the expectation that institutional and organisational structures consider these. Thus, the diversity perspective aims for inclusive structures. In the context of migration, considering diversity dimensions and their interactions presents the opportunity to overcome essentialised categories of culture [6]. Accordingly, social inequalities and power asymmetries need to inform understandings of the relationship between diversity dimensions to facilitate equal opportunities [14]. Both intercultural and diversity frameworks benefit from including an intersectionality perspective that considers the interaction and relationship of differences regarding overlapping factors of disadvantage and privilege. While the diversity perspective is gaining attention, the emphasis in Germany remains on an intercultural openness of services, which involves taking diversity dimensions into account to address the increasing migrant population. However, how such a transformation should be implemented

remains vague without a theoretical framework on the relationship between socioeconomic status, culture and social heterogeneity [13, 14]. Despite the critiques of the term, the focus on cultural differences and the lack of theoretical underpinnings, intercultural openness remains a central idea to improve access for migrants, which poses the risk that other concepts such as diversity, intersectionality and inclusion become summarised under the buzzword of an intercultural openness of services.

Improving accessibility also includes how the relationship between service providers and potential clients is understood. Instead of describing older migrants as hard-to-reach, there has been a shift to understanding older migrants as seldom heard [30]. Similarly, in German literature, the importance of actively creating relationships and connections with migrants such as outreach approaches in social work are put forward instead of waiting for people to come across services [27]. Furthermore, a common concept in German social work is to implement “low-threshold” services, which intends to provide connections between services and possible clients, reach clients where initial contact is lacking and facilitate inclusion in support structures [6]. To summarise, efforts to improve accessibility for migrants aim to create inclusive structures by addressing cultural and ethnic differences and developing contact between providers and clients. Yet, the conceptualisation and the relationships between the concepts remain mostly open and imprecise.

Methodology

The discourse perspective is chosen to explore how narratives on healthy ageing for a specific target group are reified on the institutional level and how knowledge on improving accessibility translates to courses of action and practical approaches. Following a sociology of knowledge approach, discourse can be understood as structured practices of communication that create and stabilise the meaning attributions or symbolic orders which produce power effects in social collectives of actors and knowledge policies [31]. Thereby, discourse constructs orderings of knowledge, which translate into behaviour and legitimate course of action. Firstly, this includes how ageing for migrants is understood in practice, i. e. who is defined as a migrant, how ageing is constructed for migrants and what factors influence opportunities for healthy ageing. Secondly, this research explores how services are constructed based on the knowledge surrounding older migrants and how this affects accessibility in practice. Thus, discourse analysis allows for investigating expectations on inclusion, stereotypes and othering around older migrants that influence initiatives to implement and improve culturally sensitive old-age services. The discourse perspective investigates speaker positions and the actors’ responsibilities within the discourse and reflects on narrative structures around migrants, by analysing migrant representations and problematisations at the ageing and migration intersection. The sociology of knowledge approach to discourse offers a research framework that examines knowledge constructions in discourses and interpretations of phenomena. SKAD is influenced by the sociology of knowledge [32], symbolic interactionism and Foucauldian perspectives of power [31]. Thus, this framework offers a lens to how concepts like intercultural openness are understood in practice, how challenges and opportunities for older migrants are constructed and what structures and power relationships exist in the field. Specifically, the focus is on the institutional level looking at how academic, policy and everyday information about older migrants translates into practice in professional settings.

Setting and sample

Munich is a diverse and international metropolitan area, with 1.47 million inhabitants from around 190 countries in 2021. Munich has a high proportion of foreigners (28.5%) and of citizens with a migration background (16.6%), which includes first- and second-generation migrants[1] [33]. Most foreigners originate from other European countries, with a high number of migrants from Croatia, Italy, Greece and Austria [34]. According to the city's estimates, 10.9% of all people over the age of 60, residing in Munich were classified as "Germans with a migration background" and another 19.2% as foreigners [35]. Information about nationality or country of origin for the population over the age of 60 is not available, due to a lack of age-specific data. To address the increasing number of ageing migrants, the city of Munich ran a project on the "intercultural openness of long-term care" from 2014 to 2020. This initiative introduced culturally sensitive approaches and diversity approaches in aged and long-term care services and created an increased awareness of the rising number of older migrants and their heterogeneity [36]. Munich offers an interesting location to research this process because of the city's unique arrangement of 32 service centres for older people providing municipal social care.

The interviews followed a problem-centred approach [37, 38] using an interview guide with open-ended questions on the following topics: significance of ageing for migrants, forms of support in older age, organisations and networks involved in providing support, social networks, and recommendations for actions. General impressions, highlighted topics and instances not recorded on tape during the interviews were noted in postscripts. The postscripts helped to reflect on the question guide for subsequent interviews and served as a first interpretation. These first interpretations were noted as short memos on core topics of the conversation that were compared later to memos written during the analysis. Fifteen interviews were carried out with 18 professionals (13 women and 5 men) working in aged care services (4), the city or district of Munich (4), welfare organisations (4), health and social care (2) or migrant community organisation (1) between 2019 and 2021. Two interviews took place with more than one person as the interviewees preferred to do the interviews with their colleagues to provide a more comprehensive perspective on older migrants in their respective settings. One interview focused mainly on women, as the interviewees worked for an health, counselling and educational organisation, which offers services specifically for migrant women. Due to the Covid-19 pandemic, some interviews in 2021 took place via video calls online, while the majority were arranged in person. The interviews lasted between 25 and 81 minutes. Almost all participants highlighted that they have been working in this field for several years and about half of the participants referred to their migration background and the role of their migration history in their career. All interviews were conducted in German. The quotes used in the results section were translated into English by the first author.

Analysis

Data analysis was carried out using MAXQDA and handwritten memos. Grounded theory tools such as coding, maximum and minimum contrasting and writing memos served as a first step to discovering theoretical concepts from the data using comparative analysis [39]. As a next step, the analytical concepts of the SKAD framework helped to situate the codes,

comments and memos in the discourse context by examining narrative and phenomenal structures [40]. Furthermore, the narrative patterns of older migrants helped to explore how migrants are understood regarding the use and accessibility of services, how knowledge regarding the life course, socioeconomic context and challenges is presented and how these stories lead to a course of action and specifically the need for inclusion in old age. Additionally, the concept of phenomenal structures refers to the manifestation of a phenomenon of interest, which is shaped both by the historical and sociocultural context and the meanings attached to a concrete discourse [40]. The SKAD framework provides a set of questions and patterns that demonstrate how phenomena are explained through causal relations, link to responsibilities, causes of action, values, and self-positioning. The benefit of this concept is to examine how service providers construct their roles, positions of responsibility, and proposed solutions in improving accessibility in aged care.

Findings

Representations of older migrants: service needs, culture and language

The specific needs of first-generation migrants play a central role in the construction of the target group. These representations include additional aspects such as health and socioeconomic situation, language, culture and social exclusion. Instead of limiting services to a specific chronological age, interviewees recommend providing services when old age-related health or social topics (retirement, chronic health issues, financial support for care provision) become relevant. Offering services at an earlier stage, for example around 55 years, is suggested as a preventative strategy as informants point out that migrants frequently experience age-related health issues earlier due to social and employment health risks during their life.

In their descriptions of ageing migrants, informants predominantly described people who they assumed to have a greater need for health and social services and may experience barriers in accessing them. Thus, language difficulties play a central role in descriptions of who are older migrants. For example, a woman working in aged social services responded to the question about who she thinks of when talking about older migrants:

> *“Well, I don't know but a 70-year-old Austrian woman wouldn't be this classic migrant for me. But I would put it this way: people who have grown up in another country for many years. And also, maybe a little bit, who have – well if it exists it is also very noticeable – a bit of difficulty with the language.”* (Interview 13)

This quote demonstrates that language plays a significant role in who is considered a migrant.

In general, interviewees referred to both women and men. Although, language barriers are more often associated with older migrant women, women are also described to participate more frequently in social events and sport and health promotion classes. Furthermore, it was noted that women access social support services more frequently than men, for example to enquire about questions related to their male family members. Thus, they are also accessing services in their family caregiving role.

The cultural similarity is likely another factor why an Austrian migrant is suggested as an example to delineate who is perceived as a real migrant and who is not. Across all interviews, culture plays an essential part and cultural differences are recognised to affect how health care, health behaviour and illness prevention, dying and leisure time are understood. On the one hand, migrants are described to think "totally" or "completely" differently about ageing and care compared to German agers. Specifically, attitudes towards ageing and health/illness were perceived to be strongly affected by cultural background and religion. On the other hand, cultural differences are also perceived as possible to overcome by implementing culturally sensitive services.

> *"Now, of course, one can also say that older people, who come from a different culture perhaps understand differently the subject of illness or, I don't know, images of death or dealing with old age. I wouldn't make it so significant that we're struggling with it, it exists, of course, the cultures differ, but that's not such a significant problem now. […]*
> *From our experience, 99 percent of the time it's really the language, so someone can't say they're sick. He can't express himself, he can't name his medical, physical complaints. That's the be-all and end-all of the big problem. We have migrants who speak German well and they need much less support and get along much better. So, it's really mainly about the language."* (Interview 12)

The importance of language is strongly emphasised in this interview, which is also the case in other utterances. As a result, culture is seen as one dimension that defines older migrants, which gains emphasis in combination with language and health issues and how these relate to the quality of life and uptake of services. Thus, older migrants are understood in the context of aged care services, which incorporates how social determinants of health affect ageing and how language and culture relate to literacy in health and social care.

Structural challenges in older migrant's life course

The discourse on older migrants is linked to a narrative of the life course of migrants in relation to the changing integration culture in Germany. Informants describe a shift from short-term perspectives of labour migration, which was held by employers, politics and migrants and led to a lack of integration measures, towards recognising Germany as an immigration country and an increasing awareness of providing inclusive services. One person describes that while previously integration efforts were not common that is now not the case anymore:

> *"They [the former guest workers] didn't experience any integration measures at all at the time. So, like compared to the way it is happening today." (Interview 6)*

Despite the increase in intercultural services for migrants, several informants emphasised that there is still a societal expectation that migrants assimilate into German society. Specifically, former guest workers are characterised by a continuous integration effort into a system that is not easily accessible. In the interviews, integration was used synonymously with assimilation and inclusion, which is common in spoken German. When referring to the past, the focus is on older migrants having to integrate into the German system which is

described as the migrant's responsibility. When referring to the future or to an ideal construction of services, interviewees emphasise the responsibility of the institutions to create spaces that acknowledge the diversity of clients by offering diverse food options, religious spaces, interpreters and translations, or various cultural events.

> *"That when you talk about integration, no matter what age, it's a - what's it called – a one-way street thing. The Germans demanded and still demand that the non-Germans integrate."* (Interview 11)

> *"What I find very exciting is that the generation of migrant workers, who came to Germany, is a generation that had to manage to integrate themselves into the systems in every new phase of life. That means they came here and were simply the first to have to get into this work system. They had children and were the first who somehow had to bring their children to school and had to deal with the education system and with the health [system] / And that is now also the first generation in Germany that has to deal with this health care system, with the care system*." (Interview 9)

As shown by the second quote, guest workers are described to have struggled throughout their lives to access public services which continues into old age and hinders access to health and social care services. The speaker emphasises that public institutions did not respond in time to the population with a migrant background.

Throughout the interviews, socioeconomic factors are presented as causes of social exclusion of older migrants. Informants provide extensive examples of how low pensions and financial insecurity influence housing, food consumption, use of health and social care services including care homes and participating in everyday activities such as meeting for coffee. These risks are particularly associated with the group of former guest workers whose unique challenges are insufficient information on public services, language barriers, health risks because of manual or high-risk employment, financial precarity due to low-paid jobs and a "plurilocality" /"bilocality" or "not feeling at home in Germany". The short-term perspective of the labour agreements together with limited integration measures, discrimination experiences and socioeconomic challenges are seen as major causes that have led to older migrants and especially former guest workers, feeling like they are not at home in Germany. Staying in Germany is frequently explained by contextual factors, such as better health care, receiving one's pension and family ties but is seldom described as a personal preference. This situation is either constructed as being between places of feeling at home or as a pluri-/bilocality of people, in particular, if it is possible to regularly travel between the home country and Germany. Overall, this lack of a permanent home is seen as both a major psychological issue and a challenge when accessing health and social care services, when people spend a considerable amount of time abroad. Negative experiences in Germany and language barriers have also led to a mistrust of public institutions and a lack of knowledge of health care and social support structures. The narrative of older migrants and specifically guest workers emphasises social exclusion from public domains throughout their life, which continues to obstruct their access to services in older age.

Imagining gaps in the representation of older migrants

Informants noted that stereotypes and assumptions about older migrants exist, which require critical reflection. This includes the expectation that the extended family takes care of family members although family structures are subjected to socioeconomic aspects and sociocultural changes. Instead, informants mentioned that there are gaps of knowledge regarding the needs and wishes of ageing migrants, the extent of social exclusion as well as loneliness and isolation in old age. Interviewees remarked that feeling lonely or isolated with decreased mobility is a severe concern for ageing populations and even more for older migrants:

> *"The biggest problem is of course the isolated older people, that's the most difficult one. But of course, it's a bit more difficult with a migration background or with a history of migration, but ultimately it's also difficult for people without a migration background. The older ones who live in isolation, i. e. who are not involved in any clubs, who have no connection to counselling services, who do not have a large family network or families who do not have a network, who try to cope with this care situation in isolation by themselves. That's quite a tough nut, to get to them, and well to just spread the information about services. So yes, I think that would be the most difficult area."* (Interview 9)

This topic of isolation was particularly discussed by service providers who work directly with clients as the issue of loneliness and isolation also poses the question of who is not accessing their services. Because religious communities are described to provide additional support, counselling and a social network, they are viewed as an important source of support. For the informants, the connection to religious communities presents an important opportunity to reach potential clients, which needs to be further strengthened and encouraged by service providers.

Furthermore, the lack of contact was seen as an information gap as there is the assumption that people are missing in the social support structure:

> *"I think that maybe there are still some who are not cared for, but I can't prove it, because it could just as well be that they are all already so well integrated that they go to the counselling centres, that they go to the aged care centres. […] Well, I'm personally not sure that the requirements of these older migrants are even partially captured."* (Interview 14)

Isolated individuals are assumed to experience insufficient contact or support. In an interview during the covid-pandemic, one social worker further noted that this issue is now "*exacerbated through covid, because so many social contacts in everyday life were no longer possible, which had a massive impact on many and still does.*" (Interview 15). Thus, there is a gap in the understanding of older migrants in disadvantaged situations who are not visible and not included in the existing services. Thus, establishing contact would require new ways of reaching out, for example with religious communities, in addition to adjustments to existing services.

Aged care services as facilitators of inclusion

According to speakers, migrants have not been sufficiently considered in public spaces, which impedes the accessibility and relevance of these spaces for migrants. Language barriers, lack of information and bureaucracy are mentioned as major challenges regarding the accessibility of services. Among other areas of social interactions, language barriers affect medical diagnoses and treatment, applying for financial social support, accessing leisure time initiatives or receiving care services. Another consequence of language barriers is the lack of information on services available and how to access them. In addition, several of the informants displayed frustration with the bureaucracy of accessing public offices, applying for financial support or organising translators. One person describes going to public offices as trying to enter a “medieval fortress”, which creates a barrier for Germans and migrants alike.

> *“If we look at these obstacles that are in the system, they have nothing to do with migrants, because the Germans also have difficulties. […] And when they have filled it out themselves, don't believe that they can go and hand it in and settle or clarify the ambiguities. No, you can't get in there. The offices are closed. These are fortresses. These are medieval fortresses that you can't get into, you access them by computer and if you're lucky by phone, but most migrants can't communicate on the phone. You must be able to ask questions.”* (Interview 5)

Both the language used and the extent of administrative processes present a problem in the system that creates a challenge for all residents but particularly for non-native speakers.

Thus, a common thread throughout the interviews is that the accessibility of services and the inclusion of older migrants in public support structures ought to improve. The objective towards inclusivity is emphasised as the responsibility to improve access to services is placed on service providers. The public system is described as “guilty” or “in debt” to people with a migration background who have paid taxes, social insurance and broadcasting license fees for most of their working lives but had to accept that public educational, cultural, leisure and health care services were catered towards native Germans. In the Munich institutional context, the needs of older migrants are not seen as being incorporated into public services. According to informants old age provides an opportunity to address this shortcoming from earlier in life:

> *“Just as it is with the broadcasting license fees, as nothing is offered for them or the other things. So, there was no investment anywhere for these people, neither cultural nor health nor for the housing market, although they paid taxes. Not much was invested in any of these areas of the labour market, etc., not even for their children's children.”* (Interview 10)

> *“And we simply owe it to the older migrants. Well, this society owes them, because they paid into the tax fund, but they never used anything. They're not in the public swimming pools, they're not in the gyms, they're not at any free public events. So, someone just has to show them the way, that in old age you simply have time for it.”* (Interview 5)

These shortcomings are discussed and put forward to be addressed by creating new and innovative concepts that consider the needs and wishes of older migrants. Thus, aged care is identified as a responsibility and opportunity for delayed inclusion to address and rectify what has been missed earlier.

Intercultural openness is considered the main process to make services more inclusive. Informants highlight that the perspective of intercultural openness needs to be implemented in all areas from education programmes for nurses to the management structures of institutions. However, these processes are still presented as side or add-on projects that are only occasionally and slowly changing the system. Furthermore, informants noted that the diversity of migrants is likely to increase in the future, due to more recent migration processes and specifically refugee migration from African, Middle Eastern and Central Asian countries. A person working in counselling services proposes that a shift from culturally to diversity-sensitive approaches is necessary to consider individual aspects such as trauma, sexual orientation or religious beliefs. This is understood as especially important because of the increasing diversity of migrants in the future, which is related to recent refugee immigration to Germany.

> *"On the one hand, the traumatized people and also their sexual orientation, plus I do think that religion and the religious background play a role, so to speak that it is now not just culturally sensitive, but that it is actually in a broader sense diversity-sensitive, a diversity-sensitive approach would have to be developed. And yes, it would also have to be looked at individually, i. e. what is necessary and necessary for the person so that he or she is understood well, that he or she feels comfortable and that the treatment is then also effective, or the examination."* (Interview 15)

Thus, implementing cultural sensitivity is understood as an ongoing process that continuously requires reflection on other diversity dimensions. Addressing the needs of society, including people with a migration background, means adjusting services accordingly to the demands of both the minority and majority population and adapting services to the population as a continuous process.

Addressing the gap of people who are not yet reached

Providing for older migrants poses the question of how to identify people who are not accessing services yet. Providers suggest creating low-threshold initiatives to establish connections and bring services to communities. By connecting with religious groups or local migrant communities, better contact and relationships between older migrants and services could be established.

> *"And these information events always take or took – now* [the project] *is coming to an end – place in cooperation, that means sometimes in the mosque after Friday prayers. Where people meet anyway, that means the settings approach was tried to be implemented here. To create a going structure is, in my opinion, extremely important to take into account the settings approach, a going structure, cooperative and participatory structures and to continue them. Because all these stories of people*

holding separate information events and inviting people to go there, it doesn't work, and everybody knows that." (Interview 6)

The quote refers to a "going structure", which is related to outreach approaches in social work. Thus, going or bringing structures refer to actively going into communities to facilitate participation and connections. Improving access to services is understood as a longer, "step-by-step" process that will require adjustment and responding to the needs of disadvantaged migrant groups in the population. Taking this processual perspective and the focus on the life course of migrants and health risks during employment leads to a more preventative approach towards changes in the ageing population in the future.

As figure 1 summarises, the findings demonstrate that informants emphasise the need to adapt aged care services to a diverse ageing population as an ongoing process. This process aims to address the cultural diversity and heterogeneity of older migrants and to improve access and connections between services and clients. Thereby, migrants are defined by their language, culture and health, their needs in regard to services as the socioeconomic barriers they experienced. In the discourse expectations exist on both sides, firstly for services to improve their accessibility and for migrants to make use of these adjusted services.

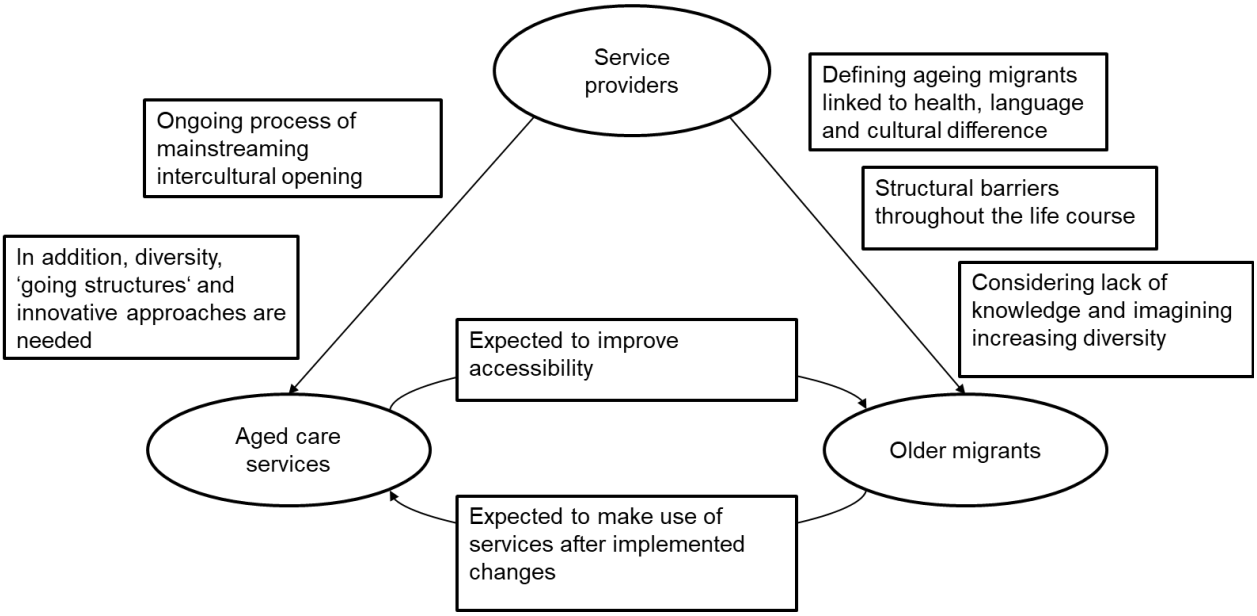

Figure 3: Institutional discourses on the understanding of older migrants and how to adapt services accordingly

Discussion

This discourse analysis demonstrates how professionals who develop, organise or provide aged care services understand older migrants in the context of public care services in Munich and how accessibility and inclusion into aged care are constructed as a public responsibility. The discourse centres on labour migrants and their socioeconomic position in Germany throughout their life course, while acknowledging heterogeneity among migrants and the increasing diversity of the ageing population. This focus on the life course perspective on older migrants and their social exclusion in the public sphere shapes

theoretical concepts of providing culturally and diversity-sensitive services and emphasises mainstreaming intercultural openness and diversity frameworks in all areas of aged care institutions.

Representation and responsibility in the institutional sphere

The narratives of older migrants in the institutional setting centre on their needs in the service sector and on social determinants that act as barriers to accessing services. Who was identified as a migrant relates to language proficiency, health care literacy and social inclusion. It is not surprising that care providers imagine their potential clients in relation to the accessibility of their services. Similarly, Ciobanu [25] shows that older migrants are associated with a "certain temporality and low socio-economic status" in Switzerland which hinders access to welfare. Furthermore, in the Dutch care context addressing the needs of older migrants is framed as a temporary solution, for example, because of language barriers, but not as a long-term reaction to the increasing diversity in the ageing population [6]. In this study, the main causes of limited accessibility are related to language and bureaucratic barriers, the discrimination and socioeconomic inequities migrants experienced in Germany and their transnational embeddedness between sending and receiving country. For example, circular migration with temporary visits to the sending country reduces the regular contact with service providers and thus requires greater effort to maintain networks with migrants [41]. Transnationalism has been gaining attention in the literature on older migrants in Europe [41, 42], yet there is little implementation of transnational policies in practice, especially in aged care. Thus, Brandhorst and colleagues [4] argue that the increasing cultural diversity and transnational lives in older age need to be addressed by a "migration turn" in aged care, which requires new policy frameworks with transnational social welfare and aged care agreements, such as portability of pension benefits. However, as discussed in the interviews, aged care services are still centred around limited mobility in older age and circular migration is a bureaucratic and organisational challenge for migrants and service providers.

The institutional discourse stresses the public responsibility to ensure inclusivity in aged care services and to acknowledge the heterogeneity of the ageing population. Informants thus felt that public services are in debt to acknowledge the cultural diversity in Germany and to address this diversity by responding with culturally sensitive services. This perspective on being responsible for tax-paying citizens also provides an alternative to reducing older migrants to vulnerabilities. Reiterating vulnerabilities at the ageing and migration nexus has received continuous critique in the past decades [25, 43]. Instead, the aim should be to arrive at a better understanding of the source of vulnerabilities and inequalities and generate more diverse images of diversity in later life [25, 44]. The consideration of the life course, the emphasis on social exclusion from public services and the prevention perspective on reaching older migrants earlier in life shape the discourse on providing inclusive aged care. This is particularly relevant in Germany as the reproductive lives of migrants, such as education, family and ageing, previously received limited attention under guest worker policies as "migration was considered temporary and linked to labour contracts and the productive sphere" [4]. Informants commented on this insufficiency in policies and argued that aged care should facilitate the opportunity for delayed inclusion in public service by informing ageing migrants of counselling facilities and creating contact, mainstreaming

cultural competency in institutions, developing new offers and services for a diverse clientele and reflecting and adjusting bureaucratic structures. The construction of aged care as a form of delayed inclusion – a response to limited accessibility to public spaces earlier in life – also stresses the process to implement accessible structures in public institutions at all phases in life and throughout the life course. Ultimately, informants remarked that health issues, social exclusion and apprehension of public services could at least partially be avoided with better cultural competency in public institutions. This perspective thus emphasises the preventive aspect of taking a life course approach to healthy ageing.

What can be gained from diversity frameworks?

Throughout the interviews implementing cultural or diversity sensitivity is presented as a core task to improve health and social care services. The aim is to implement cultural competency in all areas of institutions in line with the mainstreaming approach by incorporating cultural competency in training, education, organisational structures, counselling and services. Improving accessibility is presented as a long-term process that requires reflecting and adapting existing processes as well as developing new and innovative ideas to recognise the increasing diversity in old age. While intercultural openness remains the leading approach to implementing cultural competency in Germany, diversity management is gaining attention in aged care. The shift towards diversity mainstreaming [6] and the need to recognise the increasing diversity in older age [25] is recognised in other European immigration countries but is less established in German aged care institutions.

Mainstreaming diversity could prove beneficial to implement inclusion throughout institutional policies and structures that accommodate differences related to culture, language, religion, ethnic and socioeconomic background, gender, sexual orientation, mental and physical abilities in the ageing population. Tezcan-Güntekin [12] argues that shifting towards diversity-sensitive care can denote a shift from essentialised and static understandings of culture to intersectional perspectives that consider various forms of difference, their interactions and the associated power relations. Furthermore, taking a diversity perspective disentangles the previous overlap of culture, gender, religion, ethnic background and migration status and provides an alternative for a more nuanced perspective on what leads to limited accessibility of services [25, 44]. Hence, it offers a more detailed perspective on intersections of identity without reproducing generalised assumptions concerning older migrants' vulnerability, gender stereotypes or "traditional" cultural preferences, which have been common in the ageing and migration discourse in Germany [28, 42]. Yet, diversity frameworks have been criticised because of the vagueness of the term, which blurs inequalities and thereby may lead to an evasion of speaking about ethnic differences and the inequalities caused by ethnicity and race [6, 44]. Thus, inequities in older age need to be central to an implementation of diversity mainstreaming in aged care to ensure that the causes of inequalities are understood and addressed.

The discourse on ageing and migration in the institutional sphere underlines the responsibility of institutions to align their services to the diverse and multicultural urban population in Munich. This accountability to continuously adapt and improve public institutions is a core aspect of intercultural openness and also needs to inform diversity

frameworks to avoid placing the responsibility to access services on the individual [29]. Accessibility in the discourse refers to social (e.g. social work organisations, aged care facilities, counselling services) and health care (e.g. long-term care, rehabilitation, general practitioners) with social care acting as a connection to access the health system. Especially, residential long-term care is one example where both medical attention and social care benefit from a diversity sensitivity approach to address cultural, gender-specific or religious preferences and avoid inadequate care provision [12]. Furthermore, inclusivity in aged care is presented as chance for prevention and health promotion for older migrants by creating access to healthcare and offering physical and social activities. As figure 2 visualises, diversity and intersectionality frameworks help to shift the focus from migrant-specific intercultural approaches to develop services that cater to the diversity of clients by taking into account social inequities and cultural competency [45]. Furthermore, in the context of aged care, social work tools such as creating low threshold access and outreach approaches can further help to provide more practical frameworks on how diversity mainstreaming can be implemented. This is especially important as informants acknowledged that information on older migrants is lacking and that they only reach a limited population. Issues such as loneliness and isolation are thus likely to be underestimated among migrants and require more research in the future.

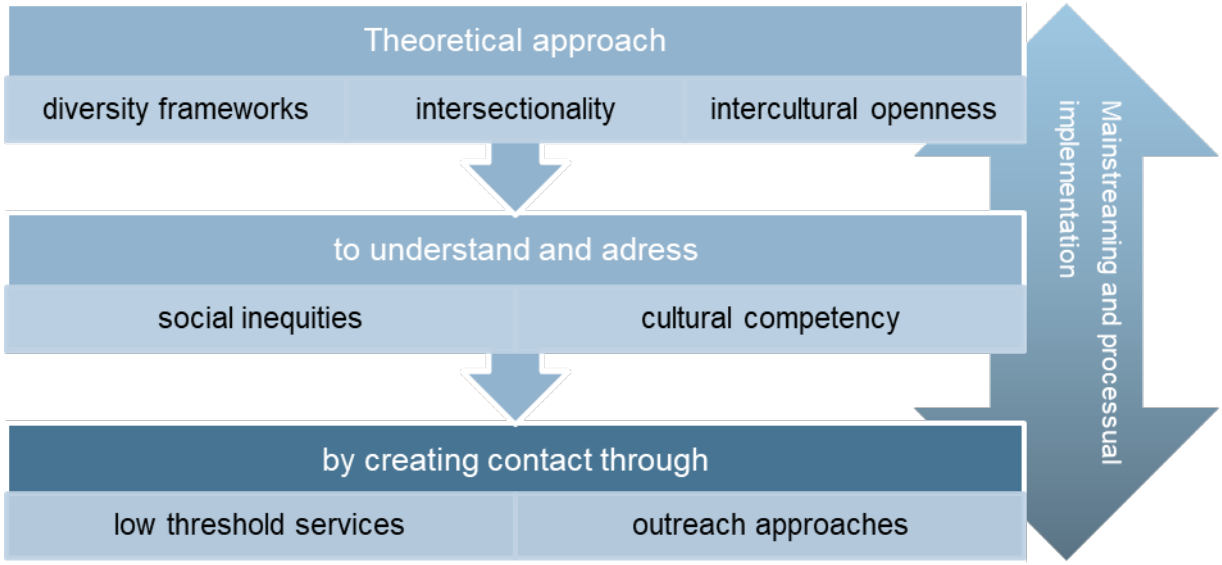

Figure 4: Creating inclusive structures for diverse ageing populations

Limitations

This research was carried out in Munich, a diverse and multicultural city. The migration history to Munich is particularly shaped by numerous arrivals of former guest workers in the 1950 and 60s. To acknowledge its migration population, the city of Munich supported various intercultural projects in the past years. This historical and demographic context influences how migrants are understood and discussed in Munich institutions. The results are thus specific to the Munich institutional context concerning the public discourse on ageing and migration in Munich. The data collection period of this study began in 2019 and continued during the covid pandemic, which had an effect on the availability of informants and might have affected how the accessibility of migrants was perceived by service providers due to

contact restrictions in 2020 and 2021 that also affected the use and availability of aged care services.

Conclusion

The institutional discourse demonstrates the aim to provide an opportunity for (delayed) inclusion in public services for older migrants, which is understood as something owed to migrants. The discourse centres on the socioeconomic disadvantages of labour migrants, the structural and language barriers they experience in Germany and the trend towards increasing diversity in older age. Professionals in aged and social care hence emphasise the need for improved access to health and social care services. Combining diversity frameworks with current initiatives of intercultural openness could provide a fruitful concept to firstly, strengthen cultural competency, bring diversity to the centre of institutions and mainstream diversity-sensitivity and secondly to better understand the causes of social inequities. Focusing on the sources of inequities and intersectionality provides a basis for inclusive services in old age and a better understanding of healthy ageing. Thus, in line with the agenda of the United Nation's Decade of Healthy Ageing facilitating inclusion in aged care can help to address those that have been left behind and support healthy ageing migrant populations.

List of abbreviations

SKAD – Sociology of Knowledge Approach to Discourse

Declarations

Ethics approval and consent to participate

The Ethics Committee of the Technical University of Munich waived the need for ethics approval for this interview study (2023-173-W-SR). Informed consent was obtained from all participants.

Availability of data and materials

The datasets generated and analysed during the current study are not publicly available due participants not giving consent to share the data publicly, but anonymized data is available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

AG collected and analysed the data and wrote the manuscript. RW contributed to the analysis and revised the paper.

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Footnotes

[1] In the German context the term migration background is used to refer to migrants. People have a migration background if they or at least one of their parents were not born with German citizenship. In this study, the term “migrants” refers to first-generation migrants who migrated to Germany internationally.

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Discussion

The publications provide a detailed analysis of older migrants' health, accessibility to health and social care, and the discursive construction of ageing well, cultural differences, and ethnicity in the context of ageing and aged care in Germany. The first article reviews the literature on forced and voluntary migrants' health throughout their life course and discusses how to address the health disadvantages of migrants later in life. The second paper focuses on ethnicity and culture categorisations in the ageing discourse. It demonstrates how migrants are constructed as ageing differently to the non-migrant population due to essentialised cultural differences and ethnic belonging that are linked with negative images of old age, such as age-related disengagement. The third paper examines understandings of what ageing well entails for migrants and shows how the construction of active ageing is related to individual and collective social responsibility. The paper thereby explores the subject position of older migrants and the phenomenological structure regarding the collective support and responsibility to age well and the public and municipal responsibilities in the discourse. The second and third papers explore ageing and migration discourses in Germany during the last two decades in documents published by health or aged care organisations, political institutions, welfare organisations, and migration or health-related magazines. For the fourth publication, interviews were conducted with 18 professionals working in, managing, or advising Munich health and social care services, which are analysed from a Sociology of Knowledge discourse perspective. Thus, this paper focuses specifically on the institutional-level and explores narrative structures and how knowledge of older migrants affects accessibility to aged care services.

The representation and othering of older migrants

How older migrants are imagined in the German discourse changes over the time span of the study and differs between the macro/national and the institutional/urban discourse. Both in the document and the interview analysis, older migrants are associated with a lower socioeconomic position, limited knowledge of the German language, and ethnic and cultural differences. These social determinants of health are related to a greater health risk, which is interpreted as an earlier onset of older age for migrants. The focus is on first-generation labour migrants from Southern and Eastern Europe and Mediterranean countries who arrived earlier in life and are now growing old in Germany. Although the heterogeneity of older migrants is acknowledged, universal assumptions about migrant preferences are frequently made. For example, migrants are described as generally more traditional in regard to gender roles and family care.

The document analysis demonstrates how the representation of older migrants develops from the early 2000s to 2019. Discursive events published in the first half of this time frame emphasise the ethnic difference between Germans and migrants and portray an image of separate or socially excluded migrant communities. This homogenisation of older migrants as the ethnic and social other and portrayal as a problem group has also been shown in Torres' (2006) research on older migrants in Swedish governmental and municipal documents. Furthermore, there is an emphasis on the ethnicity of others/migrants, while German ethnicity or culture is not discussed. In their paper on gerontological research,

Berdai Chaouni and colleagues (2021) argue that this essentialisation of ethnicity as something that "others" have obscures problems that may be related to minority status or class. Thus, the results of this research demonstrate that the nuances between migrant status, ethnicity, and culture need to be recognised to avoid an ethnicization of social problems among migrant populations.

Both in the document and interview analysis, the culture of older migrants is depicted as more traditional and family-oriented than the German ageing population. This portrayal is particularly emphasised for migrant women, who are seen as responsible for taking care of family members. Service providers noted that women access health and social care services for their family members to enquire about health issues or bureaucratic advice. In addition, interviewees remarked that migrant women particularly struggle with financial insecurity and low pensions, which is especially demanding when living in an expensive city such as Munich. Thus, women seem to find accessing health and social care services and benefiting from their networks easier than men but are understood to experience other challenges such as financial risks, taking on additional unpaid care activities, and struggling more with the German language. This gender difference is also shown by Palmberger (2017) in her study on older Turkish migrants in Vienna. She reports that women participate less in the labour market and work more at home for the family. However, both women and men actively participate in mosques, cultural centres, and political associations. Therefore, migrant and religious associations and access to aged care services play a protective role to support migrant women in old age (Ciobanu et al., 2017; Palmberger, 2017).

Over the time span of the document analysis, the focus on ethnicity and ethnic belonging decreases, which results in increased attention to socioeconomic aspects and cultural preferences. The interview analysis highlights the focus on socioeconomic risks through the narratives of migrants' social exclusion in Germany after migration. Thereby, the focus shifts from ethnicity to the societal factors that influence opportunities for healthy ageing.

Ethnicity and socioeconomic background are essential factors that must be considered and acknowledged. However, as suggested by the concept of super-diversity, ethnicity should not be a primary identifier of migrants that appears as an umbrella term for language, religion, education, socioeconomic status, or channel of migration. Recognising culture and ethnicity as a feature of all population groups and generations reduces constructions of us and them and offers a comprehensive perspective of addressing cultural values in older age. Furthermore, an intersectional lens can contribute to addressing vulnerabilities and sources of inequalities by questioning the interrelation of migrant status, gender, and class. Hence, taking an intersectional approach provides a nuanced perspective on older migrants without conflating socioeconomic challenges and culture under the terms of ethnicity or being a migrant.

Social and individual responsibilities to healthy ageing

A main criticism of existing frameworks to age well is the expectation of individual responsibility to keep active and healthy (Denninger et al., 2014; van den Bogaert et al., 2020). This expectation appears differently in public and institutional discourses. On the one hand, older migrants are described as responsible for taking care of their families and are praised for providing informal support for family members and their social networks. Thus,

activity, voluntary work, or care are located in the private sphere, whereas participation in voluntary public activities is associated with German culture. This subject position is more common in the document analysis part of this study and is linked to the more traditional image of older migrants. On the other hand, service providers discussed the responsibility of the public health and social care system to offer aged care services for all older persons. This emphasis on the public system also includes a critique that public services are not prepared for the increasing diversity in old age as only limited measures were implemented to acknowledge the growing number of ageing migrants. Thus, providing adequate services is understood as a "debt" that is owed to the migrant population.

Carlsson and Pijper (2021) relate the focus on local responsibility in aged care to a growing localisation of social care in the Netherlands, UK, and Germany. Thereby, municipalities are increasingly responsible for organising health and social care in local neighbourhoods. In the context of Dutch aged care, Carlsson and Pijper (2021, p. 2398) argue that with the shift towards localism older migrants are increasingly framed as "local communities rather than ethnic minority groups". However, the authors are sceptical that this change will benefit migrant populations as it moves national responsibility and guidelines to the municipalities, which creates room for interpretation on how to implement diversity initiatives (Carlsson & Pijpers, 2021). Yet, in the Munich institutional discourse, the shift towards public responsibility is connected to a long-term perspective of opening existing services, incorporating cultural competency, and improving accessibility for diverse ageing populations. Thus, the shift towards local communities also acknowledges the changing demographic of urban ageing populations and thus leads to a growing awareness of diversity in the aged care clientele. The narrative of public responsibility for healthy ageing, therefore, emphasises the need for diversity or intercultural frameworks to improve accessibility for all ageing populations.

Ensuring access to health and aged care services

How to improve access to health and social care services for older migrants is a central theme in the discourse of ageing and migration. This research investigates how improving accessibility and inclusivity is constructed on the policy- and institutional-level and how constructions of cultural differences and diversity influence theoretical frameworks that are applied to improve accessibility in aged care. The focus is on inclusivity in service provision, which is defined as creating environments that facilitate participation and address disadvantageous circumstances (Georgi, 2015).

The document analysis reveals two discourse strands concerning accessibility to services over the last two decades. Firstly, cultural differences are identified to obstruct access to services as migrants require cultural knowledge and health literacy to know about services and health systems. Furthermore, services do not cater sufficiently to people with different languages, religions, or food preferences. However, the repeated emphasis on ethnicity and culture shifts other aspects of accessibility (such as socioeconomic aspects) in the background. Thus, Lindblom and Torres (2022) suggest that moving away from othering based on ethnicity can provide a more nuanced perspective on older migrants' needs and preferences to achieve inclusiveness and equality of care. Due to the focus on ethnic groups and cultural differences, older migrants are predominantly positioned as "hard-to-reach" and

separate from public spaces within this discourse strand. Secondly, in more recent publications, developing connections between migrants and the public sphere is presented as essential to improving access to services. Thereby, the representation of migrant communities changes from inaccessible and private to open and resourceful structures that need to be linked to the public sphere. As argued by Brandhorst and colleagues (2021), the policy perspective demonstrates that migration and mobility are not primary considerations of policies which cater largely to immobile populations. Thus, a migration turn in aged care is needed to recognise the increasing transnational lifestyles of German residents.

In the urban institutional discourse, improving access to services is discussed as a central aim of institutions and less as the responsibility of migrant populations. Older migrants are thus positioned as “not-yet-reached” or “not informed” about aged care. In this context, the focus lies on adapting existing services, which have been designed for Germans but should reflect the growing diversity in older age. This change is brought forward by incorporating the concept of intercultural openness in service institutions and additionally recognising the diversity of migrants. One informant described improving accessibility as a “step-by-step” approach that requires reflexivity at all stages and needs to be integrated as an ongoing process. Intercultural approaches in Germany (Khan-Zvornicanin, 2016; Schröer, 2018) and diversity mainstreaming (Ahmed, 2007; Carlsson & Pijpers, 2021) have been critiqued as vague concepts, which leave ample room for interpretation and implementation. Taking a diversity-sensitive approach offers the opportunity to consider different sources of inequities and to move away from the emphasis on cultural differences. Besides, service providers stress the need to create contact with migrants in the local community and bring information on services to migrant communities, in the form of leaflets, through personal communications, or contact persons. Therefore, accessibility is strengthened through cultural competency, intersectional perspectives on social inequalities, and by combining these theoretical perspectives with outreach activities in the local communities.

To summarise, accessibility to services is primarily framed as opening and adjusting existing health and social care services, which includes new communication strategies, incorporating multilingual information material, networking with migrant communities, recognising religious diversity or training staff on cultural competence. Further measures are presented as essential additions to make existing services more inclusive, such as easy access to translation services and simplifying administrative processes. However, service providers did not prioritise creating new, supplementary, or migrant-specific social care spaces. Hence, ensuring accessibility and inclusivity for a diverse ageing population builds on intercultural and diversity frameworks as long-term and reflective processes.

Creating inclusive services: lessons learned

This research demonstrates that older migrants in Germany have been recognised as a growing population group in the past two decades in research, policy, and service provision, which has led to increased attention on improving accessibility to aged care services. However, further steps are necessary to establish health and social care landscapes that facilitate healthy ageing for all.

1) Theoretical perspectives from migration and ethnicity studies offer a valuable and necessary contribution to **Social Gerontology research** on ageing and migration.

The concept of super-diversity emphasises the heterogeneity of migrants and helps to assess migration-related social determinants for healthy ageing. Social constructivist perspectives on ethnicity challenge stereotypes and generalisations that essentialise cultural differences and *other* migrant populations to arrive at dynamic conceptualisations of ethnicity and culture. Furthermore, SKAD offers a fruitful methodology to analyse aged care provision in the context of (healthy) ageing and migration discourses. Taking a discourse perspective displays how age relations and ageism as well as stereotypes of ethnicity are linked with individual or public responsibility and translate into discourses on service provision. Thus, research and theories on social inequities must be integrated into frameworks of healthy ageing and intercultural approaches to aged care services.

2) **Healthy Ageing policies** need to consider the specific causes of poorer access (e. g. language, discrimination, or financial means) to improve health and social care services. Therefore, intersections of gender, class, migration status, and other social determinants of health need to be taken into account rather than emphasising ethnic differences between migrants and native populations. More specifically, service providers emphasised reducing bureaucratic hurdles as one important measure to improve accessibility for all older populations.
3) Informants agree that making **aged care service provision** more accessible presents a long-term process. This development provides an opportunity to build on the existing focus on intercultural openness to create diversity-sensitive and inclusive structures for all. Thereby, service providers emphasised the need to establish contact with migrant communities, incorporate outreach activities and communicate the aim for new networks and connections between religious organisations, places of leisure activities, and health and social care. Thus, reflective and adaptive approaches should guide theoretical frameworks to improve accessibility and inclusivity by considering the diversity of people.

Limitations

The documents were collected online and thus only include publicly available texts. Other publications in this field, which are unavailable online, are thus not included in the analysis. Especially in the early 2000s, only a limited number of documents could be identified online. However, central publications such as policy documents and organisational guidelines were readily available for the entire timeframe of the study. Furthermore, despite the growing attention on the ageing and migration nexus, the field is still developing, and some speaker positions repeatedly appear in the included documents. There is also a significant overlap of academic and policy/institutional discourses, which further demonstrates that publications on the topic are limited.

Unfortunately, the interview collection took place over a longer period than initially intended. Due to the covid pandemic, in-person interviews were not consistently feasible, and some interviews took place as online video meetings. The contact restrictions during the pandemic may also influence how participants perceived accessibility to services and contact with older migrants. Furthermore, some informants discussed the additional challenges of the pandemic, such as increased loneliness and reduced contact with services. In general, most professionals in the field were interested in sharing their experiences and stated that they felt

more research was necessary. However, some professionals responded that they were unavailable to participate in interviews due to time restrictions in their jobs in the care sector. Nevertheless, it was possible to include a diverse sample of professionals who work at different stages and areas in the health and social care sector in positions of providing counselling services to managing care provision.

The design of this study focuses specifically on policy-related and institutional discourses and how healthy ageing for migrants is imagined in German society. Thus, the results cannot inform on preferences and wishes of older migrants. Instead, this research provides insight into the connection between the representation of older migrants and service provision. Further research may investigate the micro-level perspective by exploring older migrants' attitudes towards healthy ageing.

Suggestions for further research

Several topics kept emerging in the data but remained side topics, which could be interesting to explore for future research. Firstly, the micro perspective on older migrants calls for further investigation. The informants also voiced this need during the interviews and wished to gain more information on this population group. Thus, a discourse perspective on the micro-level of perceived accessibility of services could provide a valuable addition to the institutional perspective of this research. Furthermore, researching social embeddedness and loneliness among older migrants still requires more research and could provide insight into specific barriers to accessing aged care services. In addition, quantitative studies on the use of health and social care services among older migrant populations are needed to address areas of lack of access and service use. Secondly, while this research discussed gender-related issues linked to service provision and accessibility, more detailed accounts of both migrant women and men in older age are needed to understand the intersection of ageing, gender, and migration, especially concerning isolation and loneliness. Finally, the challenges of very late-in-life stages for older migrants, such as hospice care, dying, and funerals, were mentioned occasionally in the interviews, but knowledge in this area is still limited and could provide an area for further investigation.

Conclusions

Older people in Germany are becoming increasingly diverse. In the context of the Decade of Healthy Ageing, this demographic trend urges us to ask how existing services can reach all older people and especially older migrants who have been shown to experience increased health risks with time spent in Germany. This study investigates knowledge constructions in ageing and migration, health and social care service provision, and improving accessibility and inclusivity in aged care. The results demonstrate different discourse strands over the last two decades on older migrants that are situated in power relations and the organisation of service provision. Older migrants have been positioned as ageing differently than the non-migrant population and are frequently described and understood in terms of cultural and ethnic differences. Furthermore, ageing well has primarily been placed in the social and collective structures of migrants and the responsibility of public institutions is only recently gaining more attention. Thus, the representation of older migrants affect how theoretical frameworks to improve accessibility and inclusivity are envisioned on the organisational- and

policy-level. Discourse analysis, therefore, provides a helpful lens to investigate how society understands and conceptualises healthy ageing for migrants and how these knowledge constructions affect responses and initiatives to address all older people. Ageing discourses are not just context-specific but become institutionalised and objectified as social practices through communication processes, service provision and underlying theoretical frameworks. Diversity frameworks in older age will require linking cultural competency with diversity-sensitive approaches. The Decade of Healthy Ageing is a chance to recognise discrimination and inequalities at the intersection of migration and older age and its effects on health, care, and social services. The aim of this research is thus to contribute to the gerontological imagination of older migrants, theoretical frameworks on service provision and to leave no one behind in the promotion of well-being in older age.

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Appendix

Data corpus

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