How local stakeholders’ social representations shape the future of ageing in place: Insights from ‘health and care social innovations’ in Wallonia (Belgium)

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Abstract
This research attempt to study the social representations underlying health and care social innovations (HCSI) implemented in Wallonia, Belgium to shift ageing policies and management towards the ageing in place paradigm. A panel of 34 experts was interviewed to understand their representations using a Delphi-based methodology. The data were processed using thematic content analysis. The core of social representations of health and care social innovations was related to five key dimensions: D1, responding to unmet or emerging health and care needs; D2, defining (new) targets and beneficiaries of HCSI; D3, disrupting care practices; D4, mobilising a network of key actors; and D5, encouraging political recognition of HCSI to favour its viability and sustainability. Local stakeholders’ social representations tended to recognise only the goal-oriented dimensions in innovations and ignore process-oriented aspects. The blind spots for workers’ participation and empowerment may jeopardise their working conditions, causing a cascade effect on the quality of services and the care relationship. This affected how health and care organisations responded to innovation and might also compromise the long-term sustainability of ageing in place practices in Wallonia.

KEYWORDS
ageing in place, Belgium, health and care social innovation, homecare, Social representations

1 | INTRODUCTION

Like many other European countries, Belgium’s population is ageing significantly. In Belgium, the dependency ratio of people aged 65 and over (when they are generally economically inactive) to those between 15 and 66 increased from 26% in 2011 to 29.9% in 2021 (European Commission, 2021) and is projected to increase to 37.7% by 2040 (Bureau Fédéral du Plan, 2016). In particular, Wallonia (the French-speaking region of Belgium) is known for its high rate of residential care in comparison to other European regions or countries. The European average is 4.3%, but 9% of Wallons over 65 live in institutions (Devos et al., 2019). If these trends continue, Wallonia will witness a 32% increase in the number of nursing home beds between 2010 and 2025 and this will considerably increase its budget.
What is known about this topic?
- Population ageing is increasingly becoming a driver of social innovations.
- Little is known about how local stakeholders understand and envision the notion of health and care social innovations in the field of ageing in place.
- The concept of social innovation is of growing interest to public health, scientific and political actors.

What this paper adds?
- Health and care social innovations were mainly oriented towards results and objectives aimed at beneficiaries’ well-being than on organisational processes or working conditions also aimed workers’ well-being.
- Five dimensions of innovation are considered in the social representations of local stakeholders, but the participation and empowerment of workers and beneficiaries is not included.
- This research deepens the understanding of social innovation in health and the enthusiasm of health and care actors and organisations, policymakers and scientists.

2 | BACKGROUND

Ageing in place (AIP) has become an increasingly popular concept in the ageing literature (Vasunilashorn et al., 2012). However, there is no consensus on its definition (Bigonnesse & Chaudhury, 2021). In line with WHO recommendations, AIP can be viewed as a complex issue that covers much more than just the healthcare services and practices specifically adapted to the domiciliary setting. It also encompasses the idea that public health strategies and interventions should ‘empower older people to retain control of their lives and make choices that are in their best interest’ (WHO, 2015, p. 36); whether through housing, support, or care, including home health services and nonmedical support (Wiles et al., 2012).

Population ageing is increasingly becoming a driver of social innovations (Heinze & Naegle, 2012). Social innovation refers to a new way of answering needs and bringing changes, particularly within social relations (Avelino et al., 2019) by embracing the ideas of social inclusion and cohesion (Ghiba et al., 2020). The urgency of this issue was acknowledged during the two global forums on innovation for ageing populations organised by the WHO in 2015 (WHO, 2016). In line with their statements in the World Report on Ageing and Health (WHO, 2015), the WHO stressed that the current healthcare system focuses on managing curable diseases and is not currently well designed to provide long-term assistance and home support. These forums provided recommendations seeking innovation for AIP, such as promoting a package of integrated health and social care services targeted to existing needs (WHO, 2016, p. 45).

European policies comprise several tools and programmes to encourage social innovation in active ageing, such as the European Innovation Partnership on Active and Healthy Ageing (Walker & Zaidi, 2019). Belgium also uses its National Institute for Health and Disability Insurance (NIHDI) to fund bottom-up initiatives for frail older adults to live at home under an agreement called ‘Protocol 3’ (de Almeido Mello, 2016). The government of Wallonia is encouraging social innovations in its regional policy plans for 2019–2024 (Gouvernement de la Région Wallonne, 2019, p. 122). As an essential part of the innovation development chain in the field of ageing, many disparate local stakeholders are already actively developing concrete policies. However, little is known about how they understand and envision the notion of HCSI in the field of ageing in place.

It is paramount to understand the local stakeholders’ social representations of HCSI and to gauge the extent to which these affect the innovative strategies deployed in the sector.

The theoretical framework of social representations (Moscovici, 2001) is particularly useful to understand how local stakeholders envision HCSI. When a new social phenomenon like HCSI appears, it is crucial to consider and analyse how different social groups develop social representations of it, as these representations can inform actions and strategies. A social representation is ‘a form of knowledge, socially elaborated upon and shared, having a practical aim and contributing to the construction of a reality common to a social group’ (Jodelet, 2003, p. 36). Through social interactions, actors develop a common vision for a new phenomenon. This vision gradually acquires a certain objectivity for group members as it is no longer one interpretation, but the sole reality (Moliner & Guimelli, 2015; Moscovici, 2001) that competes or resonates with other groups’ representations. Social representations are systems of interpretation shaped through social interactions, but they guide and organise both individual and collective activities because they are perceived as ‘objective’. They govern people’s relationships with others and the world. Because they underlie social interactions, Moliner and Guimelli (2015) referred to them as ‘cognitive determinants of practices’. Typically, social
representations are formed about social objects of concern with which people can identify and position themselves. In this sense, social representations of HCSI are significant to understand how local stakeholders picture the health and care needs of the population and policy constraints associated with AIP.

In the present study, local stakeholders are considered to be experts whose representations of HCSI are rooted in both scientific and political discourse. Analyses of these representations allowed for identification of (1) local stakeholders’ blind spots and points of foresight in relation to the scientific and political discourse on HCSI and (2) the potential cognitive levers and barriers to change and the ability to deal resiliently with current challenges in the sector.

3 | MATERIALS AND METHODS

3.1 | Context of the study

The analysis of social representations of HCSI was part of the WISDOM research, a multidisciplinary study project aimed to identify and analyse HCSI. The WISDOM research used a Delphi-based methodology to identify 42 HCSIs in the Walloon region provinces and Brussels (Callorda Fossati et al., 2017). The HCSI covered seven intervention areas (clusters): alternative housing, community projects, psychological support, respite for family carers, multidisciplinary approaches, projects with a technological component, and other minor services. Table 1 presents the clusters of identified HCSIs.

All the HCSIs described in Table 1 are not part of a central programme of the Belgian government and are independent of each other. Only three of them (HCSIs n15, n20, n27 in Table 1) are part of the ‘Protocol 3’ Convention which finances alternative forms of care and support for the older adults. All the others are initiatives that stem from historical homecare organisations or newcomer actors, relying on more hybrid forms of funding that include funding from regional and local authorities.

3.2 | Participants

To capture social representations at the individual and sector levels, two panels of experts comprising local stakeholders from health and care organisations in different geographical areas of the Walloon and Brussels regions were considered. Panel 1 (P1) comprised experts consulted individually (e.g. local actors, researchers and local officers in public agencies). To be selected for the panels, the local stakeholders needed to have direct knowledge of or experience with the sector in the Walloon context through three distinct professional pathways: management in the field, action research activities or involvement in policy development related to the sector. Panel 2 (P2) comprised of representatives of the employers’ federations consulted during collective meetings.

For P1, 51 experts were identified and contacted (72.5% women and 27.5% men) from the health and home care sector and 27 experts agreed to participate in the present study (response rate = 53%; 66.7% women and 33.3% men). Most of the experts (66.7%) had a high-responsibility function (e.g. project director or coordinator). Three researchers and one officer from a regional public agency also participated.

P2 had seven representatives (three women and four men) from umbrella organisation of non-for-profit organisations in the health and care sector: three employers’ federations in the field of home-care and nursing care and one federation of ‘medical homes’ specific to primary healthcare. These federations are all long-standing actors in the Walloon and Brussels health and care scene.

We collected data about the P1 experts’ social representations of HCSI using a self-administered questionnaire through the LimeSurvey platform. The experts answered four open-ended questions, enabling them to express their perceptions of the innovative character of the 42 HCSIs based on their first-hand knowledge: (1) What is innovative about this initiative? (2) How do beneficiaries use this HCSI? (3) What encourages the development of an HCSI? and (4) What limits HCSI development?

The P1 questionnaires yielded detailed descriptions which were emailed to P2 experts who used them to prepare a workshop. Data collection was carried out during a meeting of the steering committee of the WISDOM research, wherein all members gave their views on each of the identified HCSIs by answering the same four questions as the P1 experts.

3.3 | Data treatment and analysis

A thematic content analysis was performed on the data collected from the P1 experts by coding the written answers, segmenting them into units of meaning, and creating categories of analysis. For the P2 data, the entire session was recorded and transcribed and content analysis similar to P1 data was performed, highlighting both the dominant and marginal discourses.

4 | RESULTS

The content analyses identified five main dimensions of HCSI social representations held by the participants: D1, responding to unmet or emerging health and care needs; D2, defining new targets and beneficiaries of the HCSI; D3, disrupting care practices; D4, mobilising a network of key actors; and D5, encouraging the political recognition process of HCSI.

4.1 | Dimension 1: Responding to unmet or emerging health and care needs

 Experts generally perceived HCSI in terms of the objectives to be achieved. These objectives target specific groups or areas and reveal a complex understanding of health and care needs. HCSIs are characterised by their ability to respond to specific emerging health and
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<td>HCSI n37 'Remote Assistance':</td>
<td>telephone equipment for the older adults and a mobile teleassistance system controlled by the call centre</td>
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<td>HCSI n38 'Fall-Prevention at Home':</td>
<td>telemonitoring centre detecting falls among older adults, with immediate family notification</td>
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<td>HCSI n39 'Tele-Relief: Connected to Caregivers':</td>
<td>telemonitoring system based on solidarity and allowing respite for caregivers</td>
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<td>HCSI n40 'Smartcontrol':</td>
<td>new process of work organisation through a new technological tool for homecare workers to manage their care provisions</td>
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care needs of older adults (and their caregivers) and others whose needs have not been sufficiently met by the current health and care system. The following excerpts from the questionnaires illustrate this fundamental dimension, towards which all others converge.

This initiative is adapted to the needs of the beneficiaries and fills a gap, a new need for accompaniment, communication, and planning related to the medical care of daily life and the end-of-life course and daily life. (P1)

This innovation helps to encourage cities to better adapt to the needs of older adults. (P1)

This practice meets the specific and obvious need for beneficiaries with Alzheimer’s disease. (P1)

The specific needs that the experts referred to were diverse and classified into six categories:

a. Tackling social loneliness (about ‘Under My Roof’)

Adaptive living with students allows seniors to live together in ways that are not isolated or cut off from the living world. (P1)

b. Adapting to complex health and care needs related to dementia (about ‘It’s My Life!’)

Specific support for Alzheimer’s-type illnesses and the establishment of a centre of expertise focused on support, training, and research on healthy ageing. (P1)

c. Respite for caregivers (about ‘At Any Time’)

The meeting between the management and homecare workers of the service revealed a lack of support and respite for caregivers. (P1)

d. Assistance in taking medications at home (about ‘Pillbox’)

Medication issues alone can sometimes affect ageing in place. This innovation contributes to a reduction in the risk of errors in taking medication. The simplicity and financial accessibility of this practice allows us to solve one of the major problems of home care. (P2)

e. Improving the physical accessibility of services (about ‘The Weaving’)

The psychological support provided in combination with dietary and occupational therapy advice and wellness care makes this innovation a comprehensive support for older adults at home. These visits break the feeling of loneliness. The older adult becomes someone again, psychologically supported, and physically valued. (P1)

f. Improving the financial accessibility of services (about ‘It’s My Life!’)

Free psychological support for older adults with the disease or their caregivers who are indirectly affected, helping them to understand, accept, and gradually adapt to their difficulties. (P1)

According to experts, HCSI should prioritize the well-being and overall quality of life of older adults and caregivers, thereby aiming for social change. A vision which was mentioned in P1 but discussed in detail collectively in P2 envisaged a transformation in the work organisation to improve older adults’ and workers’ well-being. One expert suggested that HCSIs needed to promote ageing in place with innovations at both, the frontline and organisational level, by taking a more democratic approach.

I think that any structure can innovate with a social aim independent of its operations, just because it will develop a socially innovative process in the way it provides the service. However, if the way of producing the service goes towards more democracy at work, then it is a social innovation. (P2)

4.2 Dimension 2: Defining new targets and beneficiaries of HCSI

The second dimension of the discourse dealt with the groups targeted by the initiative: older adults and caregivers. Referring to one HCSI, an expert stated that:
...the willingness of older adults to come together and participate in activities. (P2)

This concerns independent older adults as well as those losing their autonomy owing to specific or complex needs (dementia, mobility issues), isolated or accompanied, underprivileged or not, and with or without health problems. Another expert insisted on the need to consider the target groups collectively and not purely as individuals.

It is very important that the HCSI proposes to take care of groups and not only individuals. This is innovative in relation to the multiple needs and demands that we face in the sector. There are few offers to alleviate the problem of isolation, allowing older adults to experience social relationships with their peers. The example of ‘Community Care Homes’ responds well to this, as does the ‘Medical Centre Home Ravia’, because there is medical care with an interesting collective dimension. (P2)

Experts referred to the target public and caregivers, who assumed a significant part in caring for older adults as beneficiary. One expert appreciated initiatives such as ‘At Any Time’ for allowing caregivers to take a break while the older adults are accompanied by a qualified team (P1).

4.3 | Dimension 3: Disrupting care practices

The third dimension refers to novelty and disruption within existing practices which was a subject of debate among experts. Several experts pointed out that non-profit organisations developed a completely new HCSI in Wallonia to fill a gap in the existing health system.

‘At Any Time’ is a response to the lack of infrastructure for Alzheimer’s disease in the province of Namur that complements the existing offer of assistance and care at home. (P1)

Another expert said that the initiatives must break away from existing practices to be considered innovative.

These practices must be innovative in terms of offering services to the population and being nonexistent in the official, recognised, and subsidised circuits. They must be experiments that open up new avenues, whether they are recent or older, that respond to the basic needs of the older adults and to needs that are not considered, such as the ‘Community Care Homes’ initiative. (P2)

Nevertheless, not all experts shared this vision. Some believed that an HCSI need not break away from existing system and could also be a critical adaptation of the standard healthcare system to enable AIP

One example is ‘The Weaving’, a psychological support service provider which provides in-home services in response to older adults’ mobility problems.

This project is innovative because it provides psychological support and assistance to frail people at home in their wish to live at home. (P1)

Similarly, an innovative project developed in another territory for another category of users adapted to a specific context was also considered an HCSI. This was particularly true for intergenerational housing projects built on existing international projects, such as ‘Under My Roof’. However, some experts did not agree with this point of view. They considered that an HCSI or adaptations that fell outside the main field, could be considered as an HCSI irrelevant to ageing in place:

The innovations here are aimed at responding to the aspirations of older people to age in place. Therefore, the whole aspect of alternative housing is not something I have taken into account. I have the impression that we often go beyond the scope of ageing in place. (P2)

Moreover, ‘newness’ might indicate an original intervention that combines existing elements. For example, an initiative such as ‘Pillbox’ might combine the professional competence of a healthcare provider with technology to manage medications.

It is the coupling of technology and remote human monitoring of medication intake by professionals, which provides an innovative solution to health problems validated by general practitioners and promotes ageing in place. (P2)

However, there was no real consensus on the innovativeness and adequacy of the technological dimension. For one expert, any technological innovation could be considered a necessary innovation for ageing in place, but it would not contribute to the goal of desired social changes:

If we want to contribute to ageing in place, we need a lot of technology, and this is my perception as a general practitioner who follows patients at home. However, they cannot be considered socially innovative initiatives. This is technological innovation. A technological tool can solve technological problems but can never solve social and political problems. (P2)

4.4 | Dimension 4: Mobilising a network of key actors

According to experts, it is essential to mobilise multiple key actors at different moments in the innovation process to
implement an HCSI. The primary experts mentioned were local workers and associative partners embedded in multidisciplinary collaborations. Workers were considered field operators and not as active key actors in design, development or evaluation process linked to HCSI, which was left in the hands of organisations’ managers.

The field operators were multidisciplinary frontline workers who worked in close collaboration in certain HCSIs: healthcare providers, homecare workers, mental healthcare providers, general practitioners, social workers, occupational therapists and professionals specialising in Alzheimer’s issues or remote assistance.

A multidisciplinary team allows support of the older adults in a global way. (P1)

Multidisciplinary approaches such as ‘The Weaving’ that combine several types of professionals in innovative practice are strongly emphasised.

The multidisciplinary nature of the professionals helped to make this new initiative known throughout the borough and to identify situations where frail older adults were particularly in need of this type of intervention. (P2)

It was also found that the development of new collaborations among members of organisations and various actors, such as a solidarity network with volunteers, was considered a driver for HCSI. Initiatives such as ‘A Breath of Air’ fostered innovation through a partnership between different homecare organisations and volunteer movements (P1).

Volunteers were also recognised as key actors who filled the gaps in the existing home-help landscape through their reassuring presence with isolated older adults. Experts described the ‘Solidarity and Volunteering’ initiative as:

The volunteers receive as much as the older adults they accompany, and this is one of the first associations in organising a network of volunteers trained to listen for the support of isolated older adults. (P1)

A few experts mentioned citizens as key actors in innovation citing by example ‘Alzheimer’s Traveller Belgium’:

It is an initiative organised by citizens who have been closely affected by Alzheimer’s problems. (P1)

Another expert appreciated intergenerational housing:

This innovation was created and developed by citizens following the observation of an alternative demand for care for the older adults in the context of the economic crisis. (P1)

Finally, some experts mentioned the role of researchers in the process of designing, deploying and demonstrating the positive impact of innovative practices.

4.5 | Dimension 5: Encouraging political recognition of HCSI

A final, transversal dimension that experts highlighted was political authorities’ recognition of HCSI to ensure the viability and sustainability of the initiatives and, consequently, the personnel involved. The dimension was debated upon among experts. Some considered it necessary for an HCSI to continue beyond its pilot phase and be consolidated in the homecare sector:

The question of ‘How does a social innovation at a given moment leave the field of experimentation and become stable and recognised?’ is fundamental because social innovation for the sake of social innovation means conducting experiments. For us, it is interesting to implement new practices that can be recognised and sustainable. (P2)

One expert gave the example of ‘Community Care Homes’ to highlight the importance of financial support.

There is a lack of financial means and no recognition or subsidy from public authorities, which hinders its sustainability. (P1)

However, recognition may carry legal or financial risks. Also, the practice and its social meaning at the time of conception might be distorted when ‘commodified’ (P2).

Beyond funding, there is also a legal framework that needs to be adapted. Sometimes, the financial recognition of public authorities risks distorting innovation if the reflection is not done with historical innovators. What is recognised can destroy the truly social aspect of the practice, whereas this is the primary objective of the initiatives. (P2)

Finally, when recognition favours an initiative’s sustainability, maintenance of jobs and dissemination on a larger scale, some experts wonder whether an HCSI is still considered an innovation and a vector of change:

This raises the question of whether, when an initiative is disseminated, we can continue to talk about social innovation. Because we realise that in the social innovations that have been identified, some are old, have been recognised, and are still identified as innovative. Therefore, this is a real question. (P2)
4.6 | Schematic conceptualisation of the results

From the results presented above, the social representations of the dimensions qualifying HCSI and their interrelations were synthesised and structured in Figure 1.

5 | DISCUSSION

5.1 | Contributions on the issue of social representations of HCSI

To enable older adults to age at home as much as possible, Wallonia has encouraged many social innovations. Local stakeholders’ shared visions of the innovative character of emerging ‘ageing in place’ initiatives involve unmet or emerging health and care needs, well-defined beneficiaries, novelty, multiple stakeholders and political recognition. These five dimensions constituted the core of the experts’ social representations of HCSI and how they expressed the common ground of what was counted as an HCSI. However, their social representations are not monolithic blocks. There were nuances within the groups that suggested either specificity due to the nature of their expertise (in particular, experts’ professional pathways and values) or the instability of social representations ‘under construction’ (i.e. emerging phenomena).

Local stakeholders’ representations were also compared with those conveyed by the political and scientific discourse. Certain resonances and divergences emerged that helped in identifying local stakeholders’ blind spots and points of foresight. As far as these social representations could be considered as ‘cognitive determinants of practices’ (Moliner & Guimelli, 2015), these comparisons enabled the identification of potential cognitive levers and barriers to transformations in the sector.

The contribution of our article for researchers lies in its original approach to study of health and care social innovations through the prism of ‘social representations’. These are not taken-for-granted by historical and new actors. Their visions may converge or diverge, revealing important issues and shaping the future orientations of the health system—in particular for ageing in place—in a given geographical and socio-political context.
5.2 | Resonances and divergences in the debate on social innovation

First, the social representations in this study were structured around five major themes found in literature and political discourse on social innovation, particularly social economy (Choi & Majumdar, 2015) and healthcare perspectives on social innovation (van Niekerk et al., 2017). However, recent research on HCSI argues that the most important dimension of innovativeness is extending financial accessibility (van Niekerk et al., 2021). This aspect was treated as a subcomponent of D1 and not a central dimension as all HCSIs are set up by public or non-profit organisations that prioritise access in their mission. To some extent, innovators are embedded in their context and often reproduce meanings, as they have limited space to change things themselves (van Wijk et al., 2019). The identified dimensions probably reflect a limited capacity for action. It can be noticed that tensions exist on what does or does not fall within the scope of HCSI. For some, alternative housing or homesharing (Martinez et al., 2020) remains outside the field of health and social care. These alternatives are mainly implemented by newcomers and challenge the views of historical actors on the field. Similarly, for historical actors in primary healthcare to consider gerontotechnologies as HCSI is a matter of concern. The point made is that of the threat of technology replacing the care provided by professionals and as underlined by the literature (Tom et al., 2019) the need of having a broader societal debate on gerontotechnologies.

Second, the results showed a plurality of social representations of the types of HCSI going beyond the classic field of personal services and homecare and healthcare. The seven areas of HCSI interventions cover a wide range of needs not met by the current care system.

HCSIs tend to be conceived as lever to fight against the exclusion of certain marginalised groups of older adults such as people with impaired cognitive abilities (e.g., dementia) as recommended by Resvik et al. (2021), people lacking autonomy to carry out daily activities, lonely or isolated people (Fakoya et al., 2020), or people whose geographical situation makes it difficult to access services.

However, it should be noted that the innovations studied are rarely oriented towards older adults with very marginal characteristics such as income poverty, heavy physical disabilities, cultural diversity or recent migration. This should be the subject of more global reflection by local actors, public policies and researchers, to avoid creating further social inequalities in health among the older adults (Greenfield, 2018; Hoebel, 2017; Kristiansen et al., 2016). More generally, it is plausible that looking at the needs of the most socially of medically marginal people could be of great inspiration for the emergence of original and disruptive HCSIs which, eventually, could also meet part of the needs of the majority.

Third, to face the challenge of deinstitutionalisation and to encourage ageing in place, a multitude of HSCIs have emerged driven by different actors. This offers multiple visions of social transformation in the landscape of ageing in place. The wide range of unmet needs pointed out by the experts reflect the limits of the care system in place and the need for actors to rethink and reconfigure the traditional model of care to find comprehensive and adequate responses by articulating better the modalities and forms of support for ageing in place by going beyond visions and working in silos. Care needs must be considered globally, and the organisation of the system must be based on networking, with a territorial approach.

Fourth, local stakeholders’ dominant social representations revealed that the HCSIs were mainly oriented towards results and objectives aimed at beneficiaries’ well-being than on organisational processes, operational practices or participatory governance. According to Grimm et al., ‘process-oriented social innovation’ is defined primarily as a means to an end and not as an expected outcome of an implemented process (Grimm et al., 2013). However, this is not how both panels thought about it, although the network of key actors (D4) and political recognition (D5) were the issues at stake. Other case studies have noted that social innovation is ‘limited to the instrumental and technocratic paradigm of social innovation as a means to an end’ (van Niekerk et al., 2021, p. 22). Social representations can be based on an approach that could be described as ‘innovation for’ rather than ‘innovation with or by’. There was no mention of participatory or democratic decision-making processes or processes that involved the key actors directly concerned, particularly the beneficiaries and the organisations’ workers. They more focused on the well-being of older adults and caregivers than on the well-being of workers and their working conditions as we find in the study by Bensliman et al. (2021). Thus, experts’ views on the social representations of HCSIs vis-à-vis AIP suggest that few HCSIs envisaged a transformation towards more internal democracy in work organisations or aimed at the well-being of both the older adults and the workers.

Two opposing lines of thought emerge. The first concerns the more instrumental HCSIs, designed and implemented by top-down decisions to optimise production processes that impact the quality and conditions of the services (Jetté & Lenzi, 2020, p. 78). This was closer to ‘innovating for’. The second concerns innovation with more participative governance, initiated or co-constructed with the key actors, users, or professionals favouring social relations and the success of the HCSI. This was closer to ‘innovating with or by’. While co-creation, or co-design, is a popular concept in policy discourse to encourage the active participation of local actors (van Niekerk et al., 2021), our results show more social representation initiatives were top-down, goal-oriented HCSIs than bottom-up, process-oriented HCSIs.

Results also showed that experts’ social representations of HCSIs expressed an aim to attend to needs of older adults but a tendency to neglect workplace organisation and working conditions. This observation was in line with a review of 67 articles on innovations in eldercare by Schultz et al., who found ‘a serious lack of research in the working environment. There was a surprising lack of innovative initiatives in recruitment and organisational processes’ (Schultz et al., 2015: p. 49).
Various academic disciplines and policy discourses (Grimm et al., 2013) have analysed social innovation as a multidisciplinary concept. Recent scientific research on health has shown an interest in social innovation (Halpaap et al., 2020) as a potential solution for fostering transformation in current health provision systems worldwide (van Niekerk et al., 2021). Despite scientific progress, health inequalities remain because health programmes are top-down processes that do not necessarily consider the lived realities and socioeconomic contexts of their served populations (van Niekerk et al., 2021). A systematic review showed strong parallels between the social determinants of health approaches and social innovation, which can impact promoting health equity and tackling health inequalities (Mason et al., 2015).

Social innovation in health is an effective process because it involves the community participation of key local and institutional actors to achieve social change and improve the overall health and well-being of populations (Ghiga et al., 2020; Halpaap et al., 2020). Farmer et al. recommended exploiting social innovation theory as an analytical framework for deploying health service innovations co-designed with the community in a purely bottom-up approach (Farmer et al., 2018).

The present study showed that local stakeholders were oriented towards the objectives but not towards complex processes. Current and future challenges of AIP require effective participation of the community, confirming the need to understand the place of community actors and beneficiaries whom the health services cater to. An essential contribution of this research is that it deepens the understanding of social innovation in health and the enthusiasm of health actors and organisations, policymakers and scientists. It also highlights that in the process of improving the quality of life for older adults or vulnerable populations, no key actors should feel that the innovations are harming them by creating unfavourable working conditions (Casini et al., 2018), an issue that has been neglected by social innovation literature.

5.4 | Strengths and limitations

A team of multidisciplinary researchers carried out this study, strengthening it with crossover expertise in social innovation, a multisectoral research issue touching on economics, sociology and public health, including ageing. The novelty of this study is that it focused on local stakeholders’ points of view by using a survey on social representations of HCSI answered by two different panels of concerned experts. Nevertheless, this study design did not include the beneficiaries’ social representations, which would have been useful for obtaining a wider, cross-sectional vision of the representations on HCSIs. However, given the objectives of this study, the choice to focus on local stakeholders in the field was relevant. We were interested in collecting the social representations of the field actors and employer federations with regard to the current and future necessary social transformations in the care landscape, as they have an active role in driving the innovation dynamics in ageing in place. For this reason, we did not consider it relevant to include trade union organisations representing workers in the sample.

5.5 | Future research

This study of representations of social innovations in a specific sector offers insights into the meaning that ‘social innovation’ takes in the field. However, it did not provide evidence of how an HCSI might directly empower or enhance the well-being of beneficiaries, patients or frontline workers. Further research is needed to understand the roots of the social representations of HCSI that recognised the dimension of multiple key actors (D4) but tended to erase the roles and needs of workers. For example, it would be interesting to analyse the role of workers in the emergence of an HSCI and the extent to which it involves participation and empowerment. Action research with frontline workers in social innovation contexts could be a promising approach. Similarly, it might be useful to address the question of how HCSIs impact well-being at work and service quality in an innovation dynamic.

6 | CONCLUSION

In this study, local stakeholders’ social representations tended to recognise only the goal-oriented dimensions in the innovations and ignored process-oriented aspects. Their blind spot regarding workers’ participation and empowerment may jeopardise working conditions and negatively impacted the quality of services, particularly in the care relationship. This study recommends that policymakers, governments and institutional (social) entrepreneurs promoting the development of HCSIs give more consideration to this process and participatory dimension; otherwise, it could affect the way health and care organisations respond to the need for innovation, impact the sustainability of HCSIs and ultimately undermine the long-term policy of ageing in place.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.
DATA AVAILABILITY STATEMENT
The questionnaires used for P1 and P2 are available upon request from the first author.

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