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Ageing in peripheral areas. Socially innovative practices to contrast the isolation of frail elderly people in Italy

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ABSTRACT Italy is one of the countries with the oldest population in the world. In spite of that fact and the alarming estimates about future demographic trends, long-term care (LTC) policy is still struggling to be acknowledged as a relevant issue in the public debate and political agenda. Against this backdrop and in sharp contrast with the frozen scenario experienced at the national level, since the early 2000s many territories – especially in the North of the country – have been developing several socially innovative pilot projects in the field of LTC, addressing the challenge of building more inclusive local care environments for frail (dependent) elderly people and their families. Among these solutions, it is possible to include those explicitly aiming at trying to combine the advantages of ageing in place with the reduction of the connected risks of isolation, particularly relevant not only in large urban areas, but also in more peripheral territories, where population density is lower and transport services are less developed. Building on this background, the paper has three main goals: 1) to provide a "workable" definition of socially innovative policies and practices in the field of LTC; 2) to analyze a set of selected socially innovative policy solutions meant to enhance the inclusion of the "cared at home" frail elderly people and their families, and implemented over the last decade in two Northern Italian Regions, Piedmont and Lombardy; 3) to investigate and discuss the factors behind the adoption of such policies and practices at the local level. Preliminary findings suggest that to make sense of the novelties observed in the selected cases under review, we ought to focus on the interplay between raising functional pressure and the emergence of local multi-stakeholder networks, with partnership involving local public institutions, with a steering function, and other key players (NGOs, bank foundations, social partners, private companies).

Keywords: Ageing in place, Long-term care, Social innovation, Social inclusion, Italy

1. Introduction[1]

According to the OECD's most recent figures, Italy is one of the countries with the oldest population in the world. With an old-age dependency ratio equal to 36.3, the share of elderly people (65+) to working-age individuals (20-64) is second only to that of Japan. In spite of that fact and the alarming estimates about future demographic trends, long-term care (LTC) policy for frail elderly people in Italy is still struggling to be acknowledged as a relevant issue both in the public debate and in the political agenda.

From a comparative perspective, Italian LTC public policies are generally assessed as being largely unfit to address the socioeconomic challenges coming from these major sociodemographic trends (see NNA, several years; Gori, 2010; Ranci and Pavolini, 2013). Although the overall figures on LTC public expenditure appear roughly in line with the average values of other European countries, the Italian case stands out due to a number of key elements. Compared with other European member states, such as France, Germany and the UK, which have developed more coherent systems to respond to LTC needs, the peculiarity of Italy consists of a polarization in the supply of LTC between two poles: informal family-based home care solutions on one hand and full institutionalization on the other (Riva 2015; Maino and Razetti 2019; Madama, Maino and Razetti, 2019). We argue that this situation is directly linked with the shortcomings (in some cases, the full absence) of intermediate solutions that, in other countries, have been established to bridge the gap between pure informal home-care assistance provided by families and residential health-care driven assistance.

Despite high functional pressures during the last two decades no major reform of LTC policy has been adopted in Italy, hence leaving unanswered the question of how to take care of the growing number of vulnerable elderly people who are largely dependent on the abilities of (shrinking) families. While institutionalization rates are comparatively low, and public home care services are poorly developed, since the 1980s, the major national measure to support elderly people in need of care consists of a flat-rate, unconditional cash-transfer, which has been shown to be highly ineffective in meeting the costs of care in the private market, thus making it a disproportionate burden for households (especially those that are medium-low income) (Albertini and Pavolini, 2015; Luppi, 2016; 2018)[2]. Most families, therefore, end up taking care of the elderly at home, often directly (through informal care, especially from female relatives), sometimes indirectly (by hiring a caregiver or a helper, who is mostly often foreign and in the shadow economy), most of the time with mixed solutions.

These "informal welfare" tools present both virtues and vices. While families often appreciate having their relatives assisted in their home environments, closely supervised by flexible and cheap workers, on a one-to-one basis, research has also underlined this model's pitfalls. Lack of qualification, exploitation and overwork, informality (often paired with migrants' undocumented status) and difficulties in managing the employer-employee relationship in a domestic and highly emotional field represent major obstacles for the provision of adequate, sustainable and equitable care services to the elderly population.

Against this backdrop, despite the institutional inertia in the field of LTC at the national level, the intersection between the mounting unmet care needs and constrained public budgets has fostered the emergence over the last two decades, in some local contexts, of a number of socially innovative pilot projects and initiatives. In sharp contrast with the frozen national scenario, many territories – especially in the richest areas located in the Northern part of the country – have in fact been developing a number of pilot projects in the field of elderly care and LTC, addressing the challenge of building in novel and creative ways inclusive local care environments for frail (dependent) elderly people and their families. Some of those initiatives, in particular, address the risk of isolation of frail elderly people, trying to combine the advantages of ageing in place with the reduction of the connected risks of living isolated, particularly relevant not only in large urban areas, but

[1] This paper stems from the two-year research project "InnovaCAre - Enhancing Social Innovation in Elderly Care: Values, Practices and Policies" which involves the University of Milan and the Vita-San Raffaele University. The project is funded by Fondazione Cariplo through the Call "Aging and Social Research: People, Places and Relations (2017)".

[2] For an updated overview of the Italian public LTC system, see Jessoula *et al.* (2018); for a review of the different LTC national systems at the European level, their features and trends, see Spasova *et al.* (2018).

also in more peripheral territories, where population density is lower and transport services are less developed.

Social isolation and loneliness determine negative effects, especially on elderly people and especially if they are associated. As pointed out by Elmer (2018), social isolation can be defined as having a small or non-existent network of kin and non-kin relationships, or minimal contacts among network's members. Social isolation is an objective condition and can be measured by observing different individual characteristics such as status and density of relationships, living arrangement, number of friends as well as functional elements such as the frequency of specific types of interactions and the availability of social support. Loneliness, on the contrary, is a painful emotional experience resulting from a perceived gap between one's actual and desired relationships. Unlike social isolation ("being alone"), loneliness is therefore subjective ("feeling alone") since it is based on the subjective evaluation that the type, quantity, and the perceived quality of one's relationships are lacking and failing to meet one's individual needs and expectations. Put simply, a person is lonely if he or she "feels" lonely.

Situating within this framework, the article deals with a selection of five case studies in which LTC needs are addressed in combination with measures to contrast the risk of social isolation among elderly people ageing at home and/or of their caregivers living in peripheral areas. In doing so, the paper has a threefold perspective. First, drawing from existing comparative studies on social innovation, the paper asks how can "socially innovative" solutions in LTC be defined. Second, the paper aims to provide a comparative overview of a set of selected programs implemented in two Northern Italian regions, namely, Piedmont and Lombardy; we explore the social innovation potential of these solutions, which stand out for falling between full institutionalization and full family-based care. Third, from a more interpretative standpoint, empirical evidence and field research allow us to advance some preliminary hypotheses about the factors that might be key to explaining the adoption of socially innovative policy solutions in those local contexts. In particular, the article develops three main hypotheses related to: the mobilization of a series of private actors and stakeholders (nonprofit organizations, bank foundations, social partners, private companies), the creation of multistakeholder networks involving local public institutions, and the strategic valorization of the financial support made available through private funding and/or the EU's social funding.

The article proceeds as follows. Section 2 addresses the most recent academic literature on social innovation to develop a working definition of socially innovative LTC and elderly care policies and to conceptualize the notion of an "inclusive local care environment". Section 3 presents a comparative overview, relying on a common analytical grid, of five selected cases of socially innovative LTC measures run at the local level in Piedmont and Lombardy. Section 4 finally turns to interpretation and concludes by advancing and discussing three explanatory hypotheses that help to shed some light on the factors that favored the setup of socially innovative solutions in the local contexts under review.

2. Social innovation and long-term care: towards a working definition

Over the last fifteen years, the concepts of innovation and social innovation have gained, especially on the impulse of the European Union, an increasing importance in the public discourse and in the reform agendas of the Union and its Member States. The interest in social innovation has become particularly intense in the decade since the Great Recession. The concept appeared able to satisfy the double need to make social protection systems not only more adequate in addressing new and old social risks (exacerbated by the recession) but also more sustainable in terms of costs; this appeared possible thanks to the mobilization of new financial and creative resources, which were particularly valuable in the presence of increasingly stringent budgetary constraints, and to the positive stimulus of the economy potentially induced by innovation itself (cf. Hubert, 2010; Ferrera and Maino, 2014; Tepsie, 2014; Maino, 2017). Among the most frequently mentioned "challenges" to justify the need for stimulating social innovation processes – alongside long-term unemployment, social exclusion, poverty and migratory flows – are those linked to the rapid aging process occurring in Europe (cf. Caulier-Grice *et al.*, 2010; CE, 2010; Hubert, 2010). Therefore, it appears crucial to clarify the contours of the concept of "social innovation" and, in particular, its meaning in the

specific context of policies for the (frail) elderly. What does "social innovation" mean in the LTC and elderly care field? In which sense can a policy measure for elderly people who are frail or no longer self-sufficient be qualified as "innovative"? What are the current trends in the EU on this front?

From a general viewpoint, many authors note that social innovation is not a new concept; it could in fact be traced back to the works of the founding fathers of sociology – from Durkheim to Weber to Tarde – although with a meaning quite different from that commonly attributed to it today (Moulaert *et al.*, 2017). However, the first explicit mention of social innovation in its current meaning traces back to the second half of the 2000s, within the EU agenda. Since then, two phases can be distinguished (Hubert, 2010; Sabato et al., 2015). In the first phase, started with the relaunch of the *Lisbon Strategy* through the *Renewed Lisbon Strategy* (2005-2010), the promotion of social innovation – although partly achieved through the Structural Funds, the Open Method of Coordination and the Seventh Framework Program – struggled to be identified in European documents as a separate and clearly defined policy objective, while the priority seemed still to lie in supporting innovation that was understood in a technical-industrial sense. Social innovation kept being "between the lines", and its presence in the European agenda, although growing, remained sporadic and often implicit (Sabato *et al.*, 2015). It was with the *Renewed Social Agenda*, launched in 2008 (EC 2008a), and some initiatives promoted by the Commission between 2009 and 2010 that social innovation became explicitly thematized by the Union and appeared systematically in some of its official documents, including in the *Europe Strategy 2020* (EC, 2010), which considered it a key-area in pursuing the general objective of a smart, sustainable and inclusive growth (Sabato *et al.*, 2015) and in the subsequent *Social Investment Package* (SIP) promoted by the Commission (EC, 2013a), as well as in the *European Pillar of Social Rights* (European Parliament *et al.*, 2017).

It was in this second phase that emerged the definition of "social innovation" that has been more frequently used in the official documents produced by the European Union in recent years, namely, that proposed in 2010 by the Bureau of European Policy Advisers (BEPA) (Hubert, 2010). Although not officially adopted by the EU, there is no doubt that its influence has had a significant impact both in terms of policymaking and in the academic debate, as well as among experts. As highlighted by Sabato *et al.* (2015), the BEPA and its definition have in fact played a central role in the agenda-setting process that explicitly imposed the issue of social innovation on the attention of European policymakers, then merged into the *Europe 2020 Strategy*. According to BEPA – in line with what was proposed by the Young Foundation in a document previously commissioned by the Bureau itself (Caulier-Grice *et al.*, 2010) – social innovations should be "social in both their ends and their means" and should consist of "new ideas (products, services and models) that simultaneously meet social needs (more effectively than alternatives) and create new social relationships or collaborations. They are innovations that are not only good for society but also enhance society's capacity to act" (Hubert, 2010, p. 33). Taken literally, this definition would imply that one could speak properly of social innovation only in the presence of interventions (not necessarily of policies), meeting at the same time the following four necessary conditions:

1. offering a new response to a social need (*novelty and responsiveness*);
2. doing it more effectively than existing solutions (*greater effectiveness*);
3. renewing or improving social skills and relationships (*greater inclusiveness and empowerment*); and
4. determining a better use of goods and resources (*greater efficiency*).

Such a definition, however, cannot be taken as unproblematic. In addition to its evident normative connotation, the BEPA conceptualization appears at the same time extremely broad in terms of the range of measures classifiable under its label (ideas, products, services and models) but undoubtedly highly restrictive in terms of empirically observable objects. To be such, social innovation should in fact be both *product* and *process* innovation. The former should also consist of a result (*output*), which – in addition to being more effective than the existing alternatives in satisfying the social needs present in society – should also be more efficient in the use of available resources; however, the latter should ensure that the output itself is achieved through a renewal of social interactions, in light of the principles of the involvement and empowerment of the beneficiaries, the inclusion of the various stakeholders called into question by the policy, the widespread participation in decision-making processes, the adoption of collaborative rather than competitive logics and

that of a bottom-up rather than a top-down approach. Given this restrictiveness, in our view, it is more useful to consider the formulation proposed by the BEPA (Hubert, 2010) as the stylization of an ideal type, an ideal limit concept that, as such, tends to be lacking in definition of real empirical referents and is mainly useful as a coherent and unitary conceptual framework from which to measure the distance of the observed reality and its peculiarities.

Reviews of the main definitions produced by the literature and numerous European reports indeed show high variability in terms of characteristics identified, explicitly or implicitly, to define social innovation (Jensen and Harrison, 2013; Moulaert *et al*., 2013; Tepsie, 2014). From this point of view, the attempts recently proposed by the literature to break down the general (and otherwise generic) concept of social innovation and detect different types or dimensions (tendentially complementary), more easily observable at the empirical level, are certainly valuable. Beyond the specificities of the single proposals (Evers and Ewert, 2014; Tepsie, 2014), what seems to emerge from empirical research is the opportunity to increase the denotative power of the concept of "social innovation" by adopting operational definitions at a lower ladder of abstraction, which, on the one hand, allows the capture of different degrees of innovation and, on the other hand, takes into account the specificities of the policy and the welfare context in which solutions that can be qualified as "innovative" are located.

In line with this operational approach, in order to investigate the specific connections between social innovation, elderly care and LTC, we suggest considering the policy guidelines promoted by the EU over the past decade to address the challenges posed by the aging of the population, as well as the research initiatives supported in this field by the Union itself (Razetti, 2018). Overall, and coherently with the paradigm of social investment, the policy discourse promoted by the European Union locates aging and LTC issues in the wider life cycle of the individual, thus emphasizing the importance of an approach aimed primarily at preventing or delaying the emergence of dependency (EC, 2008b; EC, 2008c; SPC, 2010; EC, 2013a; EC, 2013b; SPC-WG-AGE, 2014; Cibinel *et al.*, 2017). A *preventive* and *proactive* rather than a *reparative* approach is considered essential to curb the demand for assistance, reduce costs (direct and indirect) for the whole system, and improve, at the same time, the quality of life of the elderly and their caregivers. In this sense, social innovation, favoring a discontinuity with respect to long-established policy practices, becomes a significant functional element in the development of new models of assistance inspired by social investment (Fransen, 2014). Although within the EU's reports on aging, references to social innovation became more explicit only from 2013 onwards, there is no doubt that the attention given to some basic guidelines for renewing processes and products in the LTC field contributes to defining a common ground between social innovation, social investment and LTC, i.e., healthy and active aging; prevention and rehabilitation; coordination and integration between the different components of the system (formal and informal care, social and health care); the mobilization of a plurality of actors (public, private, for-profit and nonprofit) – above all at local level – in the functions of codesign and coproduction, financing, organization, governance, monitoring and evaluation; individual and collective empowerment; home care instead of residential care; and the transversal use of ICT. If applied, these guidelines should help contain the demands for assistance, qualify and increase their supply, reduce their costs, and increase the quality of life of older people, as well as that of their formal and informal assistants.

Moreover, a review of the research projects supported by the European Union over the last decade on social innovation in the field of LTC policies (through the Seventh Framework Program, Horizon 2020 and other specific initiatives promoted by the Commission) highlights the initial development of operational definitions of social innovation that are useful for empirical analysis policies under examination in this article (for an overview see Razetti, 2018). Beyond specificities, these definitions tend, first, to stress the context-sensibility of the concept (for instance, depending on the features of the more general care regime), i.e., in the Italian model, the areas in which it would be a priority to stimulate innovation processes would be those of integration, support for families in their search for caregivers, qualification of assistance, and recognition of informal skills (Schulman and Leichsenring, 2015).

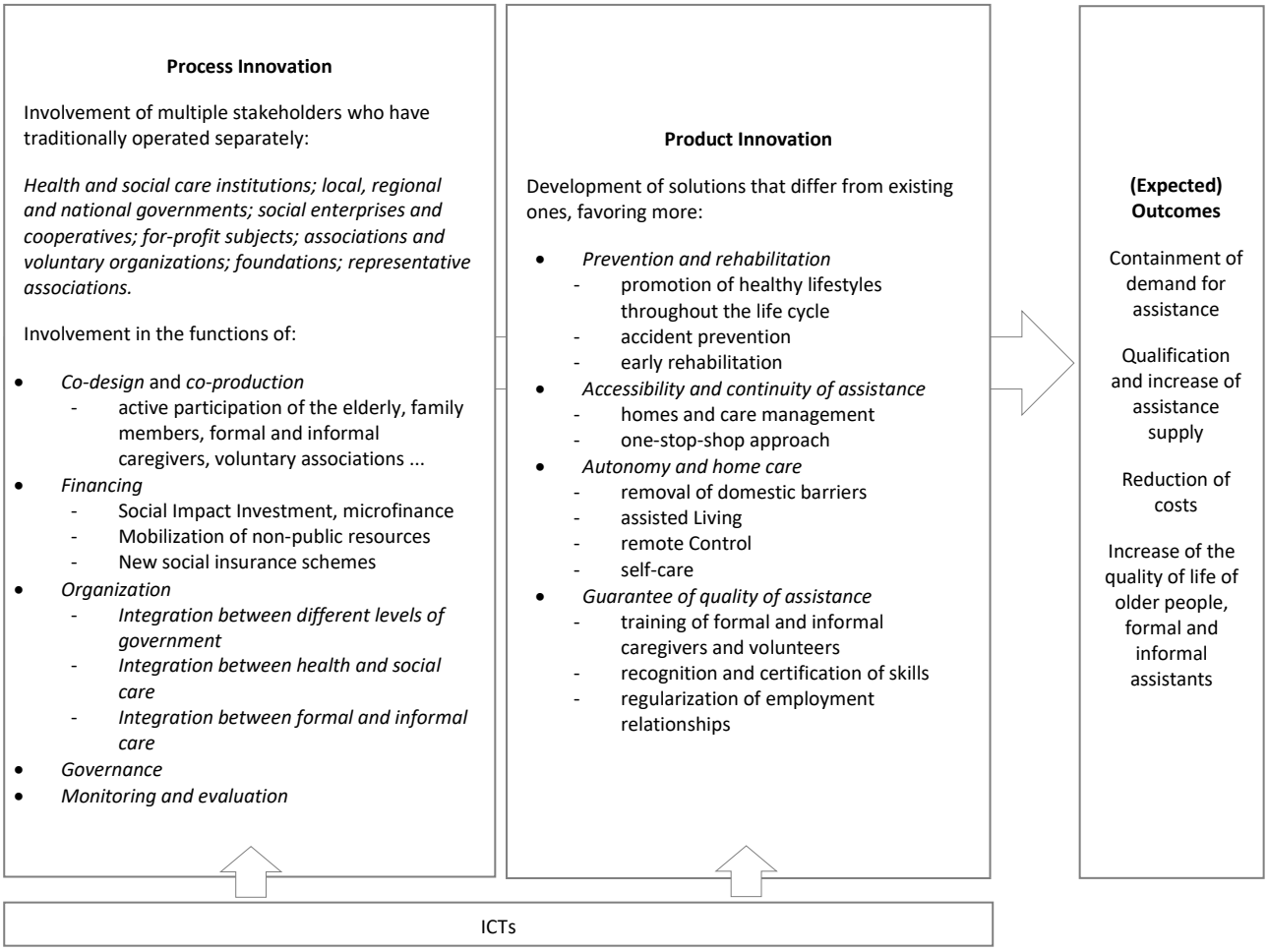
Second, research on social innovation and LTC generally adopts an extensive interpretation of what can be understood as "socially innovative" in long-term care policies. Consistent with the policy discourse outlined

above, these definitions tend, on the one hand, to interpret social innovation as a "lever" to promote social investment, which explains the attention paid to wider concepts, such as those of active and healthy aging; on the other hand, and strictly connected with the first remark, the conceptualizations of innovative LTC policies tend to view as beneficiaries not only the elderly but also their formal and informal caregivers.

3. Towards socially innovative practices to contrast the isolation of frail elderly? A comparative overview of five cases

These development lines are outlined schematically in Figure 1, which stresses the multidimensional nature of innovation by distinguishing *process* and *product* innovations in LTC policies. Considering the Italian system of policies for nonself-sufficiency, its overall distance from this design is clear. Some peculiarities of the Italian model evoked in the previous section – in particular the widespread use of cash benefits combined with a large use of informal care and the (often irregular) employment of foreign family assistants – seem to pose nonsecondary obstacles to these kinds of innovations (cf. Di Santo and Ceruzzi, 2010; Zilli, 2018). The greatest difficulties would be concerning integration (between migrant workers, families and professionals, health and social services), the qualification of caregivers, and the access to and use of information and communication technologies (ICTs).

Figure 1. Process and Product Innovations in LTC Policies: A Scheme.



Source: authors' elaboration.

At the same time, the most recent literature has begun to gather evidence on the existence, at the local level, of multistakeholder network experiences that proved capable of introducing some form of innovation into these policies (Crescentini *et al.*, 2018; Cibinel *et al*., 2017). On this backdrop, in this section we describe five cases of "innovative" LTC measures from two Northern Italian regions: Piedmont and Lombardy. These cases have been selected as illustrative experiences of interventions aiming at filling the existing gap between informal family-based home care solutions on one hand and full institutionalization on the other hand, by means of the introduction of at least one kind of innovation among those listed in Figure 1 on both the process side and the product side.

Regarding the process dimension, the five cases illustrated below are characterized by the involvement of a plurality of actors who have traditionally operated separately: local administrations and Plan offices, Territorial areas, service consortia, third sector organizations, voluntary associations and volunteers, and families. The activation of these actors and the setup of multistakeholder networks, strongly rooted at the local level, allow them to qualify the cohesion effects they produce on their communities as "inclusive local care environments", i.e., networks of integrated and territorially localized services, built-up to address the needs linked to aging and LTC, with particular attention to the most vulnerable members of the community.

Regarding products, in all cases, projects have tried to implement solutions enhancing at least one dimension among prevention and rehabilitation, accessibility and continuity of care, elderly autonomy at home, and quality of provided care; many innovative projects crosscut these four dimensions. Both process and product innovation may be supported by the use of new ICTs. In all cases, the intent, by their promoters, is to positively impact, by means of the project itself, the final outcomes of the LTC policy, not only in terms of increasing the quality of life of older people and their formal and informal assistants but also – depending on single experiences – of containing the demand, and/or qualification and increase of assistance supply, and/or reduction of costs. In addition, all selected cases try to address the risk of social isolation, as defined in section 1, of frail elderly people and/or of their caregivers, particularly in rural and mountain areas. These measures try indeed to combine the advantages of the ageing in place approach with the reduction of the connected risks of living isolated, particularly relevant in peripheral territories, where population density is low and the access to services is often complicate due to an underdevelopment of transport facilities.

The reconstruction of cases is based on information taken from official documentary sources, as integrated with data provided by projects' managers. The illustration of projects follows a chronological order, focusing first on three experiences from Piedmont (§ 3.1), then on two projects run in Lombardy (§ 3.2).

3.1. Innovative projects in Piedmont

3.1.1. "Veniamo a trovarvi" project

The very first round of "Veniamo a trovarvi" (*We Come to See You*) was launched in 2009 as an initiative of the local bank foundation (Fondazione CRC)[3] in close collaboration with an association (La Bottega del Possibile) committed, since 1994, to promoting the "culture of home care". The project aims to favor the permanence of elderly people at their own domicile by reinventing the role of residential structures existing in the area. For this first experimentation, the Municipality of Bernezzo was selected, which is a small village (3,500 inhabitants) located in a peripheral mountain area.

[3] Fondazione CRC is a non-profit, private and autonomous institution, which pursues aims of social utility and the promotion of economic development, through the provision of contributions to public and private non-profit entities and through projects promoted directly, in partnership with local players, in the sectors of education, welfare, art and culture, local development, public health, scientific research and sports activities. The Foundation operates in the province of Cuneo (Piedmont) and has a net asset of 1,319 billion Euros, which places it among the top ten bank foundations in Italy.

Two major lines of intervention characterize the project. The first consists of a survey of the care needs present in that mountain community through the activation of the so-called "Itinerant Home Visitor" (IHV), a person in charge of regularly visiting elderly people (those aged 70 or more), either alone or in pairs, to monitor their health status and needs. As highlighted in FCRC (2012), this type of service has relied on long-established pioneering experience accumulated since the early 1970s by the social services of the close Val Pellice Mountain Community[4]. To carry out this delicate function, an intermediate care technician (nurse) was chosen. Once the needs of the elderly have been mapped and a core of particularly fragile subjects has been singled out, the second line of intervention consists of the activation of care services (made available at the local residential health structure and/or delivered at home), aimed at allowing fragile people to stay in their own home for as long as possible. The usual relationship between the user and the structure is thus reversed, i.e., instead of waiting for the health of the elderly to deteriorate enough to enter the structure, the structure itself was tasked with looking for potential users and providing them with services useful for delaying as much as possible his/her institutionalization. The dialog among the operators of the residential structure and the IHV is the method adopted to define, on a regular basis, the mix of interventions most suited to individual cases.

From the financial point of view, for the first year, the costs of the project were fully covered by the CRC Foundation (with approximately 116.000 euros), which basically supported the expenses due to the IHV and allowed the selected elderly to access for free the services provided by the nursing home located in Bernezzo. In the second year, 50% of the costs were charged to the users, while the remaining part was still supported by the Foundation (with 50.000 Euros). From the third year onwards, the costs were entirely borne by the families using the service.

The evaluation of the project, which was carried out by the CIS (*Centro Iniziative Sociali*) on behalf of the foundation, showed that the hypothesis that the activation of these services leads to a reduction in health expenditure does not appear confirmed by facts (FCRC, 2012). However, it was noted that, in some cases, the project has led to net savings in healthcare spending, thus becoming an effective alternative to the more expensive nursing home; savings, it was emphasized, have been achieved not so much on the costs borne by the social-assistance services – whose contribution to the integration of the fee depends on the income status of the beneficiary, which is not predictable *a priori* – or on the costs of the share connected to the health component paid by the LHE (FCRC, 2012, p. 104). More generally, according to the analysis proposed in FCR (2012), the problems linked to the replication of this intervention model seem to be ascribable to the presence of clearly "visible" costs – additional to those of the previous situation – in the face of "invisible" savings, which are potential missed costs (in terms of missed hospitalization in the nursing home and/or at the hospital), due to the adoption of an approach aiming at preventing the deterioration of pathologies, which are measured over a longer time span than the experiment has been carried out.

In spite of these mixed results in terms of savings, the model carried out in Bernezzo has been subsequently replicated, thanks to the support provided again by Foundation CRC, in several municipalities of the province, including its capital, Cuneo, thus leading to the first experimentation of the model in an urban environment (56,000 inhabitants). While a new evaluation round is still to be implemented by the CRC Foundation, the person in charge of these measures stresses the relevance of these innovative ways of delivering services being carefully accompanied in terms of process management, to foster learning dynamics and defuse potential conflicts. For these reasons, in the attempt to ensure continuity to these measures and support their activation by new residential structures willing to follow Bernezzo's path, the CRC Foundation has invested in operators' specific training, has stimulated a structured dialog among the directors of the different residential structures involved, and has supported newcomers by putting them in "tandem" with structures already participating in the project.

Based on the experience accumulated by the CRC Foundation over the ten years since the beginning of the project, some remarks can be advanced. Involvement in training activities by not only the operator selected

[4] For more information, see also https://www.bottegadelpossibile.it/wp-content/uploads/2018/11/La-signora-della-domiciliarit%C3%A0_Lora-del-Pellice-LA-BOTTEGA-DEL-POSSIBILE.pdf (accessed on: 20th May 2019).

as the “Itinerant Home Visitor” but also the entire staff of the structure has proved crucial to avoiding or defusing deleterious competition, if not full-blown envy dynamics, among operators who, often overworked, could view those colleagues selected to work outside the structure as being “privileged” (less controlled, with a slower pace of work, and so on). At the same time, making operators rotate in this function would be unfeasible, as the relationship between the IHV and the elderly people he/she takes care of is deeply based on trust and often requires a long time to build. To increase trust, particularly in mountain and rural areas marked by high levels of diffidence towards strangers, consciousness-raising and communication activities are of major importance (for example, a letter from the mayor explaining the new services offered, having the information conveyed by a priest at Sunday mass, and so on). The financing scheme initially adopted and sketched as described above was revised, because in many cases, it ended up arousing unrealistic expectations in terms of never-ending free access to the services. Ultimately, the experiment has shown that, while probably reducing some costs thanks to prevention measures, the initiative tends to increase costs as it promotes higher take-up rates.

3.1.2. A casa/Chez soi

The project “A casa/Chez soi” (*At home*) was carried out in the period 2011-2013 within the framework of the fourth operational program of cross-border cooperation between Italy and France "ALCOTRA 2007-2013". *At home* aimed at promoting the permanence at home of people in situations of "fragility" (elderly, families in difficulty or people with minor disabilities) residing in mountain and peripheral areas and to reduce their risk of social isolation. The initiative involved, on the Italian side, the Mountain Communities of Varaita and Po Bronda and Infernotto Valleys, then other rural areas of Fossano and Savigliano (in the Province of Cuneo), and, on the French side, the territory of the Hautes-Alpes Region (in particular, the Briançonnais area). The lead partner was the Italian Consortium for the social assistance function "Monviso Solidale", in partnership with "Vivre et Vieillir Chez Soi”, in France[5], and EPACA in Italy. EPACA - Ente di Patrocinio e Assistenza per i Cittadini e l'Agricoltura is the Agricolture Employers’ Organization historically committed to the enhancement of rural and mountain areas and to contrasting their depopulation.

To promote the ageing in place approach and reduce, at the same time, the risk of isolation in mountain contexts, the basic tool consisted in enriching the offer of social and health services already present in the area through the activation of the figure of the so-called "Non-Professional Home Collaborator" (*Collaboratori Domiciliari non professionalizzati*). The Non-Professional Home Collaborator (NPHC) was identified among persons already present within the reference territory and who, although lacking the typical specializations of professionals specifically trained for caring, were motivated to do a job of this type showing "spirit of collaboration, good interpersonal skills and effectiveness in everyday domestic life" (Consorzio Monviso Solidale 2014, p. 42). Once selected, NPHCs were specially trained (altogether, 61 people were involved in training activities preparatory to assuming the role of Collaborator).

The activities carried out by the NPHC might consist in the support for the management of daily life, for home care, for transports (such as accompanying the elderly to GP or hospital visits and other public and private office), but also in the delivery of meals, medicines, shopping and basic necessities. All these activities were part of the larger network of services offered by the territorial Home Assistance Service in support of frail people: the non-professional home helpers intervened upon request of the Social Assistant of reference for the Municipality of residence and their actions were fully integrated into an Individualized Project, signed through a "Contract of collaboration" among all the subjects involved in the project.

[5] "Vivre et Vieillir Chez Soi" is an association that provides social and health care services in the French territory of the Hautes-Alpes, which presents problems similar to those typical of the Italian context. As stated in the Final Report of the project, the experience of the Association was useful in making it clear how the range of home-based operators can be wider than that generally considered in Italy and better calibrated compared to the conditions of people's need requiring intervention.

In terms of governance, a cross-border board was set up for project management. According to Cibinel *et al.* (2017), this board would have made it possible to "monitor and systematically orient the activities of the project and enhance the results on both sides of the border" and would have facilitated the activity of exchange of experiences between service operators in two countries with in-depth seminars and internships in the services of the neighboring country (p. 66).

According to the Final Implementation Report of the project (Consorzio Monviso Solidale 2014, pp. 46-47) among major achieved results are mentioned the identification of a "sustainable" intervention model, inspired by proximity and non-specialization criteria, suitable for facing conditions of personal self-sufficiency, but isolation and social solitude; a mapping of the needs present in the territory and a coordination of the interventions with the Social Workers operating in the mountain and rural areas, with an indirect effect of integration and qualification of the whole network of the services, a strengthening of the level of integration between health services, socio-assistance and local social actors to prevent or delay the institutionalization of the elderly and to promote social cohesion; the promotion of female and youth employment in the provision of services to the elderly (the people who are willing to become NPHCs were, in fact, mostly women and young people); the maintenance of elderly people in their own homes in safety and autonomy, expanding the home care service: over 90% of the approximately 40 activities to support the maintenance of their home were indeed directed in favor of people previously not known by the Services. According to what is reported in the Final Implementation Report, which dates back to 2014, in Italy the results of the project have allowed the maintenance of the collaboration relationship and the continuation of the experimentation not only in the initial territories but also in the plain health district.

The project, which involved a total investment of almost 325.000 euros, was 66% funded with resources from the European Regional Development Fund under the Italy-France operational program.

3.1.3. Co.N.S.E.N.So. – Community Nurse Supporting Elderly in A Changing Society

Co.N.S.E.N.So. has been a project carried out under the INTERREG Alpine Space Program (2014-2020)[6], involving five regions of the Alpine area: Piedmont (as lead partner) and Liguria (Italy), Provence-Alpes-Côte d'Azur (France), Carinthia (Austria) and Slovenia. The objective of this three-year project (December 2016 - December 2018) has been to promote the healthy and active aging of the population, allowing the elderly – in particular those living in isolated mountain areas – to live in their own home for as long as possible. In the intentions of the promoters of the project, these final goals should have been achieved mainly by the development of a new caring model, putting the elderly at the center of health and social services and based on the activation of the so called “Family and Community Nurse” (FCN).

During the project, it emerged that major needs of elderly people living in territories selected for the pilot (for Piedmont, the Maira and Grana Valleys) concerned transports and socialization, while care activities had to address problems such as the scarcity of resources, especially human resources, available for taking charge of social needs, and an insufficient degree of coordination with GPs (Cibinel *et al.* 2017, pp. 59-60). Isolated people without a family network, living in the municipalities of the upper Maira Valley and in isolated villages, reported as their main problem a low degree of socialization and the impossibility of going to the GP, to the pharmacy, and more generally to reach the shops for purchasing basic necessities.

As reported in Cibinel *et al.* (2017, p. 58), the FCNs, which operate under the responsibility of the Local Health Enterprise, following an initial evaluation phase, offer the elderly entrusted a series of services. These range from the support in common everyday life activities to the promotion of social inclusion, from the prevention of domestic accidents to the assistance in possible therapies and monitoring of health indicators up to the

[6] This is an EU transnational program aimed at providing a common framework to facilitate the cooperation between economic, social and environmental key-players in Alpine countries, as well as between various institutional levels. The first round of transnational EU cooperation for the Alps was launched in 2000. In the current programming period (2014–2020) Alpine Space is investing 139 million Euros in 56 different projects in seven Alpine countries.

prevention of chronicization, complications and relapses of previous pathologies with the consequent possibility – as reported in the website page of the Piedmont Region dedicated to the project – of reducing avoidable hospitalizations, as well as transfers to retirement homes.

This might become possible thanks to the specific role played by the FCN, which should acquire an overall vision of the subjects entrusted, followed in agreement with and in support of the various figures who, for various reasons, interact with the elderly: the General Practitioners (GPs), the specialist services, the family members, the caregivers, the social assistance services, and so on. In particular, the FCNs are responsible for reducing the risk of isolation of the elderly (constantly assessed and monitored as to her/his frailty factors), by promoting her/his access to the opportunities of relationship that the local context makes available. As to socialization, it is worth mentioning that FCNs have also organized a series of meetings to promote the adoption of healthy lifestyles (because of a very high rate of diabetic patients showing a very low medical compliance) as well as "walking groups" conceived both as a new meeting opportunity and as a preventive physical activity. This latter initiative was made possible, during fall and winter, thanks to the cooperation with local structures (both private and public) which offered for free their spaces for these activities. Furthermore, a local voluntary association made available a means of transport to ease the mobility of elderly people, under the coordination ensured by the FCNs and with the financial support of the local Association of Municipalities.

In summary, as reported in Cibinel *et al.* (2017, pp. 58-59), the FCNs of the project Co.N.S.E.N.So. can be described as a professional who takes care of the elderly (healthy or sick) person and of his family, following them over time through home visits and/or telephone contacts; monitors the elderly person's global health status, including through periodic checking of some vital parameters; if necessary, performs nursing services; acts according to an educational and preventive approach, promoting the adoption of correct lifestyles both at the individual and at the community level; activates social and health services existing in the area; make the person in touch with the community and the services it offers (e.g. GPs, neighborhood, local administration, voluntary associations).

To reach these goals, the development of a specific FCNs training model has been one of the objectives pursued by the project. As to the Piedmont experience, the professional figures identified as those most suited for playing the role of FCNs were involved in a training course thanks to a partnership with the University of Turin, which activated a first level master lasting one year, whose fees were covered by the Cuneo Local Health Enterprise. Currently 4 FCNs are active in 10 Municipalities of the Maira Valley and in 3 Municipalities of the Grana Valley. Based on the information reported in the strategic document drawn up by the Mountain Unions of the Grana and Maira Valleys, Co.N.S.E.N.So. has contracted young FCNs. Within the territory covered by the project, all elderly residents (population aged 65 or over), regardless of their state of health or autonomy, are assigned to a FCNs, which deals full-time with assisted patients (about 500) through regular home visits, whose frequency is established based on the needs of the elderly. As noted for the *Veniamo a trovarvi* experience, many strategies were carried out, together with local civil and religious authorities, in order to overcome the initial mistrust and resistance by residents towards the FCNs.

The total budget of Co.N.S.E.N.So. amounted to 2.052.400 euros, thanks to a co-financing of 85% of the European Regional Development Fund – ERDF. As for users, the access to the provided service was totally free. The Local Health Enterprise has co-financed the project, making available a senior nurse from the District (as a link between the young FCNs and the services available in the area), two service cars (to allow the nurses to commute through the two Valleys), as well as the necessary health equipment. Finally, it should be noted that the project Co.N.S.E.N.So. worked in synergy with the *Veniamo a trovarvi* project (see above § 3.1.1), by exchanging the lists of users taken in charge, by sharing mutual assistance assessment tools, information leaflets for the population, and avoiding possible overlaps among the services.

In conclusion it appears worth mentioning that the initiatives activated during the pilot are still under way (although at a lower intensity) and new financial resources coming both from the Region (and its experimentation on "Health Ambulatories") and the EU (through the National Strategy on Internal Areas) are being directed by the local Health Enterprise towards the inclusion of new "patients".

3.2. Innovative projects in Lombardy

3.2.1. The "Invecchiando si impara … a vivere" project

"Invecchiando si impara … a vivere" (*As we age we learn... to live*) is the project that 19 Municipalities of Seriate and Grumello del Monte Territorial Area (a mountain zone in the province of Bergamo) have developed, together with a network of partners, to favor the healthy, active and positive aging of the people who live in their territories[7]. It is aimed at developing a system of services and activities that help people to maintain their autonomy and self-sufficiency, to continue living in their own home, surrounded by their affections and friendships, in health and with the possibility of taking care of relationships, interests, pleasures and to cultivate new ones, in the awareness and conviction that life is constantly evolving regardless of age.

The beneficiaries are elderly people who need help and support as well as caregivers and families (children, relatives, friends, neighbors who take care of them). The project has three specific targets: 1) assistance for over 65, people partially or not self-sufficient, when a real path of social-health integration is necessary; 2) monitoring, for 65-75 years people who show initial signs of physical and cognitive diseases; 3) orientation, for 55-65/70 years people still active socially and at work for which prevention actions are planned.

The object of the project is threefold: involvement of the community as a whole to contrast ageing effects; maintaining as long as possible the elderly at home; creating and consolidating a local and provincial network for supporting the autonomy of the elderly. Parallel to the strengthening of existing services, new ones have been designed and created, as for example protected apartments where elderly people can continue to live independently[8]. Two "Home-based Care Shops" have also been built up: they are help desks that offer information, advice and support to families who care for elderly, disabled and minors. Alzheimer Cafés[9], family and community assistants, light health services (two [10]surgeries for not pharmacological therapies are already at work), light residency have been created.

In order to activate the community, "sentinels" are identified and trained: they are responsible for intercepting and reporting needs that are not immediately obvious, enhancing the relationships with proximity points/persons (traders, pharmacists, neighbors).

The partnership is made by three local public institutions and five Organizations in the Third Sector while the entire network involves several stakeholders such as trade unions and associations as well as some companies and health care structures. As reported in the Project Report, partners and network members are expected to be able to activate an articulated, relational system supporting the project at several levels: institutional (municipalities, interest unions…), community (e.g. associations, traders, parishes, pharmacies, General Practitioners, pediatricians), communication (local media), potential donors (companies, foundations, banks, large retailers, and so on), beneficiaries (families who use the services, recreational and entertainment centers for the elderly).

The project has received the three-year contribution (1,000,000 euros) by the Cariplo Foundation through the "Welfare in Action" call, third edition.

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[7] The 19 Municipalities have a total population of approximately 123,000 inhabitants and more than 50,000 resident families. A ratio of 17.2% of elderly over 65 compared to 16.5% of population 0-14 years.

[8] The projects intend to create at least 10 protected apartments in three years.

[9] It is a meeting place for people with dementia and their families and caregivers. It offers the opportunity to socialize and spend time pleasantly, in the presence of professionals in the educational, health and psychological fields.

[10] Project report (2017) – *Presente e futuro nella filiera della cura. Invecchiando s'impara (a vivere)*, Fondazione Cariplo, available at: http://www.invecchiandosimpara.it/wp-content/uploads/2017/10/relazione-di-progetto.pdf (accessed on: 11th June 2019).

3.2.2. The "Place4Carers" project

The Camonica Valley is the mountain territory where the "Place4Carers" pilot project, currently ongoing, is being tested (December 2018 - January 2020). The idea on which the community-based and participatory initiative relies is that a tighter coordination between the elderly, the families and the territorial services is necessary in order to make caregiving activities more effective and sustainable both for cared people and for those who take care of them. The final goal consists in providing greater support to family caregivers, partly lifting from their shoulders the heavy burden of caregiving. Consider that the risk of isolation does not concern only assisted people, but also family caregivers, often "obliged" to spend most of their time at home with their relatives.

The project is articulated into thee main steps. The first concerns a mapping of the needs of the family caregivers in the remote mountain areas of the Camonica Valley; the second step consists in the co-generation of a new model of "social and community service" for supporting family caregivers, through their direct engagement in the design and production of the services; the third and final step will lead to the implementation and evaluation of the pilot. In parallel, the conditions for the transferability of the model into other mountain areas (particularly, the *Valtellina*, in the Northern part of Lombardy) and the relevant stakeholders necessary for favoring this kind of process will be looked for by the project partners.

Through a questionnaire, it emerged that the very priority for caregivers in the Camonica Valley – mainly women, aged 50-70 and with very high care burdens – was to have better access to information on available services and economic facilities, also to compensate for a consistent out-of-pocket expenditure (averagely equal to almost 570 euros per month). A desire of a peer-to-peer sharing of experiences also emerged, for reducing the caregivers' feeling of isolation and loneliness. Finally, caregivers also expressed the request to get some training as to daily caring activities. Starting from these premises and to address these needs, a new service - called "SOS caregivers: stare bene per far star bene" (*Caregivers SOS: feel good to make feel good*) – has been activated, based on the abovementioned users' co-design and co-production principles. The service is articulated into four main areas. The first is the "Citizens' Committee", a group of family caregivers, which will meet once a month with the support of an experts' team (from the Territorial Enterprise for the Social Services, the Local Health Enterprise and the local nursing homes), for defining the priorities of the initiatives to be run. The "Experiences and advises" area pertains instead to the possibility, again once a month, for groups of family caregivers to share their experiences, also thanks to the presence of a professional acting as a mediator. "Informarsi fa bene al cuore" (*Getting informed is good for your heart*), the third area of "SOS Caregivers", is about (both paper and online) materials explaining the different solutions available in the territory for caregivers and non-self-sufficient persons. At the end of the pilot, a training course will be organized for the local GPs to inform them about the project and about the active services for caregivers. Finally, training will be delivered once a month by professionals which will be charged to provide caregivers with useful instructions for the daily management of the elderly, such as nutrition, personal hygiene as well as caregivers' risks of burn-out ("Sapere di più, sapere meglio", *Know more, know better*).

The project has been funded by Fondazione Cariplo (197.500 euros) and is coordinated by the Università Cattolica del Sacro Cuore di Milano (EngageMinds HUB), in collaboration with the Politecnico di Milano (in charge of the qualitative and quantitative evaluation of the initiative), the NEED Institute and the Research Area for Innovation and Development of the Valle Camonica ATSP.

Table 1. Socially Innovative Practices to Contrast the Isolation of Frail Elderly: The Five Cases under Review.

	Period	Territory	Type of territory	Main Goals	Main Actors	Main tools for contrasting isolation
Veniamo a trovarvi	2009-on going	Province of Cuneo (Piedmont)	Mountain and urban	• Promotion of autonomy and home care • Prevention	• Municipalities • Bank Foundation • Residential Health Structures • Third Sector Organizations	• Itinerant Home Visitor
A casa/Chez soi	2011-2013	Province of Cuneo (Piedmont)	Mountain	• Promotion of autonomy and home care • Community Empowerment	• Mountain Communities and Municipalities • Consortium for the social assistance function • Third Sector Organizations • Rural Employers' Organization	• Non-Professional Home Collaborator
Co.N.S.E.N.So.	2016-2018	Province of Cuneo (Piedmont)	Mountain	• Promotion of autonomy and home care • Prevention • Services' integration • Community Empowerment	• Local Health Enterprise • Municipalities • Voluntary Associations • University	• Family and Community Nurse • Walking Groups • Transport Services
Invecchiando si impara… a vivere	2017- on going	Province of Bergamo (Lombardy)	Mountain	• Promotion of autonomy and home care • Prevention • Services' integration • Community Empowerment	• Municipalities • Residential Health Structures • Third Sector Organizations • Research Centers • Trade Unions • Companies	• Protected Apartments • Home-based Care Shops • Alzheimer's Cafés • "Sentinels"
Places4Carers	2018- 2020	Province of Brescia (Lombardy)	Mountain	• Co-design and co-production • Community Empowerment	• Municipalities • Bank Foundation • Third Sector Organizations • University • Research Centers	• Citizens' Committee

Source: authors' elaboration.

4. The factors behind: a discussion *(preliminary)*

Drawing from the empirical evidence collected in relation to the cases under review, this section aims to discuss some preliminary hypotheses about the factors that might help to explain the adoption of socially innovative policy solutions in the local contexts under review. Despite the flourishing strand of literature dealing with social innovation (cf. § 2), only a few studies have thus far explicitly addressed innovation in the social field from an explanatory standpoint. The development of an inventory of causal factors and enabling conditions, as well as the empirical validation of hypotheses, is, therefore, still lacking.

Against this backdrop, building on an in-depth review of the main findings of existing comparative studies, Table 2 offers the first collection of those factors that have been acknowledged by the literature as possible "drivers" or "barriers" to social innovation. The list may be organized by looking at a multiplicity of dimensions, ranging from aspects concerning local governance settings to institutional features and legal constraints.

Table 2. Drivers and Barriers to Social Innovation: A Review.

	Drivers	Barriers
Governance and multistakeholder partnerships	• Existing forms of interaction and cooperation between public and nonprofit sectors and/or between public and private sectors • Stronger involvement of the subnational level (type and degree of decentralization) • Poor performance of public welfare programs	• Traditional and well-established barriers dividing public-private sectors • Top-down approach (centralization) • Successful functioning of the welfare system
Financing and sustainability	• Use of public procurement • Mobilization of private resources • Instruments that increase users' freedom of choice and empowerment	• Lack of public resources • Lack of incentives to find alternative resources • Uniform solutions forced upon users
Legislation	• Legislation enabling interaction between actors from different sectors • Legislation enabling the use of innovative financing tools	• Legislation favoring traditional actor constellations • Legislation hampering the use of innovative financing tools

Source: authors' elaboration from the review presented in Razetti (2018).

Although all these factors are helpful for understanding the overall background in which social innovation is more likely to occur, we contend that the inventory falls short in shedding light on aspects properly related to the politics dimension of social innovation, that – quite the contrary and based on many empirical cases, including those presented in this article – may be expected to play a crucial role. In particular, in our view, readings purely based on policy and background elements are ill equipped to fully grasp the related factors

because they are unable to capture the agential and/or conflictual dynamics that might emerge in the policy arena. More precisely, building on these latter considerations, we argue that, to make sense of the adoption of new programs that alter the allocation of resources in a local community (such as the provision of LTC), one cannot avoid paying specific attention to the presence and mobilization of actors and stakeholders in the local context, as well as to the preferences and instances that they convey in the policy arena. Accordingly, on the basis of our evidence, we expect that two sets of factors are key in shaping the emergence and implementation of socially innovative solutions at the local level, namely, the presence and mobilization of multiple actors and stakeholders in the LTC sector (such as nonprofit organizations, bank foundations, social partners, private companies) and their ability to set up multistakeholder networks in which local public institutions act as leading and steering partners.

Although the findings that emerged from the five cases under review do not lend themselves to be generalized, they can nonetheless feed into further research around the drivers of social innovation. When looking at the five programs analyzed herein, it becomes evident that the setup of multistakeholder networks, strongly rooted at the local level, allows them to qualify, together with the cohesion effects they produce on their communities, as inclusive local care environments, i.e., networks of integrated and territorially localized services built-up to address the needs linked to aging and LTC, with particular attention to the most vulnerable subjects of the community. Most notably, in all five cases, the setup of these networks – characterized by the involvement of a plurality of actors who had traditionally operated separately, such as Local administrations and Plan offices, Territorial areas, service consortia, third sector organizations, voluntary associations, volunteers, and families, with public authorities often called to play a vital steering role – was at the same time a manifestation of innovation and a sort of precondition to foster it in terms of processes and products, as well as a way to channel external financial resources in LTC initiatives. Additionally, the five cases suggest that social innovation processes may imply the creation of new professions and professionals (i.e. in Piedmond), and/or the activation of co-design/co-production strategies (i.e. in Lombardy and in Piedmont) that involve a plurality of actors already at the early stage, including the ideation of the measures.

We want to conclude with a final remark that relates to the future research agenda. The investigation of the five initiatives under review has offered some promising insights into the factors that may trigger the adoption of socially innovative solutions at the local level. However, to effectively test our findings about the drivers and, possibly, to shed light on the barriers to social innovation, our analysis would need to be complemented by an in-depth study of some failed initiatives. In other words, the politics of social innovation deserve to have in the future more attention than has thus far been given to them in social research, in LTC policy and beyond.

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