



## Health, active ageing and tourism

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### 1. Introduction

Joint initiatives involving public health services and the tourism sector are not an obvious combination. Public health and tourism come from different backgrounds and business cultures, have divergent opinions, and speak in dissimilar languages (Pyke, Hartwell, Blake, & Hemingway, 2016). However, common ground exists in that tourism destinations which incorporate health and well-being into their strategic development can enhance and promote physical and mental health for residents and tourists alike (Hartwell, Hemingway, Fyall, Filimonau, & Wall, 2012). Public health and tourism are also entwined through shared values of societal good. For tourism, this can be achieved if its stakeholders share, cooperate and engage in dialogue with other sectors of society. For public health, the health of the population is not solely the responsibility of the health services, but is a wider multi-sectoral issue (Hartwell et al., 2012).

This research note draws on a multi-sectoral social innovation project involving local governments, health professionals and tourism businesses, addressing a specific health concern; the health and well-being of older people. Ageing populations have significant implications for the costs of health and social care provision and there is an impetus to explore innovative ways to address this societal challenge. One way forward from a health perspective is to explore how older people could be supported to be independent for longer, which underpins the project described here.

The project provides an opportunity to reflect on the extent to which tourism businesses can engage with and tourist facilities be used to support community initiatives, and whether through social innovation, there is potential for tourism to be part of active ageing initiatives and the wider public health agenda. This research note reports on these two

aspects.

In the context of the project, tourism businesses were commonly understood to include visitor attractions, cafes, restaurants, leisure centres and parks and gardens, and entrepreneurs taken to be the owners of small to medium enterprises (SME's), most commonly cafes, restaurants and privately owned attractions.

### 2. Social innovation

Social innovation refers to innovative activities and services that are motivated by the goal of meeting a social need, most commonly fostered by organisations whose primary purposes are social (Mulgan, 1996). Often the starting point for innovation is a need that isn't being met, combined with an idea of how it could be met. Essential in encouraging social innovation is the belief that "people are competent interpreters of their own lives and competent solvers of their own problems" (Mulgan, 1996, p150). As such, involvement in the social innovation process by those who have identified the need and whose problem is trying to be solved is crucial. Often ideas generated are not inherently new in themselves, but combine ideas that were previously separate. Social innovation led projects come with a risk and are a long term investment (Mulgan, 1996). Insights from a scoping review (Crossen-White, Hemingway, & Ladkin, 2020) indicate that the concept of social innovation is poorly defined, however appeals across disciplines as a potential means of generating innovative policy responses. In health care, social innovation is seen as a new way to think about delivering support services for end users. In tourism, innovation concepts are evident in planning and policy (Rodríguez, Williams, & Hall, 2014) and reviews of innovation in tourism research (Gomezelj, 2016; Marasco, de Martino, Magnotti, & Morvillo, 2018; Pikkemaat, Peters, & Bichler, 2019) provide a sense of

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the breadth of work. However, a notable absence is social innovation. This is a reflection of the divergent cultures of health care and tourism, primarily social and business respectively.

However, there is potential for convergence. Social innovation shares common ground with social entrepreneurship; both concerned with identifying problem-solving opportunities for unmet social needs. They are also being held as a means to overcome the market-driven approach of for-profit organisations through reinvestment of profits to deliver positive outcomes for communities or stakeholder groups (Phillips, Lee, Ghobadian, O'Regan, & James, 2015). The latter is common in community tourism initiatives, and could be extended to include aspects of public health and well-being into tourism activities more widely.

### 3. The sail project

The Staying Active and Independent for Longer (SAIL) Project ran for a four year duration (January 2017 – December 2020), funded by the EU 2Seas Interreg programme. This funding allows coastal areas on both sides of the English Channel to work collaboratively on common issues. In the context of the Interreg maritime cross-border programme, the sea is both seen as a natural barrier and a link for cooperation. Whilst most do, not all regions have a direct link to the sea, but are included where cooperation is beneficial to tackle common needs. As such, there is an administrative and territorial dimension for inclusion. The coastal regions in the countries included in the project (Belgium, France, England, Holland) are facing specific challenges in relation to ageing, and are confronted with a particular mix of ageing populations; a combination of local permanent residents and seasonal second residents and tourists, all of whom are of an increasing average age.

The overarching SAIL project objective was to stimulate active ageing by identifying new ways of helping people remain active as they age and methods of countering isolation. The project used a social innovation process to identify new partnership opportunities and combinations between sectors. This process involved iterative dialogue with residents, health providers, third sector agencies and tourism businesses to identify needs, explore ideas, and design and develop projects. Ten pilot projects were devised through this collaboration in the partner regions, focusing on reducing social isolation and increasing movement and well-being as identified by the groups. The pilots were varied in scope, some taking place in the community, others within residential care settings. The community pilots developed options either related to physical activity or social events. Examples of physical activities include walking football or walks combined with gentle movement (Move and Se(a), Ostend) exercises at stopping points along the route and guided walks (Dementia friendly walks, Norfolk). Examples of social events were lunch clubs either held in a community space (Vitality Market, Domberg) or arranged in partnership with a local restaurant. In residential care settings the focus of activity was upon physical exercise with the introduction of soft gym, mini golf or guided walks within the local area. Initiatives based around cooking and eating together, and supported walks with exercise were identified through the discussions as the most valuable.

### 4. The tourism sector response

The tourism sector was identified as potential partners in facilitating social and physical activities for the older populations out of season, to foster all year-round business opportunities.

It was evident that visitor attractions, cafes, restaurants and leisure centres were willing to support multi-stakeholder engagement to facilitate activities and events involving older people in the areas. The motivations to engage were predominately economic by generating business opportunities in the low seasons, (for example, use of cafes and restaurants to host get togethers) but also being part of a community that works for the common good. The businesses responded in practical

ways, offering the use of cafes, restaurants and specific tourist venues and attractions (eg. Donkey Farm) as meetings venues at the discussion stage and subsequently as venues for activities. Voluntary donations were also offered in the form of donations of food and beverages to support organised events. Some anecdotal evidence suggested that cultural differences in social norms and values had some bearing on the willingness to donate time and resources, suggesting different regional engagement.

The social innovation process facilitated new partnerships throughout the project, particularly in the early phase of SAIL. In this first stage, meetings were held with a wide range of tourism entrepreneurs, health care providers and third sector organisations around the potential for collaboration. These meetings provided for the first time opportunity for dialogue. However, there was a challenge regarding how to engage and reach second residents and tourists to be part of these discussions. For both groups, data collection in the form of surveys is costly and time dependent. There are also challenges in identifying second residences within the community. As a result, the activities that were proposed by and appealing to permanent residents did not necessarily have the same appeal to tourists. Creating cohesion between the different groups of older people proved to be the least effective outcome of the SAIL project.

In terms of success of the activities undertaken and the extent to which tourism businesses were able to collaborate was determined predominately by two factors. First, any event organised had to be appealing to draw attendance from residents and tourists. The findings revealed that those pilots that centred around either physical activity or food and drink, bringing people together, and intergenerational events that fostered community cohesion held the most appeal. The timing of these activities was also crucial in terms of avoiding the peak tourist season, and offering a balance between in-week offerings and weekends. Ensuring lead times are long enough and to enable targeted marketing was also a concern. Second, being able to organise and host specific events requires a strong network of businesses and other partners, thereby reiterating the importance of establishing connections. This included those responsible for legislation to be part of partnerships to enable flexibility and agility in legislation to allow for events to take place.

A further observation was that leisure, sports and recreation providers, formed a significant part of stakeholder engagement in SAIL and were well placed to offer facilities to promote physical activity. Municipal parks and gardens also were valuable in terms of access to physical space. The focus of SAIL on tourism business and infrastructure altered during the duration of the project to include leisure and sports, and was a valuable lesson learned.

### 5. Concluding thoughts

Returning to the introduction of this research note, businesses were willing to engage with and support activities to promote healthy ageing, particularly in the low season and off peak times when demand is low. Cafes, restaurants, and visitor attraction SME's could see the value of working with organisations outside of their usual networks, with the establishment of new partnerships a successful aspect of SAIL and an integral part of social innovation. There are also opportunities through corporate social responsibility whereby for-profit firms create social value through their CSR programmes. New partnerships and sectoral collaboration between tourism and health services aligns to the public health agenda which recognises that a populations health should be the responsibility of multiple sectors. Tourism, leisure and recreation can be part of innovative policy responses to support active ageing through initiatives derived through social innovation, such as in the case of SAIL. The relationship between tourism and well-being has potential for further development.

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