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Research Article

Resisting social innovation: the case of neighborhood health centers in Belgium

Resistencia a la innovación social: el caso de los centros de salud en los barrios de Bélgica

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Abstract: The role played by powerful social groups in opposing or even halting the diffusion of social innovation is insufficiently studied regarding modern time social innovations. This is especially relevant in cases aimed at meeting social groups with few resources, such as people in poverty. This paper examines this in the case of Neighborhood Healthcare Centers in Belgium, a social innovation with potential to offer accessible care to less resourceful inhabitants. It documents how these organizations made an effort to expand but were met with sustained resistance of doctors' associations and political opponents. It concludes that the inherent merits of social innovations which benefit vulnerable groups are insufficient to warrant their diffusion, as initiatives might run against the interests of more powerful groups.

Keywords: social innovation, opposition, healthcare, poverty, diffusion.

Resumen: El papel que desempeñan los grupos sociales poderosos para oponerse o incluso detener la difusión de la innovación social no está suficientemente estudiado en relación con las innovaciones sociales modernas. Esto es especialmente relevante en los casos de encuentro con grupos sociales de escasos recursos, como las personas en situación de pobreza. Este artículo examina esta situación en el caso de los Centros Vecinales de Salud en Bélgica, una innovación social con potencial para ofrecer atención accesible a los habitantes con menos recursos. El artículo documenta cómo estas organizaciones hicieron un esfuerzo por expandirse, pero se encontraron con una resistencia por parte de las asociaciones de médicos y opositores políticos. El texto concluye que los méritos inherentes de las innovaciones sociales que benefician a los grupos vulnerables son insuficientes para justificar su difusión, ya que las iniciativas podrían ir en contra de los intereses de los grupos más poderosos.

Palabras clave: innovación social, oposición; salud, pobreza, difusión.

1. Introduction

Social innovation with potential for structural social change does not reach wide diffusion just by its own merit, but instead depends on wide range of contextual factors. In recent decades there has been a lot of academic, civil society and policy interest in the process of upscaling and

spreading social innovation [from here on SI], usually with emphasis on identifying enabling governance conditions (Boelman et al., 2014; Gabriel, 2014). This article will shift the focus to the role of interest groups that resist social innovations with potential to reduce poverty, drawing more attention to power relations in SI processes (Hölsgens, 2016). We will discuss power relations in the context of structural poverty reduction (Ghys, 2018), using the case study of Neighborhood Health Centers in Belgium[11].

The approach of neighborhood health centers [from here on NHC] is aimed at placing the needs of patients more central in the organization of first line healthcare (doctors, nursing). The social innovation alters the social relations within first line healthcare in three important ways. First, NHCs work with a forfeit system where the health insurance (mandatory in Belgium) pays a monthly fixed rate, after which all medical attention is without costs for the patient. Second, NHCs are group practices that house multiple disciplines, at a minimum doctors and nurses, but often also physiotherapists, physiologists, and even social workers. This allows for immediate referral of the patient. The third aspect is the local focus, since NHCs operate territorially for a certain neighborhood. Additionally, they try to analyze and adjust to the local healthcare needs and context (for example being close to industry) in prevention campaigns and their offer of services (for example hiring a nutritionist if obesity is high). Although it is explicitly not just aimed at people in poverty (being open to all residents), this SI has potential for poverty reduction (see De Maeseneer et al., 2012).

Regarding poverty, we will use a relative conception of poverty (Townsend, 2010). Poverty shall be understood as a situation in which persons have such a lack of resources in relation to the general distribution and living patterns that they become socially excluded in multiple domains of life (Ghys, 2016). We shall approach poverty as a structural societal problem (Royce, 2015; Vranken, 2001; Jordan, 1996), since it is both related to the general distribution of resources in society (inequality) and to the reaction of social forces to this lack of resources (exclusion). In Belgium, the poverty rate in 2018 was 16.4% (Coene, 2019) according to the EU poverty line of 60% of the median income and has been hovering between ten and fifteen percent for decades.

2. Opposition and social innovation

In poverty research, various authors noted the analytical importance of including power relations (Royce, 2015; Green & Hulme, 2005; Gans, 1995). This is different for the newer topic of SI, which we shall broadly understand as societal reactions to social needs through the transformation of social relations, leading to new forms of organization, roles, ideas, etc. Already a considerable amount of literature exists on the growth and diffusion of SI (Westly & Antadze, 2009; Simon et al., 2014; Davies, 2014). Furthermore, attention is often paid to identifying challenges and favorable governance conditions for further growth (Brandsen, 2014; Oosterlynck et al., 2016). The underlying assumption of much SI research is that: a) SI is in general favorable; b) we all support favorable innovation. This is increasingly problematic. Already in the work of Karl Polanyi (Polanyi, 1968), societies reactions to protect itself are not always considered positive, but could lead to violence, exclusion, or just societal failure. More recently, amongst other Sinclair and Baglioni (2014) point towards possible negative consequences of SI. In the specific context of poverty, we must accept that not all social innovations in the end contribute to social inclusion (Martinelli, 2012; Ghys, 2016; for a related discussion see Alcock, 2005). Furthermore, in a key contribution Heiskala points out that the feasibility of SI often depends on who's perspective we take: "Many social innovations bring benefits to all or many people but it is equally possible to have social innovations that mean increased power resources to some while they at the same time bring increasing inequality and suffering elsewhere" (Heiskala, 2007, p. 71).

[1] The data collection for the research was funded by the Flemish Poverty Network (VLAS), this particular project benefited from the guidance of Stijn Oosterlynck, who also gave valuable feedback on this paper.

Even if they have the potential to address social needs, social innovations can thus go against the interests of (powerful) actors, which creates reasons for SI to encounter resistance. As Westly and Antadze (2009, pp. 10-12) indicate, social innovation is also different from other types of innovation in regard to diffusion, because often the groups experiencing the social needs are not able to generate demand for them. This is especially true for people in poverty (who are defined by their lack of resources), who thus partly depend on others or the government to mediate this demand. This vulnerability makes social innovations in poverty reduction an interesting case to study the role of power struggles.

Since altering social relations is at the core of SI, early authors such as Moulaert et al. (2005) and Novy and Leubolt (2005) have certainly payed attention to power relations in the process of SI. Yet the explicit study of power in relation to resistance to (or failure of) SI has been overall limited. Rick Hölsgens (2016) was one of the first to draw explicit attention to the importance of power struggles in the diffusion of SI. Drawing inspiration from theories on the social construction of technology (Pinch & Bijker, 1984), Hölsgens explains how social groups often tend to favor certain designs or oppose certain products or services altogether. He transfers this principle from technological to social innovation, giving a historical (newspaper based) case study of the struggle for woman suffrage in the Netherlands (1883-1919) as example. He concludes that we should not just look at the actions of those enabling innovation, but also that: "Opposition, and dealing with this opposition, is an at least equally important factor in the diffusion of social innovations" (Hölsgens, 2016, p. 64).

In this article we want to answer Hölsgens (2016) call for more empirical research on the role of power and opposition in SI, but also connect the point closer to current debates on SI. After all, the case of woman suffrage has limits in relation to current debates, since a) it takes place a completely different historical context; b) it deals with constitutional change. The latter fits only the broadest definitions of SI that include bare ideas or laws (see f.e. Mumford, 2002), were the bulk of recent case study-oriented SI researches focus on innovative (local) organizational forms that meet social needs. In practice they usually study projects, from cooperatives in trash collection in Brazil (Leubolt & Romão, 2017) to family support by volunteers in Belgium (Cools & Oosterlynck, 2015). The case of Neighborhood Health Centers classifies as SI by any standard, and as a key case will help to further demonstrate the relevance of power relations in the diffusion of SI.

3. Methodology

This paper includes a case study on Neighborhood Health Centers in the Flemish (Dutch speaking North) region of Belgium. The data used in the paper was originally collected in the context of a study (Ghys & Oosterlynck, 2017) on the challenges of this SI in relation to structural poverty reduction. While considering earlier experiences, most of our empirical material focuses on the period of 2012-2016, since during this period the NHCs both made a clear attempt to diffuse and were met with strong opposition on multiple levels of governance.

The data was collected using a specific framework to analyze the relation of SI to structural poverty reduction (Ghys, 2018). This analytical framework consisted of five key factors, further split into twelve sub-factors and over thirty points of attention for data collection and coding. Due to lack of space we will only describe this framework in general (see *ibid*). These five factors were the relation to political conditions; relation to production of poverty; relation to the position of people in poverty; the scale, weight, and continuation of the SI; and the relation to the government. The empirical material in this article on diffusion will focus mainly on the last two topics. Note that this paper will stick to a sociological approach and avoid medical jargon or judging the medical quality of NHCs compared to the regular system.

This case will cover the diffusion of NHCs within Flanders in general (including interviews with national actors and national news coverage), but to study the particular local interaction it

also zoomed in on four NHCs in particular. These were selected to provide a variation on age, including the two oldest centers ('De Restèl' in Alken; 'De Sleep' in Ghent) and two that started in the last decade ('De Vlier' Sint-Niklaas; 'De Zilveren Knoop' in Lier). They also varied on size (both the largest and smallest); as well as on urban-rural context (one in a city and one in a village, with the other two in between).

The data was collected using a combination of two techniques that gave us insight in the role of power in the diffusion of this SI, in addition to the study of available documents and previous research. The first was semi-structured interviews (Rubin & Rubin, 2005), in order to gather qualitative data from involved actors. There were in total nine interviews with eleven people (some were double interviews). These included five interviews with actors active in the NHCs: four with coordinators of a local NHC and one with the (now former) coordinator of the national association of NHC. The other interviews were with policy makers (in higher functions) in the corresponding cities, and one with a key civil servant in the Flemish administration. All quotes are translated from Dutch by the author. Given the politically sensitive nature of the subject all interviews will remain anonymous.

The second method of data collection was an analysis of written media on the subject. This was done via a GoPress Academic scan of the eight main newspapers in Flanders on the term 'Wijkgezondsheidscentra' (Neighborhood Health Centers) between 1985 (start of archive) and January 2017. This resulted in 290 articles that were analyzed. Those provided additional factual information on the diffusion of this SI; as well as allowing us to reconstruct the societal debates surrounding NHCs and contextualize the interview testimonies within these.

4. Context and relation to poverty reduction

In this section we will first briefly narrate the origin of this social innovation, and describe its potential benefits for structural poverty reduction, building our study (Ghys & Oosterlynck, 2017) and that of De Maeseneer et al. (2012) and Willems (2005).

The NHCs were originally part of the wave of social innovations following in the wake of the May 1968 movement, with medicine students rethinking the organization of first line healthcare. The principles of this SI are not limited to Belgium. The first group practice calling itself a neighborhood health center opened in the rural town of Alken (one of the examined cases) in 1976. In 1993 the NHC 'De Sleep' in the city of Ghent (also one of our cases) started using the forfeit system, making it the first NHC to fully embody the model that is discussed in this paper. In the Flemish region the SI has developed only slowly, partly due to opposition of medical interest groups. There also exists an association of NHCs on the national scale, which helps with administrative support, promoting the diffusion of this concept and political representation.

The transformation of social relations that NHCs encompass has potential to contribute to poverty reduction, mainly by making first line healthcare more accessible to people in poverty. First there is the financial aspect. In contrast to private practices a NHC does not work per commission (doctors thus have a fixed wage), but by a forfeit subscription system paid by the health insurance of the client, who then commits to visiting the center. In Belgium healthcare is subsidized and health insurance mandatory. The bulk of the costs (there remains a 'buffer cost') of normal medical procedures and medicine are reimbursed by the health insurance, but only after consultation (the patient thus has to initially pay the full cost). Such costs can lead to delaying or abstaining from using services (f.e. for Belgium see Tilly, 2014). The forfeit system takes away this barrier by making access to healthcare costless, since the client pays for insurance and the health insurance already paid the forfeit.

Second there is the multidisciplinary approach of NHCs, in which various professions are housed in the same building. The advantage of this is that doctors can immediately send people to other staff, which could allow for a more integral approach of the patient and avoids them leaving the process. Some NHCs further improve accessibility for weaker social groups by hiring

social assistants (who can help sorting out the clients' paperwork) or providing translation services for immigrants (an important clientele of this SI). Finally, NHCs often conduct an (periodic) analysis of the (health) needs of the neighborhood, to which it tries to adapt its services and campaigns, for example against lice in schools or by aiming them towards young mothers, etc. A similar analysis is often made before starting a new NHC, which among other things resulted in NHCs predominantly being located in poorer neighborhoods.

It must be noted that the model of a NHC is not specifically aimed at people in poverty. Interviewed coordinators put great emphasis on stressing that they are a universal service with a territorial operation, thus being open to all residents of a particular area. In fact, the SI needs stronger socio-economic clients (on the assumption that statistically they are healthier) to balance out their business model. Yet as we saw this model has clear benefits for people in poverty, and previous research indicated they also disproportionally reach a poorer audience than private practices (De Maeseneer et al., 2012; Willems; 2005). This is achieved by installing collective services with a territorial approach that offer an alternative to the market logic of private practice. The latter is part of the reason that despite success of individual centers this SI has diffused so slowly over time.

5. The frustrated diffusion of Neighborhood Health Centers

5.1. Current diffusion

At the moment of writing there are 35 members of the association of neighborhood health centers in Flanders (31 at the moment of data collection). Together they reach about 3% of the population, but those include a large group of people in poverty (Interview, coordinator association of NHC). This patient population has steadily grown, both in all the interviewed centers as in total, as table 1 shows[22]. The patient population in 2015 ranged from 565 in the smallest NHC to 6850 in the largest.

Table 1: Evolution care population

Year	2010	2011	2012	2013	2014	2015
Care population	48.102	53.142	55.844	61.938	64.709	70.262

Source: Personal communication with association of NHC

However, despite this steady growth the diffusion of this SI has developed slowly (Interview coordinator association NHC). We must consider that the biggest growth is in the patients per center, not the number of centers (although in the last years a few new projects started). Various interviewees indicated this is an important reason to want to further diffuse the SI, since the maximum number of patients was reached in multiple centers. The NHCs are also spread very unevenly across the map of Flanders, most of them clustered in the central cities of the region, with seven of them being in the city of Ghent. Until recently they did not exist at all in the province of West-Flanders, and in general they are underrepresented in smaller towns and villages (Mathijsen, 2010).

5.2. The vulnerability to opposition

In order to appreciate the obstacle that opposition poses to this particular SI, we have to zoom in at how the process of starting a new NHC exactly works. There are generally two ways in which a new NHC emerges. In the first case a group of medical doctors decides to cooperate, or an existing group practice decides to switch to the forfeit system. In this case the embedding in

[2] Information from correspondence with association of neighborhood health centers.

local social organizations comes afterwards. In the second case, NHCs start from social organizations: "Neighborhood health centers, very often start from a poverty association. From local projects that say, 'we need a NHC'. In some locations this comes from the OCMW [Local social services], on some locations from another NHC" (Interview coordinator NHC Alken). In this case they start with a coordinator that has to attract doctors and other medical staff.

When a NHC starts, and especially when it starts with few doctors, it is financially vulnerable. This is because the forfeit system recognizes individual doctors, but the NHCs themselves as centers have no legal recognition as such. This means all other staff and costs needs to be paid a (fixed) wage from this one (fixed) source of income, making this SI vulnerable in its startup phase since it is at the mercy of local patients and doctors:

> *"You have to start small, because at the start you have no patients. So, starting a center is financially not evident at all."* (Interview coordinator NHC De Sleep).
> *"You start with zero patients, so the first month your forfeit gains are zero, but you have to pay the fixed wage of your doctors, the rent, gas and electricity, you have to buy expensive medical software at the start, computers, printers, examination tables, medical equipment. So, the start has serious costs while you have zero income, but once your patient count goes up, your income rises. And after five years you are fully independent"* (Interview coordinator NHC Lier).

As the last and all other interviews with coordinators indicate, once up and running this SI is financially self-sufficient. It is specifically at the startup, thus the moment of diffusion, that support is needed.

There exists no coherent strategy in Flanders to diffuse or upscale this social innovation. On a national level, the Flemish government only provides some support in the form of building subsidies via de VIPA fund for (health)care infrastructure. At some instances in the history of NHCs, subsidies for new centers came from provincial governments, or from other higher scale charities (the lottery fund, the church, etc.). One important scale for support is the local scale: "Starting an NHC, in the first three to five years, is a big work. Naturally, you immediately need infrastructure, a house, furnishing. We see that some local governments have a budget for this" (Interview coordinator NHC Alken). We saw that in the city of Ghent, the only city where NHCs are more or less fully diffused, support from the local government played an important role: "It is not easy to financially make things meet [for starting a NHC], they have a considerable number of patients to process. So, the city decided to give a startup subsidy. They have done this by giving a number of new NHCs a startup subsidy" (Interview policy actor Ghent). It also happens that the City leases land, but recently they changed to a system of loans. However, the main threat in this is that there exists no real strategy for diffusion in Flanders. The diffusion of NHCs happened through trying to puzzle together (often temporary) pieces of subsidies where these were available. In cases they were not, the spread of this innovation lagged for decades.

5.3. Opposition of political and interest groups to neighborhood health centers

> *"In Flanders this has been a difficult process. Partly because of political conditions, partly because of how corporatist the profession of doctor is in Flanders. Today it is still a struggle to change that system"* (Interview coordinator association NHC).

The support for NHCs amongst social civil society organizations has steadily grown throughout time. There has been political support for NHCs from various parties, although it has been shattered over time and location. Most political opposition in Flanders comes from right wing parties (the nationalist and the liberal party), although they only recently used ideological arguments against this more socialized form of healthcare.

In the scan of written media, we paid attention to open criticisms of the NHCs (in opinion pieces or interviews). Political actors on the center and the right did not speak out publicly against this SI until 2013 (although they voted against it on some occasions). In the five articles that they

did, they mentioned complaints from medical doctors as the reason. However, there are fourteen articles in which doctors and their interest groups directly criticize the NHC, mainly by local doctor circles ('huisartsenkringen') or the spokespeople of the Belgian Association of Doctors Syndicates (BVAS) and the Flemish Doctor Syndicat (VAS). Common critiques are unfair competition, overconsumption of health services (because costless), but also direct ideological attacks ('communists!').

This opposition is very noticeable according to the national coordinator: "Doctors are fundamentally against us, because with us doctors are paid a fixed wage, they don't work as independents. This is absolutely not appreciated so (…) we often get scolded for all sorts of things" (Interview coordinator association NHC). There is thus a direct financial incentive to resist this innovation. This opposition and these critiques are also noticeable on the local level:

> *"We once had a situation in which local colleagues, old doctors, [they send] a debt collector at our door, saying they were going to close the operations and block everything"* (Interview coordinator NHC Alken).
> *"Yes, there remains a lot of negativism with the doctors concerning NHCs. Yes, it is 'costless so it cannot be good'"* (Interview coordinator NHC Sint-Niklaas).
> *"In the beginning we had some trouble with other doctors that still worked in the pay per consultation system. Yes, with the old ones, they accused us of making advertisements, which was not true"* (Interview founder NHC De Sleep).

Sometimes it takes a very personal turn, as recounted by this coordinator while speaking about attempts to spread the SI to the neighboring province:

> *"You can be shocked about how it works sometimes. When doctors are being put under pressure and are being told 'you are no longer welcome in the circle of doctors if you do that [join a NHC]. Really, they get written off. And then they say: 'there is serious opposition, we are not going to do it'"* (Interview coordinator NHC Sint-Niklaas).

The resistance often accumulates around criticism on the efficiency of NHCs and their reliance on subsidies: "We are always accused of not being efficient and relying too much on money of the government (…). But this is not our goal, we are not trying to make profit" (Interview coordinator association NHCs). It must be noted that consultations in both this model and private practice are subsidized, as well are among other things prescribed drugs, the training of doctors and the tax exemption of their income. For the government NHC's are not by definition more expensive than the regular system (see KCE, 2008). Our interviews (and analysis of newspaper articles) indicate that the opposing doctors are mainly worried about competition:

> *"Often a NHC is seen as a threat or as unfair competition because we work with the forfeit system and do so called free healthcare. But of course, it is not free. The money all comes from the same pot, we just use it differently"* (Interview coordinator NHC Alken).
> *"They often think of us as unfair competition. (…) to start you need to find subsidies. And I think that aggravates the doctors that think: 'we also do efforts for socially vulnerable groups and we get no extra money'. I always say: 'if you think this is a goldmine, you could always do it yourself'"* (Interview coordinator NHC Lier).
> *"If they find it competition, I don't understand it. Because 80% of the doctors has a stop on patients because they have too much work"* (Interview coordinator NHC Sint-Niklaas).
> *"I think this is a general story in Flanders. The NHC are viewed with skepticism, as competition where healthcare is practiced for free. In general, a lot of doctors are afraid of new NHCs because they think they will lose patients"* (Interview policy employee Ghent).
> *"[In talking with doctors] definitely competition played a role in the background. It was of course not expressed explicitly, but you could sense it played a role in the background"* (Interview policy actor OCMW Lier).

As some of the previous quotations indicate actors within the NHCs don't see themselves as competitors and try not to aggravate the other doctors, for example by proposing cooperation or by first asking new clients to consider going back to their old doctor or proposing alternatives [33].

For our argument it is crucial to observe how this opposition of doctors as a group often translates into political obstruction. A first example from within the four examined cases is how the city of Lier objected to support the diffusion of a new NHC, amongst other reasons out of pressure from doctors:

> *"What also played a role [in not supporting NHC], was that a lot of reactions came from the sector of doctors. That sector said about the initiative that 'we think that we already do things on accessibility' (…). Actually, they were very strongly opposed to the idea of the Neighborhood Health Center' and that played a role because that profession (…) made approaches towards the city council, the social service council and the city"* (Interview policymaker OCMW Lier).

This is also the impression the NHC had of the situation: "We encountered local resistance of the doctors and of the local administration that let itself sometimes be influenced by that. They say, 'that is not needed, can't we make healthcare more accessible in some other way?" (Interview coordinator NHC Lier). In understanding this support of local governments for the cause of private doctors, we have to take into account the established and prestigious position that doctors enjoy in local societies. A similar situation occurred in Sint-Niklaas, where the local government retracted subsidies: "The city initially promised resources to start. Because of protests of the doctors' circle those were retracted. This was inconvenient because this happened right before our launch and it concerned 70.000 euro" (Interview coordinator NHC Sint-Niklaas). According to the NHC, the political obstruction was very direct: "We have a deputy that is also a doctor (…). I have seen that he said at some point in the city council [open to public]: 'I demand that the college of deputies forbids the NHC to receive regular patients. They can only concern themselves with poor people'" (Interview coordinator NHC Sint-Niklaas). An article in the newspaper Gazet van Antwerpen (2004, p. 17) confirms that the city postponed support for the NHC, and the concerned deputy affirmed in the article that this was largely motived by opposition of doctors.

In the last two examples the launch of the NHC was delayed, but it eventually happened. One infamous case which was mentioned in multiple interviews and articles was how doctors successfully resisted the diffusion of this SI in the town of Eeklo:

> *"There is always protest when new centers are founded. Eeklo is a very sad example of that in the previous months, where they came very close to completing a new NHC (…). But a doctor was also a local deputy, so it did not get passed (…). It got into a very negative spiral and the plan was eventually abandoned"* (Interview coordinator NHC Sint-Niklaas).

This case is of particular interest because the (now former) minister-president of Flanders had allocated money from the rural fund to support this NHC; but had to rewind this in 2014 because of protests from doctors' circles. Another example is how the diffusion of this SI to the province of West-Flanders was stuck for decades (in 2016 the first three centers started): "If you go to West-Flanders and say aloud you want to start a NHC, you should try it, it is a very sobering experience" (Interview coordinator association NHC). This and other experiences have demotivated the national association in the past to play a coordinating role in the diffusion of this SI:

> *"We learned our lesson regarding founding. Things should come from below, preferably (…). You really need a doctor that is willing to risk his neck locally or a group practice that wants to switch. This happens. So we plotted a few conditions that are absolutely required, but we have just such*

[3] There exists a rule ('derdebetalersregeling') in Belgium that allows third actors (for example social services) to be billed directly for medical expenses, given the doctor is willing to do the administration. There is still a small 'buffer' cost, but the financial effect is similar to forfeit.

> *bad experience with trying to start centers top-down. That causes too much opposition"* (Interview coordinator association of NHCs).

It is thus not just the opposition we must take into account, but also how it is dealt with internally.

So far, we have discussed the obstacles this SI encounter on a local level, but political opposition to the diffusion can also be found on the national level. First of all there is the issue that the operation of a NHC is not legally recognized, nor receives support as such but counts as a group practice, an issue that according to our interviews and De Maeseneer et al. (2012) has greatly frustrated the NHC community. According to an anonymous civil servant close to the case this lack of recognition is for political reasons: "Because they are not really enthusiastic to go against the doctors' association. It is sometimes seen like that. This has been dragging for five years, this recognition ruling. I would be amazed if it would happen now" (Interview civil servant Flemish government). Our newspaper analysis indicates that small parliamentary debates over the recognition and support of this SI resurfaced sporadically throughout decades, with no resolution until the present. The one exception to this, the including in the VIPA infrastructure fund, has also seen waves of support and obstruction throughout time. Some years ago, this fund stopped approving all NHC projects: "Often the centers were able to buy and build a new location after a few years. Because of this they saw that building was interesting because they could get VIPA means from the Flemish government for building purposes. But now this is all tilting, so that the NHC cannot make use of it" (Interview policymaker Ghent). The civil servant of the Flemish administration confirmed this was a conscious decision, but countered that it was motivated by frustration over the uneven spread of this SI, and was done hoping that it would spread towards smaller towns with high poverty. In 2016 this situation got resolved after an agreement was reached and the minister of care Vandeurzen (Christian democrat party) announced that 6,5 million euro extra would be allocated to the construction of new NHC via the VIPA fund. This triggered plans for the startup of new centers in the provinces of Antwerp and West-Flanders where the provincial government provided additional support.

However, these and other efforts were frustrated when the complete obstruction of the diffusion of this SI came later in 2016 by decision of minister of health de Block (Liberal party), herself a medical doctor. Minister de Block announced in October 2016 a full stop of the further diffusion of NHC by freezing any new requests for recognition by the forfeit system. While denying this move had ideological reasons, she did admit this was explicitly aimed at the NHC (Van Garderen, 2015, p. 5), for whom she ordered a halt until an extra audit for the cost-efficiency of the system was conducted. On top of this, seven million euro would be deduced from the budget of existing centers that used the forfeit system. The audit was eventually completed and concluded that NHCs are not more expensive, leading to a lift of the freeze in 2018. Still, this seriously delayed, cancelled or altered (away from the model of this SI) the trajectory of various emerging projects.

6. Conclusion

In this article we provided further arguments for the idea that power relations and the obstruction of interest groups play an important role in the development and diffusion of social innovations. Just like technological innovations, social innovations are socially constructed (Hölsgens, 2016). We echoed this point specifically in the context of poverty reduction. As Westly and Antadze (2009, pp. 10-12) indicate, groups that are experiencing social needs might not be able to generate demand for them. If this is true, then this makes people who live in poverty especially vulnerable in regards to obtaining social innovations that benefit their needs most, as well as to being subjected to social innovations fit for the interests of more powerful groups. The latter should also deserve more attention in a critical SI research agenda.

To show this dynamic at work, we presented the case of neighborhood health centers in Flanders, Belgium. Although virtually all individual NHCs have proven sustainable and the concept was being widely endorsed by social organizations, this SI has known a particularly slow diffusion in Flanders, both compared with NHCs elsewhere and with other SI of similar age in Flanders (Ghys, 2018). Building on previous research, we assessed that this SI had a limited but real potential to contribute to poverty reduction, through de-commodifying first line healthcare and improving the access to further help within a territorial approach. Note that these improvements are partly obtained by going against the normal market logic in healthcare (which admittedly is already partly de-commodified in Belgium), and limits the potential income of medical professions. Although very sensitive to the issue, the association of NHCs does not have poverty reduction as an explicit goal, sticking to a universalist approach. Yet we saw how through civil society organizations the demand for this SI was formulated, resulting in various attempts to start new NHCs in Flanders. This however ran against the interests of more powerful groups, primarily private doctors' syndicates, and secondary certain rightwing political actors. We documented how on various occasions these interests were able to halt the diffusion of this SI, among others through publicly discrediting the concept, discouraging other doctors and most importantly pressuring politicians into withholding subsidies for new NHCs. One remarkable observation is that although NHCs are frequently discussed in the context of poverty reduction, these discussions in substance rarely touch on poverty, yet actively reduce the potential to contribute to structural poverty reduction.

Although every so often windows of opportunity emerge for small spurts in diffusion, the point is that there has never been a coordinated effort to spread this SI. This further adds to the insight that social innovations in general, but especially innovations in the field of poverty reduction, do not scale or spread based on inherent merits (Ghys, 2018). A more strategic approach is required for SI to structurally contribute to tackling societal problems.

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