



WP T2

ASTAHG ALPINE SPACE TRANSNATIONAL
GOVERNANCE ON ACTIVE AND HEALTHY
AGEING

REPORT ON THE AHA GOVERNANCE MODEL

D.T2.1.2

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NIJZ | National Institute of Public Health (Slovenia)

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ACRONYMS

AHA	Active and healthy ageing
AS	Alpine Space
ASTAHG	Alpine Space Transnational Governance of Active and Healthy Ageing
EU	European Union
EUSALP	European Union Strategy for the Alpine Region
HiAP	Health in All Policies
MCDA	Multicriteria Decision Analysis
MoU	Memorandum of Understanding
OECD	Organisation for Economic Co-operation and Development
PSG	Project Steering Group
SDoH	Social Determinants of Health
TGB	Transnational Governance Board
TWG	Thematic Working Group
WHO	World Health Organization
WP	Work package



1 INTRODUCTION

Demographic change constitutes a major societal challenge in most industrialised countries that requires combined efforts from different stakeholders, including public authorities, industry, academia and civil society across policy areas to support Active and Healthy Ageing (AHA) (e.g. Rechel et. al., 2013; WHO, 2002; 2013). This challenge is amplified in the Alpine Space (AS) region by its distinctive characteristics, including considerable regional variation both in demographic change and population growth projections, ultimately calling for tailored interventions to foster Active and Healthy Ageing (AHA). In addition to that, the AS area is composed of regions that belong to different countries which, thus far, has limited the scope for trans-regional and transnational cooperation to tackle the ageing challenge. Further, AHA policies are often restricted to a few areas of public service provision, such as healthcare and welfare authorities. Potential synergies from cooperation across sectors, for instance, cultural, economic or housing policies, are thus often neglected (WHO, 2012; 2013; 2017; OECD, 2015).

1.1 The ASTAHG-Project at a glance

The Alpine Space Transnational Governance of Active and Healthy Ageing (ASTAHG) project aims to tackle this challenge by following a *multisectoral, transnational, and multilevel* approach to improve AHA in the AS. It is *multisectoral* as it aims to facilitate innovation across sectors, such as social care, healthcare, long term care, independent living, mobility and transport, as well as culture and tourism; and it follows a *transnational* approach as it brings together stakeholders from different regions of the AS to exchange experiences, ideas and innovations, streamline strategies to address the



ageing challenge and to share knowledge and best practices across geographically and/or politically defined contexts. The project's *multilevel* approach aims at cooperation between stakeholders on local, regional, and national level to identify, implement, evaluate and improve upon successful AHA policies and to harvest potential synergies through efficient cooperation along all stages of the policy cycle.

The overall objective of the project is to improve capacities and coordinating efforts in support of AHA between sectors and different levels, and to respond with tailored initiatives to AS territorial needs. It aspires to enhance governance capacities related to regional AHA policies, foster the transfer of innovation for AHA in the AS, and to develop a social innovation framework for generating and adopting innovative solutions for AHA involving both public and private actors (ASTAHG, 2018). To achieve these objectives, ASTAHG will establish a *Transnational Governance Board* (TGB) for AHA to bring policy makers and other stakeholders in the AS together, to develop a network, and to foster the exchange of successful AHA policies, initiatives and innovations. The TGB is defined as “*an open network and the participation of members is free of charge and voluntarily*” (MoU, 2019). Whilst all ASTAHG partners are founding members of the TGB (Managing Committee), other interested organisations and stakeholders may apply to join at any time. (MoU, 2019). The TGBs main objective is “*to promote an ‘age-friendly’ Alpine Space Area creating synergies between interested stakeholders and governance levels and helping the Alpine Space local, regional and national authorities and other stakeholders to collaborate in promoting innovative solutions that address the needs of the ageing population*” (MoU, 2019).

To this end, ASTAHG will also develop a portfolio of good practices in AHA governance and establish an AHA innovation observatory which classifies AHA initiatives and solutions with context and efficiency indicators (ASTAHG, 2018). A framework for AHA innovation based on the Quadruple Helix model (Carayannis & Campbell, 2009) will foster collaboration between different actors from local, regional and national



governance, industry, as well as academia and civil society (ASTAHG, 2018). ASTAHG will also align its efforts and results with the EU Strategy for the Alpine Region (EUSALP) so to further enhance the level of transnational governance throughout the AS.

The ASTAHG project has been designed in several Work Packages (WPs), each of which contributes towards the common aim and objectives (Figure 1). Horizontal activities are concentrated in WPM (Management) and WPC (Communication). Whilst WPM is concerned with overall project management and ensures sound and smooth project implementation, internal communication between partners and with the funding organisation, WPC is dedicated to the development and execution of an efficient communication strategy, engagement with Quadruple-Helix actors in the TGB; exchange with other AHA initiatives, in particular EUSALP; dissemination of project outcomes as well as engagement with AHA stakeholders and a wider public audience.

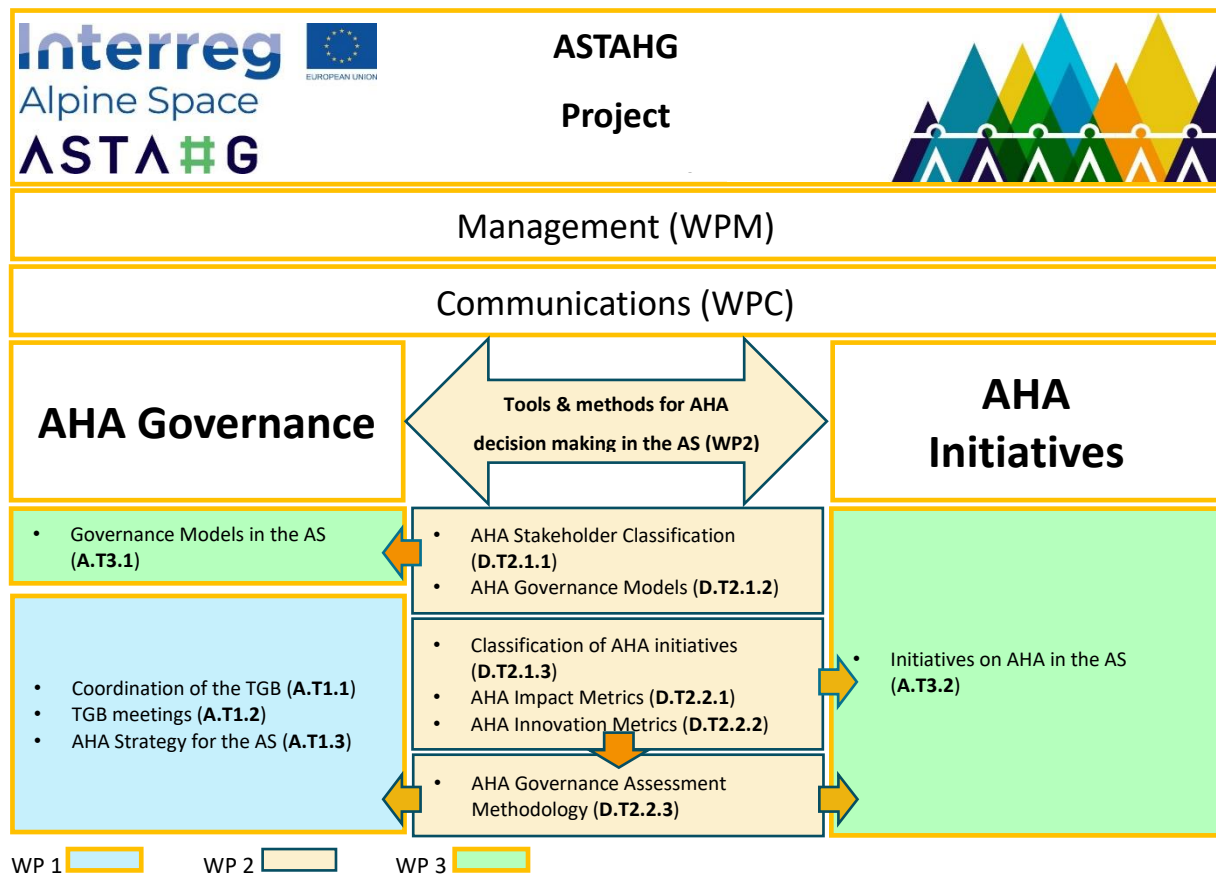
WPs 1 to 3 are concerned with project implementation. In this context, WP1 aims to establish and manage the TGB that will be composed of public and private actors, pertaining to different levels (regional/local) and sectors as well as representing AS territorial characteristics (ASTAHG, 2018). The TGB is organised in different thematic groups and meets regularly in order to share experiences, knowledge and expertise and to develop a sustainable AHA strategy for the AS based on intersectoral, transnational and multilevel cooperation. The activities in WP1 range from the coordination of the TGB (A.T1.1) to the organisation of regular TGB meetings (A.T1.2) and to develop an AHA strategy for the AS (A.T1.3).

WP2 develops and provides tools and methods for the project, in particular a classification of AHA stakeholders (D.T2.1.1), a model for AHA governance in the AS (D.T2.1.2, this report), a classification of AHA initiatives (D.T2.1.3), as well as AHA impact evaluation metrics (D.T2.2.1), AHA innovation evaluation metrics (D.T2.2.2) and an AHA governance assessment methodology (D.T2.2.3). WP3 is concerned with the application and use of tools and methods developed in WP2: data gathering and analysis of AHA



governance models (A.T3.1) and the identification and monitoring of innovation in AHA in the AS (A.T3.2).

Figure 1: Components of the ASTAHG project and WP2 in context



Source: Own drawing based on ASTAHG (2018).

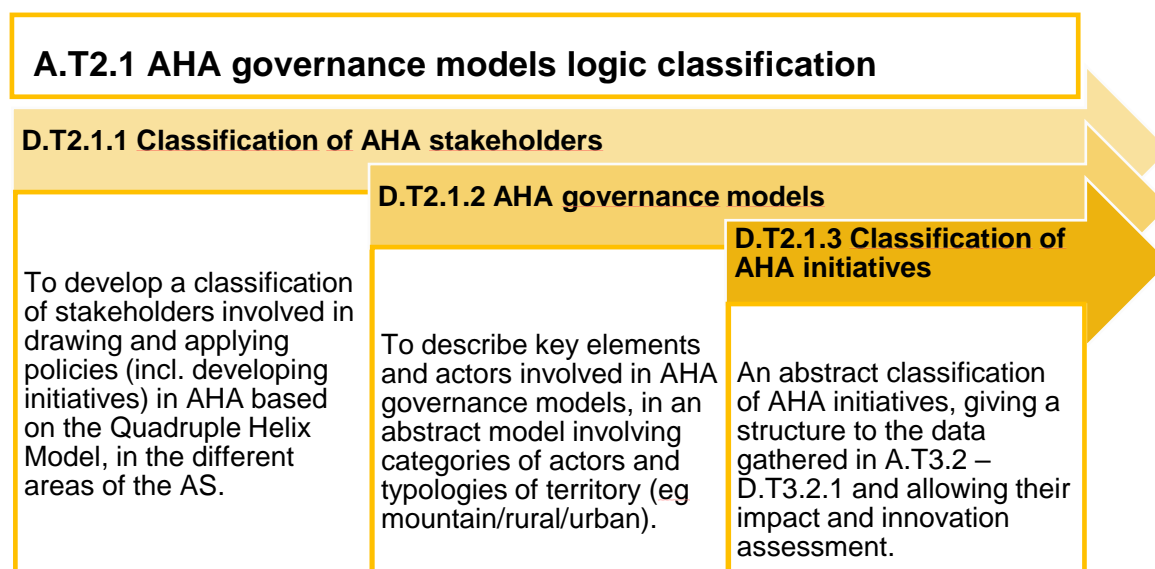


1.2 Contribution of Work Package 2

As depicted in Figure 1 above, the overall aim of WP2 is to provide tools and methods for the ASTAHG project to bridge the gap between AHA governance and AHA initiatives and to enable efficient AHA decision making in the AS. WP2 thereby aims at supporting activities both in the context of implementing a Transnational Governance Board (WP1) as well as activities in WP3, which will gather data and information on AHA initiatives and governance models in the AS. Whilst deliverables D.T2.1.1 (AHA stakeholder classification) and D.T2.1.2 (AHA governance models) play a particular important role in the conceptualisation, design, and composition of the TGB by contributing both theoretical models and structuring the space of relevant stakeholders in accordance with the Quadruple Helix Model (Carayannis & Campbell, 2009), they also provide tools for WP3 to collect context specific data on relevant AHA actors and governance models prevalent in the AS region. Deliverable D.T2.1.3 (classification of AHA initiatives), on the other hand, is more concerned with developing a tool to gather information on policies, initiatives and innovations which aims at improving Active and Healthy Ageing in the AS. This tool will, in turn, provide a framework for WP3 to collect and analyse relevant information from each project region, and help structuring the evidence on cross-sectorial AHA policies, initiatives, and innovations which may have the potential to:

- support AHA of the population in the respective project regions
- improve the sustainability of social, health and care systems, as well as other areas of public service provision, and
- contribute towards the competitiveness of local economies by encouraging innovation for AHA in the AS.

Figure 2: Deliverables in Activity T2.1 - AHA governance logic classification

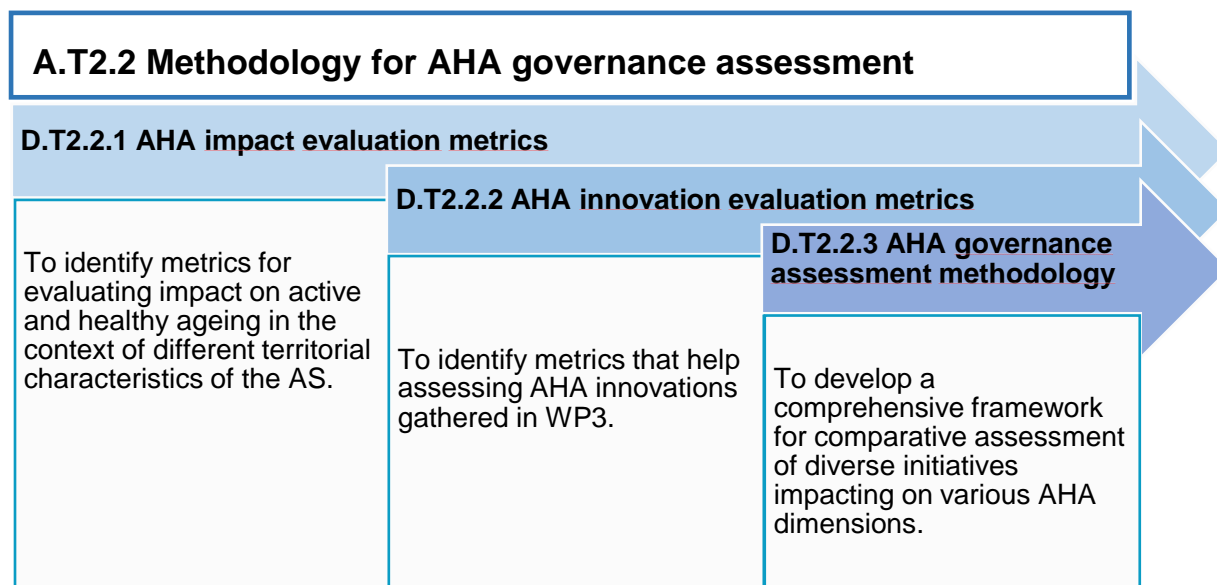


Source: Own drawing based on ASTAHG (2018).

Activities in A.T2.2 (Methodology for AHA governance assessment, Figure 3), are concerned with developing tools and methods for efficient cross-sectorial AHA decision making in the AS. In this context, Deliverable D.T2.2.1 (AHA impact evaluation metrics) gathers indicators that may help quantifying the impact of AHA policies, initiatives and innovations on various dimensions of AHA with the aim to support decision makers identifying promising AHA interventions in their respective contexts. To better understand the innovative character of AHA policies, initiatives and innovations, deliverable D.T2.2.2 further proposes innovation evaluation metrics, whilst both deliverables ultimately feed into the development of an AHA governance assessment methodology (deliverable D.T2.2.3). The latter is based on the concept of multicriteria decision analysis (MCDA) and will help decision makers in prioritising amongst policy alternatives that may all lead to various favourable effects across relevant sectors but generally compete for limited resources. All three deliverables also form the basis for data collection and analysis in WP3, with the ultimate aim to identify and monitor innovation in AHA in the AS through the development of an AHA innovation observatory.



Figure 3: Deliverables in Activity T2.2 - Methodology for AHA governance assessment



Source: Own drawing based on ASTAHG (2018).

1.3 Aim and structure of this report

This report presents a model for the governance of AHA in the AS. The aim of the model is to strengthen coordination, to support innovation in active ageing and to improve the overall effectiveness and efficiency of AHA governance in the AS. Upon implementation, the governance model should further raise awareness for the necessity and potential of intersectoral, interregional and transnational synergies achieved through cooperation in AHA governance.

This report is structured in three main sections. Chapter 2 describes how the model was chosen and developed. This chapter builds on existing literature, the extensive exchange with project partners and AHA stakeholders in the region and the results of the AHA stakeholder classification exercise carried out within the ASTAHG project. The third



Chapter describes the model itself. It describes the structure of the governance model, the activities which should be carried out, and the policy areas to be covered. Chapter 4 describes the practical application of the model. A first step towards implementing the governance model developed in Chapters 2 and 3 has already been taken by the signing of a Memorandum of Understanding (MoU) between the project partners to set up a Transnational Governance Board (TGB) for AHA in the AS (Annex 1). Hence, Chapter 4 builds on Chapters 1 and 2 as well as the MoU to outline how the model should be applied in practice. In addition, it shows linkages to AHA governance tools developed in other parts of the ASTAHG project. The report ends with a conclusion outlining the next steps to be taken within the project.



2 MODEL CHOICE & DEVELOPMENT: PRAGMATIC DESK REVIEW AND STAKEHOLDER EXCHANGE

The governance model presented in this report builds on a review of the (academic) literature and of best-practice examples, the results of other work packages of the ASTAHG project as well as on intense cooperation among the ASTAHG project partners and observers who are important AHA stakeholders and the founding members of the TGB (see Chapter 4). The goal of the review was to identify the most appropriate governance model to address the specific challenges of the policy area (active and healthy ageing) and the region (alpine spaces). Therefore, the region-specific as well as policy-specific literature was consulted alongside general literature on governance.

Based on this review, a first draft of the governance model was developed which was presented to and discussed with the project partners at the third Meeting of the ASTAHG Project Steering Group (PSG) in Trento in May 2019 and at the ASTAHG mid-term conference in December 2019 in Marseilles. Feedback by the project partners and first results from the AHA information survey (see report D T2.1.3) were then used to develop the MoU and to refine the model.

In the following, key activities of AHA governance will be outlined. Thereafter, the most appropriate form of governance of AHA in the AS will be discussed.

2.1 Key activities of AHA governance

The term governance is used widely but not always clearly defined (see for example Stoker, 1998). This report uses the definition of Stoker who distinguishes *governance*



from formal *government*. While government describes the way in which formal institutions of the state maintain public order and solve collective action problems based on a monopoly of legitimate force, governance describes the pursuit of the same goals by actors who do not possess the coercive power of states (Stoker, 1998). In short, “[t]he *essence of governance is its focus on governing mechanisms which do not rest on recourse to the authority and sanctions of government*” (Stoker, 1998, p.17).

The region of the AS is not a nation-state, but a transnational region including territories of several member states of the European Union (EU) as well as Switzerland. As such, there is no central actor with a legal mandate to take charge of AHA policy across the regions. The understanding of governance by Stoker, then, provides a useful vantage point to think about how to develop and implement AHA policy across the AS without the mandate and powers of government. Further, the concept of governance allows for the inclusion of both public and private actors which, as it will be argued throughout this report, is of central importance for the development and implementation of efficient and effective AHA policies.

What then are the key functions and activities in AHA governance? Drawing from literature on public policy making (e.g. Howlett and Giest, 2012) and on health and AHA policy (WHO, 2002; 2012; 2013; 2017; OECD, 2015), this report identifies six areas in which AHA governance across the AS region could be beneficial.

The first is **evidence support** which is understood as the production and sharing of evidence and knowledge. There is a lack of data both regarding the needs of older people and the impact of specific policies. This has been recognised for example by the WHO Global Strategy and Action Plan on Ageing and Health which includes “*improving measurement, monitoring and research on Healthy Ageing*” as its fifth strategic objective (WHO, 2017). The second key function is the **setting of goals and targets**. The fact that



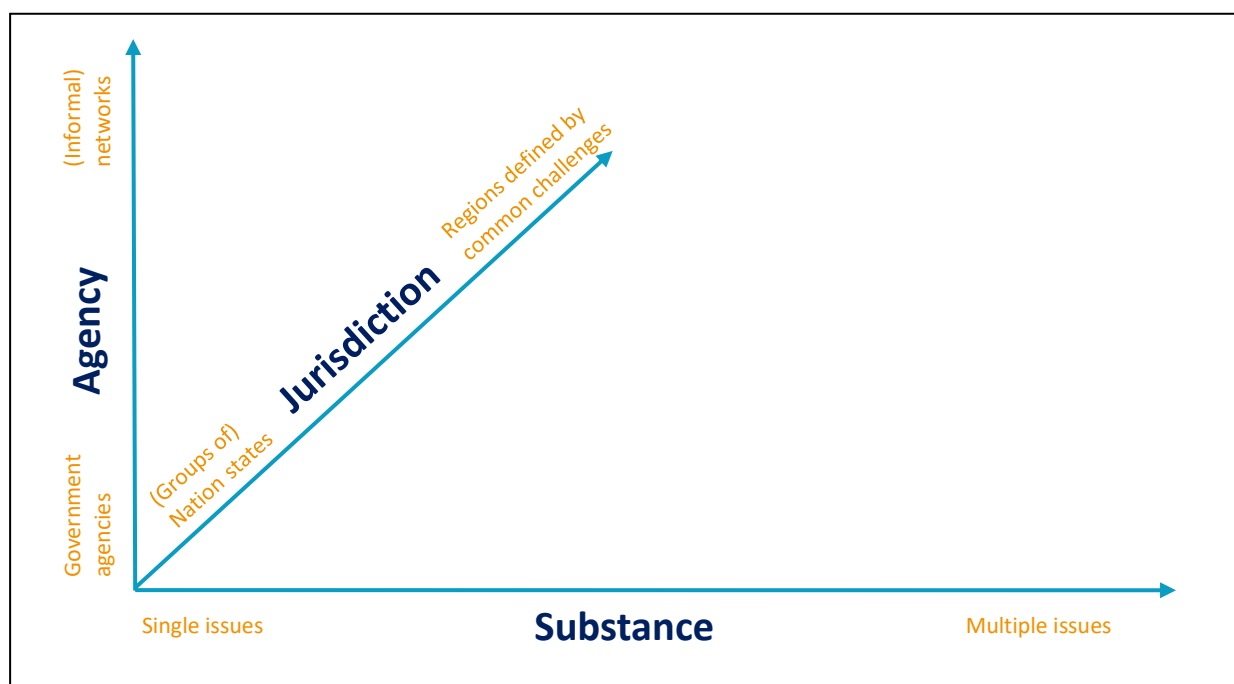
the AS region does not yet have a common approach to AHA policy means that potential gains from economies of scale, cooperation and complementary policy actions *across the states and regions* of the AS are not exploited.¹ In addition, as will be outlined in more detail below, health and peoples' ability for active and healthy ageing are influenced by actions in a range of policy areas (WHO, 2013; 2017). Hence, there is also an opportunity to exploit complementarities and synergies *across policy areas* by coordinating actions taken by various actors across the AS. **Policy guidance** describes the process of supporting actors across the AS in the choice of right - i.e. the most effective, efficient and/or innovative - policies, initiatives and actions. **Coordination** is a key governance activity to ensure that complementary actions are taken to achieve mutually agreed goals while fragmentation and duplication of actions is minimised. Guidance and coordination thus describe the process of helping actors across the region turn goals into actions in a coherent, efficient and effective manner. The making, influencing and implementation of **legislation** is another core function of governance. While governance actors, in line with the definition by Stoker, generally do not have legislative power – at least not for the entirety of the AS region – formal rules and norms are crucial policy instruments. However, individual stakeholders involved in the field of AHA in the AS region are able to influence legislation and legal regulations in their region or municipality – and some are even able to make laws within their national multi-level governance system. Stakeholders are therefore advised and invited to influence policy making and stipulate policy changes beneficial to AHA at all levels. Finally, considering **finances** in the development and implementation of AHA policies in the AS is important as it entails not just setting appropriate incentives for AHA actors through suitable business models and/or payment and reimbursement mechanisms, but also - on a larger scale - should contribute to the long term sustainability of (publicly financed) budgets in the social-, health- and care systems, as well as other policy sectors involved.

¹ See also the OECD governance strategy for "ensuring policy synergies between levels of government" (OECD, 2015, pp. 98-103).

2.2 What form of governance?

Different forms of governance arrangements can be mapped in a three-dimensional space along the axis of *agency*, *jurisdiction* and *substance* (Balsiger & Vandever, 2012; Price, 2014) as depicted in Figure 4.

Figure 4: Three-dimensional governance space



Source: Own drawing based on Balsiger and Vandever (2012) and Price (2014).

The agency axis describes the institution in charge of taking policy decisions. In modern nation states, agency is vested in many actors. At one end of the spectrum are government agencies with the exclusive mandate to decide on public policies in specific areas. For example, agency to decide on the interest rate in most states rests with the central bank. At the other end of the spectrum are (informal) networks between public and/or private actors. For example, Balsinger and Vandever (2012) mention networks among NGOs in the field of wildlife protection. Further, agency can be assigned vertically between public or private actors. In federal states like Germany and Austria or in



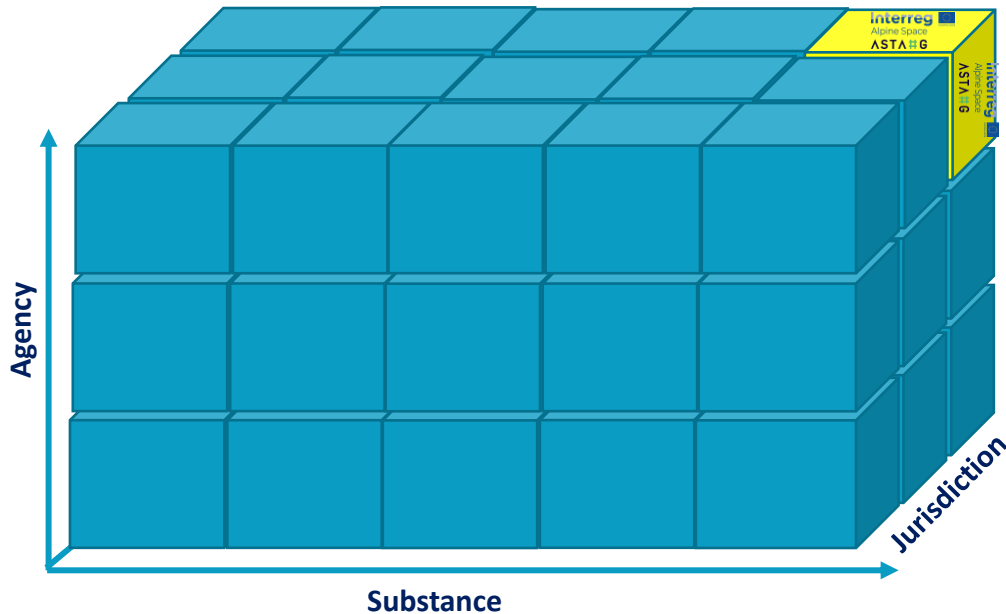
supranational organisations like the European Union, for instance, policy making authority is assigned to actors on different levels (municipal, regional, national, supranational) in different policy areas (Oates, 2008).

The second axis, jurisdiction, relates to the geographical area for which policy decisions are made. Returning to the earlier examples, central banks set interest rates either for individual countries or, as in the case of the Eurozone, for several nation states sharing the same currency. In either case, jurisdiction of the agency is clearly defined by legal boundaries. Jurisdiction, however, can also be problem centred. Many policy challenges such as the protection of wildlife do not respect state boundaries. Therefore, it can be preferable to develop governance solutions for regions defined by common challenges rather than by existing legal arrangements.

The third dimension addresses the substance of governance: which issues should be addressed, how many and to what degree? In some policy areas, the mandates are narrowly defined. Central banks, for example, often have the narrow mandate of adjusting monetary supply and, in some countries, overseeing commercial banks. In specific cases, a wider mandate spanning several issues or sectors can be preferable. For example, this can be the case if there are complementarities between sectors and/or policy areas or if coordinated action on several issues is necessary to achieve a specific target.

As the will be argued in the remainder of this chapter, governing AHA policies in the AS requires a **multi-issue (-sectoral), multi-level** governance model consisting of a **network of actors** with jurisdiction over a **region defined by common challenges**. In other words, a governance model located on the outward end on all three axes is best suited to address the challenges particular to this region and policy area (Figure 5).

Figure 5: ASTAHG within the three-dimensional governance space



Source: Own drawing based on Balsiger and Vandevier (2012) and Price (2014).

2.2.1 Jurisdiction

A central tenant in the theory of governance is the decentralisation theorem formulated by Wallace Oates (1972, p.54) which states that in the absence of externalities or increases in cost-efficiency from centralised provision, public policies should be provided at the lowest level possible. The theorem builds on the understanding that there is variation in the policy preferences of individuals and that different local policies will be more directly in line with individuals' preferences than one unitary policy of a centralised government could ever be. If there are benefits from policy coordination or cooperation over a larger geographical space, however, decision making should be elevated to a higher level to exploit these benefits. AHA is influenced by actions in a range of policy areas (see below) which are addressed at different levels in the countries of the AS with so far little cooperation between local actors across national borders. In



addition, there are EU-wide² and global initiatives (WHO, 2017) to promote AHA by supporting coordination and information sharing. However, the continental or global reach of these policies means that they naturally do not address the regional particularities of the AS. There is hence a gap in AHA governance between, on the one hand, the local and regional AHA policies of the different regions of the AS and, on the other hand, the more general European and global approaches. Filling this gap and improving cooperation across national and cultural boundaries in order to address a common challenge, facilitate the dissemination of innovations, exploit synergies and enable learning between actors is at the core of the ASTAHG project. In other words, the project originated from the understanding that AHA in the AS will benefit from a governance structure for a **region defined by common challenges** which complements the existing national and EU-level structures and policies.

An argument could further be made that different governance structures should be developed to connect actors from urban, rural and mountainous regions respectively because there are specific challenges to AHA inherent to the geographical characteristics.³ For example, the decreasing availability of health care providers is more acute in rural and mountainous regions than in densely populated cities. At the same time, however, there are many challenges which affect all regions equally. While public transport takes different forms in cities and on the countryside, it is crucial for the inclusion of older people in both areas. Thus, developing separate structures for different regions could lead to additional fragmentation and duplication of efforts and thus to preventing the targeted exploitation of synergies and gains from cooperation.

² The European Union named 2012 the “European Year for Active Ageing and Solidarity between Generations”. The European Innovation Partnership on Active and Healthy Ageing (EIP on AHA) established in 2011 aims at increasing the average healthy lifespan in Europe by 2 years by 2020.

³ For example, see OECD 2015 for a discussion of ageing policies and governance in urban areas.



As a corollary, this report recommends *one* governance structure connecting actors from *all* regions of the AS.

2.2.2 Substance

Active and healthy ageing are closely related and require actions across a range of policy areas. Healthy ageing is defined by the World Health Organisation (WHO) as *“the process of developing and maintaining the functional ability that enables wellbeing in older age”* (WHO, 2017, p.4) and active ageing is understood as *“the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age”* (WHO, 2002, p.12). Both concepts emphasize that older people should remain a resource to their families, communities and economies and both share an understanding that, in order to achieve AHA, action is required across **multiple sectors**. As stated by the WHO Global Strategy and Action Plan on Ageing and Health *“most policies, systems or services have a direct impact on older people’s ability to experience Healthy Ageing”* and while action in no one sector is sufficient, *“[w]orking together [across sectors] can have important efficiency gains, as action in one arena may reduce the need for others”* (WHO, 2017, p.13). In addition to the availability and quality of health and social services, the 2002 Active Ageing Policy Framework by the WHO lists economic, social, physical, cultural and behavioural factors as well as gender as determinants of health outcomes (WHO, 2002, p.19). The interrelatedness between health and other policy areas is also at the core of the concepts of the Social Determinants of Health (SDoH) and Health in All Policies (HiAP). SDoH emphasises the strong relation between health and socioeconomic factors and class status. HiAP is an acknowledgment of the multiple factors determining health outcomes and a recommendation that public policies should systematically take into account the health and health systems implications of decisions, seek synergies and avoid harmful health impacts in order to promote population health and health equity (WHO, 2013).



In sum, health and care policies are central to AHA policies, but additional coordinated action in other policy areas is required. Health encompasses physical and mental health which both are influenced by a myriad of factors including pollution, nutrition, social inclusion, employment status or education. To be effective, health policies must hence be comprehensive and include preventative measures for health promotion and disease prevention, curative services and mental health services. Related to the topic of health promotion, AHA policies should include measures to promote *healthy lifestyles* such as engaging in physical activities, consuming a healthy and balanced diet and abstaining from the consumption of tobacco and alcohol. Health policy for older people is intrinsically linked to *care policies* to support individuals in need of health and social care (long-term care).

In addition, there are a wide range of policy areas in which actions can and should be taken to support AHA.⁴ Governments and stakeholders should work to build *age-friendly* and *enabling environments*. Age-friendly environments help individuals to maintain their mental and physical capacities over the life-course and they enable individuals with reduced capacities to engage in the activities they value (WHO, 2017, p.10). Accessible and affordable *public transport* services are important in rural and urban areas to allow older people to continue participating in public and family life and to prevent loneliness and isolation. Similarly, *housing policies* and support for *independent living* are important for older people to live more active and healthy lives. This can include barrier-free buildings for people with disabilities, accessible parks and recreational spaces for social encounters and physical activities or street lighting for safe walking.

⁴ For a comprehensive list of relevant policy areas, actions and programmes see *Active Ageing: A Policy Framework* (WHO, 2002), the *Helsinki Statement on Health in All Policies* (WHO, 2013) and the *WHO Global Strategy and Action Plan for Ageing and Health* (WHO, 2017).



Voluntary labour market participation allows older people to remain active, to earn an income which reduces the risk of old-age poverty and to contribute economically to society. Similarly, voluntary and civic engagement contributes to the social inclusion of older people and prevents loneliness which has positive effects on health. *Education* and *life-long learning* policies should therefore help older people improve, maintain and update their skills to remain active in the labour market. Stakeholders from the AS further pointed out that age-friendly environments can create new opportunities for *tourism*. Improved infrastructure and cultural activities can increase the attractiveness of the region for older tourists and residents alike. In other words, AHA policies not only improve the living conditions of older people, they can also have clear economic benefits for businesses located in the AS.

2.2.3 Agency

The range of policy areas in which actions should be taken to support AHA clearly call for a **network of public and private actors at different levels**. In line with the aforementioned decentralisation theorem, the governance model should cover all levels to exploit the benefits of cooperation, innovation and experience sharing over the entire region, while also leaving space to collect local data and for common strategies to be adapted to local needs, contexts and regulations. Further, the incorporation of new actors for concerted action is crucial for legitimate and effective ageing policies and has been recommended by the OECD as one of three governance strategies (OECD, 2015, pp.94-97). Both private and public actors should be involved because both play an important role in developing, adapting and implementing AHA policies (WHO, 2017, p.25). Public actors include the public administration on different levels across the described policy areas. Universities and research institutes can make important contributions to improving the evidence-base for AHA policy making, too. Other



important stakeholders include hospitals, care providers, cultural institutions, non-governmental organisations, social enterprises as well as for-profit businesses for example in the tourism industry.⁵ Further, the dissemination and adoption of innovations both require close cooperation between research institutes, governments, industry and society stakeholders – the so-called Quadruple Helix of innovation (Carayannis & Campbell, 2009).

⁵ For further information on the relevant stakeholders in the area of AHA, see the ASTAHG Report D.T2.1.1 “Classification of AHA stakeholders”.



3 THE MODEL

The AHA governance model for the AS proposed in this report combines the functions and forms of governance described so far. It includes three levels of governance which interact across seven governance activities and a theoretically unlimited range of policy areas. This chapter reflects upon how AHA governance activities should be distributed horizontally and vertically within a governance structure. Chapter 4 will then apply these insights and outline how the described activities are assigned across the Transnational Governance Board (TGB), the Thematic Working Groups (TWGs) as well as local and regional public authorities and stakeholders.

3.1 Vertical distribution of governance activities

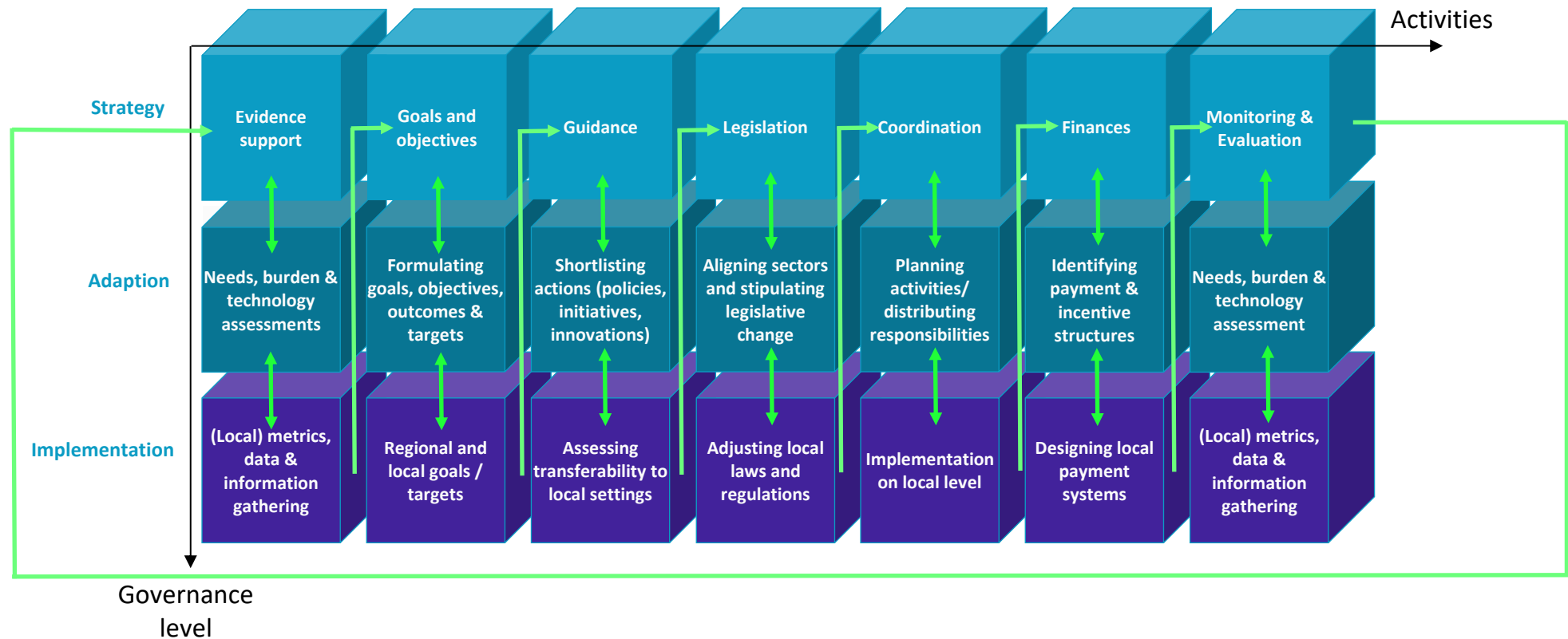
The governance model includes seven areas of activities: evidence support, the setting of goals and objectives, guidance, legislation, coordination, finances and monitoring and evaluation. In each area, activities are shared vertically between actors within the governance model. The vertical distribution of governance activities is shown schematically in Figure 6.

The highest and most centralised level consists of a Board which develops strategies, sets targets, suggests activities, provides guidance and recommendations, supports the exchange of information between actors in the field of AHA. It helps actors from across the region to coordinate their activities, to allow for complementary actions and to prevent the duplication of efforts. In short, it ensures that actors in AHA policy across the region can benefit from synergies and cooperation. The mid-level supports the



activities of the Board. It provides input to inform the decision-making within the Board and expertise to operationalise the Board's decisions. At the local and regional level, stakeholders make decisions on the adoption and implementation of policies, monitor their success and provide information back to the Board to inform future decisions.

Figure 6: Activities in AHA across governance levels



Source: Own drawing based on synthesis of AHA governance models desk review.



The sequence of activities follows the iterative steps of traditional policy cycles (see for example Howlett and Giest, 2012). The first step is concerned with **gathering evidence on challenges** in the field of AHA in the AS. This activity entails both the assessment of population needs for services and support in the area of AHA, and the evaluation of policies, initiatives and innovations that may have the potential to serve such needs in a cost-effective manner. To this end, the data gathering goals are set by the Board and operationalised by the mid-level. Regional and local stakeholders then collect the data and report it back to the Board. In the second step, **goals and objectives** are set to address these challenges. The core objectives are set centrally and then elaborated and linked to concrete targets at the mid-level. Regional and local stakeholders can set further goals, e.g. for specific projects.

The third step describes **direct actions** by the governance board and its members. Depending on the powers of the actors involved in the governance model, these actions include guidance, legislative actions, coordination of activities and initiatives as well as funding of selected projects, actions and initiatives. *Guidance* on innovative and good practices should be provided from the central level to regional and local stakeholders. In this way, stakeholders across the region can benefit from each other's experiences and the spread of innovations can be accelerated. The mid-level should shortlist actions for regional and local stakeholders while the latter are tasked with the final selection of the appropriate measures in line with local needs and contexts. Direct *legislative actions* are only available to public authorities with law-making powers. However, even stakeholders without own legislative powers should coordinate with each other and try to stipulate legislative changes to support AHA in line with their specific technical, sectoral and/or local expertise. *Coordination* of activities across levels of governance and policy areas is at the heart of AHA governance. Coordination is already built into the multi-level, multi-issue design of the governance board and is inherent to the formulation of common goals and objectives. In addition to that, the



governance board can support AHA by coordinating activities to promote AHA and raise awareness for ageing policies which can then be implemented by regional and local stakeholders across the AS. Finally, activities should be carried out in the area of *finances*. This entails designing appropriate incentive structures through suitable reimbursement mechanisms for those actors that will deliver AHA services to their respective target populations. Reimbursement mechanisms should be set in a way that goods and services provided through publicly financed social, health and care systems reach those individuals who can benefit the most. The aim is to maximise interventions' outcomes on a societal level whilst simultaneously tackling inequalities. Further, many AHA services require explicit consideration of appropriate business models, depending on, for instance, their mode of delivery or range of potential outcomes and/or beneficiaries involved. Finally, when planning AHA policies in the AS, stakeholders should always consider the long-term sustainability of the respective (publicly financed) social, health and care systems, as well as budgets in other policy sectors involved.

In the last step, the actions taken are **monitored and evaluated** to inform the refinement of data gathering tools and, subsequently, the formulation of new goals and strategies.

While the graphical representation of the vertical distribution of activities may imply power relations, it is important to note that we do *not* propose a hierarchical relation between the centralised Board and decentralised stakeholders. Rather, improvements in AHA governance can and should be pursued equally through top-down approaches to benefit from coordination and the exploitation of synergies (symbolised by downward arrows) as well as bottom-up approaches like the detailed analysis of local needs and the identification and promotion of best practices (symbolised by upward arrows).



3.2 Horizontal dimensions of governance activities

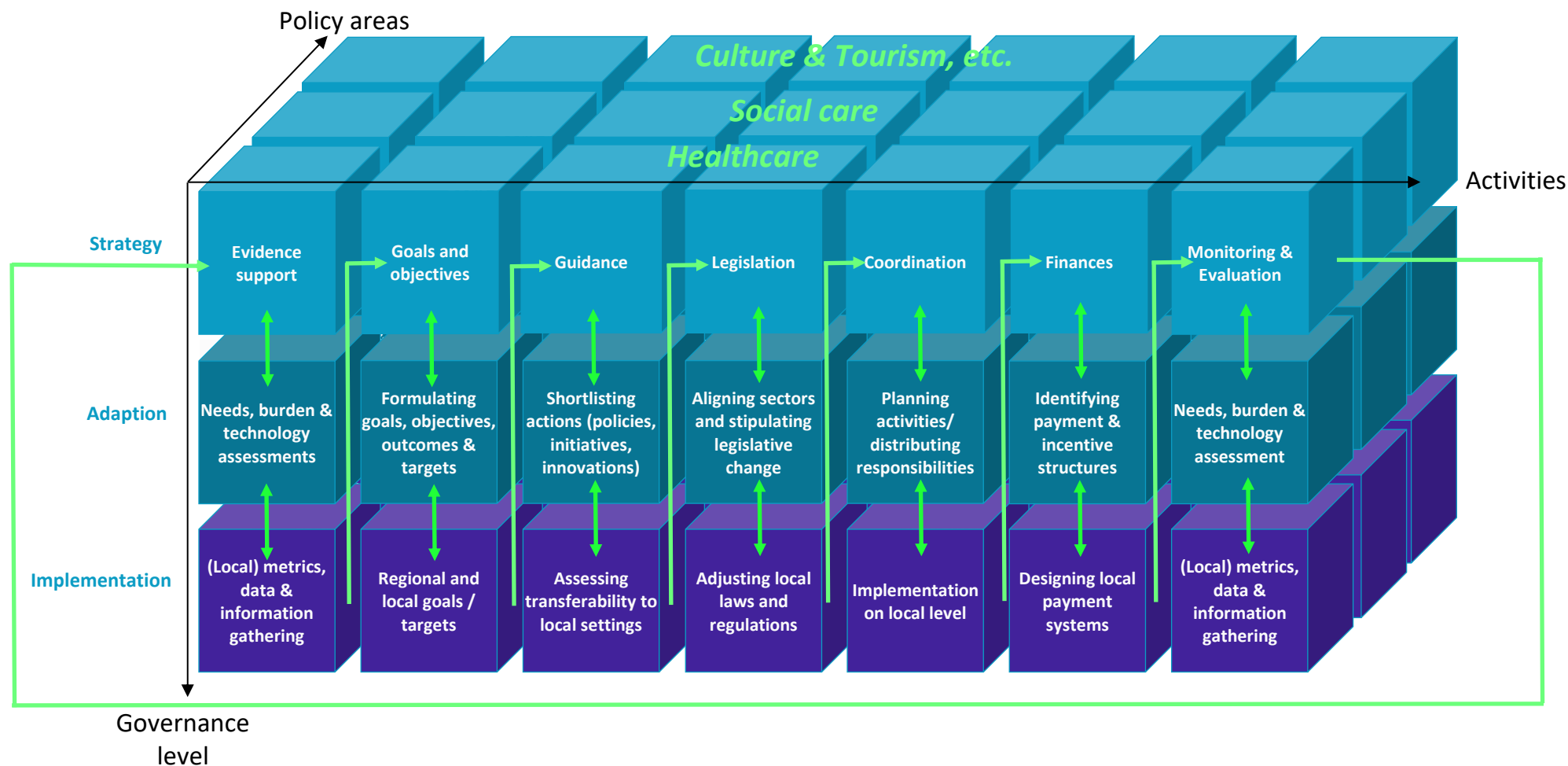
The horizontal dimension of the governance model relates to the various policy areas which affect AHA and which hence should be coordinated with each other (OECD, 2015; WHO, 2017). Health, social care and (long-term) care policies are the most obvious examples. Transport, housing, culture and education are other often cited policy areas which have an influence on the lives and health of older people. Tourism is one of the primary industries in the AS which can benefit from the creation of age-friendly environments and contribute to AHA by offering activities for older people.

As depicted in Figure 7, actions and activities should be carried out across each relevant policy area and all levels of governance. Further, the governance model has been developed to accommodate a theoretically unlimited number of policy areas. The horizontal dimension can easily be expanded to add new areas such as labour market policy if required.

The crucial aspect of the horizontal dimension is that cooperation occurs *across* traditional policy areas to overcome policy ‘*silos*’ (OECD, 2015, p.104). Only when actions across policy areas are coordinated to complement and support each other can synergies be fully exploited.



Figure 7: Horizontal dimension of the AHA governance model



Source: Own drawing based on synthesis of AHA governance models desk review.



4 PRACTICAL USE OF THE MODEL

The governance model developed in the last chapter was the basis for a Memorandum of Understanding (MoU) between the partners of the ASTAHG project to set up a Transnational Governance Board (TGB) and, linked to the board, multi-sectoral Thematic Working Groups (TWGs) centred around policies or initiatives for an initial period of three years (MoU, 2019).⁶ The TGB and the TWGs work with regional and local authorities and stakeholders. The three levels – TGB, TWGs and regional and local stakeholders – correspond to the three levels of governance described in the model: strategy, adaption and implementation.

The TGB is designed as an open network in which actors participate voluntarily and free of charge. The founding members are the project partners of the ASTAHG project: The Autonomous Region Friuli Venezia Giulia, Area Science Park, the Autonomous Province of Trento, the Local Health Authority n.1 Dolomiti, the Centre for Ethics and Poverty Research at University of Salzburg, the European Centre for Social Welfare Policy and Research, the professional network of home care service providers in Provence-Alpes-Côte-d’Azur, the National Institute of Public Health and the Geneva International Network on Ageing.⁷

Membership in the TGB is open to public and private organisations legally established in the AS region as well as transnational and thematic organisations on AHA established outside the AS region. Invited to participate are, in particular, AHA policy makers from

⁶ The full Memorandum of Understanding is included in the Annex 1 of this report.

⁷ See Annex 2 for contact details.



different territorial levels (local, regional, national) and different sectors (healthcare, social care, culture, mobility, tourism, etc.); public and private providers of (innovative) AHA services, technologies and products; civic society and interest groups such as associations representing the interests of older people; universities, innovators and researchers; employers and business organisation and actors in the silver economy. There are two forms of members: full members and observers. Only full members have voting rights on the board (MoU, 2019). Applications for membership can be made to the Managing Committee.⁸

This section on the practical use of the model is based on the considerations outlined in the last chapter and the structure agreed in the MoU and describes the tasks which each of the three layers of governance should carry out for the proposed governance model to achieve the goal of improving AHA governance in the regions of the AS. However, the guidelines to use the model should be understood as *recommendations* rather than rigid rules. The governance model is a work in progress which needs to adapt in accordance with the number and nature of its members and their priorities.

4.1 Transnational Governance Board (TGB)

The TGB represents the highest level of governance structure and it deals primarily with **strategic questions** across the seven functions of governance. Across these functions, the TGB should develop **strategies, agree on targets, suggests activities and to provide guidance and recommendations** to members of working groups, regional and local authorities and other stakeholders.

⁸ For contact details of all members of the Managing Committee please see Annex 2.



4.1.1 Mission

In the MoU, the founding members of the board defined their principal objective as promoting an *“‘Age-friendly’ Alpine Space Area creating synergies between interested stakeholders and governance levels and helping the Alpine Space local, regional and national authorities and other stakeholders to collaborate in promoting innovative solutions that address the needs of the ageing population.”*

Specific goals for the board set out in the MoU are to

- *“**support** cities and regions in the Alpine Space area to develop, implement and evaluate initiatives (policies, services, projects) with the aim to answer to the challenges of an ageing society;*
- ***promote** networking and knowledge sharing among its members;*
- ***build** synergies with existing initiatives such as the WHO Global Network of Age-Friendly Cities and Communities, the WHO European Healthy Cities Network, the 2013 Dublin Declaration on age-friendly Cities and the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA).” (MoU, 2019)*

4.1.2 Managing Committee, Coordinator and General Assembly

The TGB includes the TGB **Managing Committee** which is in charge of strategic decisions and overall management, a TGB **Coordinator** leading the Managing Committee and the TGB **General Assembly** which is composed of one representative of each participating organisation.

The duties of the Managing Committee as outlined in the MoU are to implement the decisions of the General Assembly, to debate topical issues and to adopt positions and



decisions. The latter includes positions and decisions related to the evaluation of AHA practices carried out by the ASTAHG project.⁹ The Managing Committee further prepares the meetings of the General Assembly and the work programmes for the TGB. Finally, the Managing Committee decides on membership applications and it can formulate additional eligibility criteria for TGB membership.

Decisions within the Managing Committee are taken by simple majority. Each organisation has one vote. A quorum of at least half of the organisations represented in the Managing Committee is required. In case of a tie-vote, the TGB **Coordinator** can cast the deciding vote.

The **General Assembly** represents the entirety of the TGB. It consists of one representative of each member organisation and meets at least once per year.

4.2 Thematic Working Groups (TWGs)

The TWGs are part of the TGB. They are **intersectoral** groups formed by members of the TGB organised around specific AHA topics. The working groups provide technical support to the TGB by helping in the development of policies as well as the (ex-post) evaluation of actions. The TWGs further act as intermediaries between the TGB and regional or local authorities and stakeholders. Where required, the TWGs can specify, elaborate or adapt the strategies or recommendations by the TGB for local actors to improve the top-down processes. In addition, the TWGs collect and aggregate

⁹ See reports on the classification system for AHA initiatives, policies and innovations, the AHA innovation evaluation metrics and the AHA impact evaluation metrics.



information from the local level and communicate them (bottom-up) to the TGB to inform future policy decisions.

4.2.1 Coordinator and Synergy Leader

Each member of the TGB can join one or more TWGs. Each TWG nominates a **Coordinator** and a **Synergy Leader**. The Coordinator communicates and coordinates the work of the TWG with the TGB Managing Committee. The Synergy Leader is part of the Managing Committee and he or she is in charge of finding and exploiting synergies in the area of activity of the TWG.

4.2.2 Evaluation expert group

One specific TWG is the Evaluation Expert Group. It will be composed of experts appointed by the Managing Committee. The group will be tasked with evaluating initiatives and projects proposed and developed by members of the TGB.

4.3 Regional and local authorities and stakeholders

Regional and local authorities and stakeholders are in charge of policy implementation. This includes making decision on the adoption of policies, implementing them and monitoring their progress. The selection of the stakeholders is based on the model described in ASTAHG report D. T2.1.1 “*Classification of AHA stakeholders*”.



Regional and local authorities and stakeholders can be members of the TGB. However, to maximise the reach of its activities, the TGB should aim to also involve non-members in its activities.

4.4 AHA governance tools provided by ASTAHG

The work of the AHA governance model will be facilitated by several tools developed by the ASTAHG project. First, a classification system for AHA initiatives, policies and innovations is being developed which will form the foundation for an AHA innovation observatory. The classification system and the observatory allow for the collection and dissemination of innovative and best practice approaches to improving AHA in the AS¹⁰.

Second, an AHA impact evaluation metrics and an AHA innovation evaluation metrics are developed which will enable policy makers to identify and assess promising AHA activities more easily and in a transparent manner. Finally, the ASTAHG project is developing an assessment methodology to assist AHA governance through support for evidence-based decision making in the field of AHA. The governance assessment methodology will help to continuously improve the work of the TGB, the TWGs and the overall AHA governance in the AS. Thereby, it makes an important contribution to the sustainability and long-term success of the AHA governance model.

¹⁰ Report D. T2.2.1 AHA Policies, Initiatives & Innovations.



4.5 Recruitment of members for the governance model

The success of the governance model is contingent on the participation of a sufficient number of stakeholders in the TGB, the TWGs and at the regional and local level. The identification and recruitment of stakeholders within the ASTAHG project is pursued through a stakeholder mapping survey (see report D T2.1.1.) and through the Work Package Communication.

In accordance with the ASTAHG Communication Strategy, a website¹¹ and a flyer have been created to inform interested parties about the goals and activities of the project. All project partners are providing information on the project on the websites of their respective institutions and the social media accounts “@ASTAHG” (Twitter) and “ASTAHG project” (Facebook) have been created to increase the visibility of the project.

Further, all project partners use outreach and recruitment strategies adapted to their regional contexts. A core element of these strategies is the organisation of local events on AHA to which local and regional stakeholders identified in the stakeholder mapping and identification exercise (D T2.1.1) will be invited.

¹¹ <https://www.alpine-space.eu/projects/astahg/en/home>



5 CONCLUSION AND RECOMMENDATIONS

The goal of the governance model proposed in this report is to strengthen the horizontal and vertical cooperation between stakeholders in AHA in the AS to improve the life of older people and to contribute to the overall development and quality of life in this region. The first steps towards the implementation of the governance model have already been taken with the identification of stakeholders and the signing of a Memorandum of Understanding for the Transnational Governance Board among the initial board members.

However, it is important to underline that this report should be only a first step. The model was developed in a way which allows it to evolve with the changing needs of the region. New stakeholders and policy areas can be added where required and the geographical reach of the model can be adapted where necessary. The governance model should therefore be understood not as a static prescription of actions, but as a dynamic model over which stakeholders should take ownership and which can and should evolve with the changing needs of the people of the regions of the Alpine Space.



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7 ANNEXES

Annex 1: Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING FOR THE SETTING UP OF THE TRANSNATIONAL GOVERNANCE BOARD

The ASTAHG Project Partners

Recognising jointly that:

Demographic ageing is a major challenge in Europe, and the average population age is particularly high in the Alpine Space, especially in the mountain areas (Eurostat, 2013). This challenge requires systematic transnational cooperation both at horizontal level (policymakers of health, social care, transport, culture, tourism) and at vertical level (regions, provinces, municipalities), together with the involvement of the public and private sectors (R&I, local communities, social business). The aim is to support innovation for active ageing, through actions tailored to the specific context of the AS region, but also through capitalizing from the particular strengths of this geographic area in Europe.

Taking note that:

The overall objective of the ASTAHG Project is to foster innovations in public administration and relevant public authorities which tackle the challenges arising from population ageing in the Alpine Space:

- by improving the public authorities' capacity to coordinate efforts from different sectors and at different levels;
- by responding with tailored initiatives to alpine territorial needs;
- by developing common strategies, a portfolio of good practices and an observatory of innovations to tackle the challenge of population ageing through setting up a working group of Alpine Space policymakers and stakeholders; and ultimately
- by enhancing transnational, cross-sectorial and multilevel cooperation with the involvement of organisations from the public and private sector.

Considering that:

The ASTAHG project stipulates to set up a Transnational Governance Board (Output OT1.1) with the aim to gather public/private actors from different levels/sectors/territorial specificities who impact on the AHA of AS population;

The target groups of the Transnational Governance Board are: AHA policy makers and actuators from different territorial levels (Local/regional/national) and different sectors (healthcare/social care/culture/mobility/...); public/private providers of (innovative) services,



technologies and products for AHA services targeting older people; interest groups, e.g. associations of older people; Universities, innovators and researchers; business support organisation; promoters of silver economy.

The main scope of the Transnational Governance Board should be bringing together 4helix actors of AHA and ccoordinating AHA governance policies at the Alpine Space level.

Looking forward to the results of the surveys and analyses already developed and carried out in the context of the ASTAHG project, including structured analysis of governance models and AHA stakeholders, the signing Parties agree to capitalize the project results in the best possible way in order to feed the upcoming work of the Transnational Governance Board with recommendations and ideas, to be shared also with the responsible authorities, decision and policy makers in participating countries in order facilitate the of transnational co-operation in AS on AHA issues;

In this context, the signing ASTAHG Project partners and the other signing organizations, conscious of the need for a collaborative approach to addressing the challenges of an ageing population in the AS area, agree on the following:

- To set up a Transnational Governance Board (TGB) on Active and Healthy Ageing;
- To undertake to work jointly in the Transnational Governance Board to facilitate knowledge sharing and joint action in promoting and transferring best practice and in supporting the development and scaling up of solutions into strategies, policies and services delivery models in the Alpine Space area;
- The initial duration of the TGB is three year after the end of the project, with possible further extension;
- For the first three years Friuli Venezia Giulia Region will act as Transnational Governance Board coordinator; any decision on further roles and responsibilities will be taken by the Managing Committee of the Board.
- A initial description of composition and rules of the TGB is agreed and included as Annex; further definition of rules and roles will be decided by the Managing Committee of the Board.



ANNEX
to the Memorandum of Understanding for the
TRANSNATIONAL GOVERNANCE BOARD

Agreement on composition and rules

Legal form

The Transnational Governance Board (TGB) is an open network and the participation of Members is free of charge and voluntarily. All ASTAHG partners are considered as founding members of the TGB (Managing Committee); all other interested organisations and stakeholders may apply to join at any time.

Term

The Transnational Governance Board will be set up for a three-years term after the end of the project. After three years, the duration may be extended by decision of the Managing Committee.

The Board shall acquire the official composition from the date of signature of the agreement by (at least) all ASTAHG partners.

Purpose

The Board's main objective is to promote an "Age-friendly" Alpine Space Area creating synergies between interested stakeholders and governance levels and helping the Alpine Space local, regional and national authorities and other stakeholders to collaborate in promoting innovative solutions that address the needs of the ageing population.

The Board aims in particular to:

- support cities and regions in the Alpine Space area to develop, implement and evaluate initiatives (policies, services, projects) with the aim to answer to the challenges of an ageing society
- promote networking and knowledge sharing among its members;
- build synergies with existing initiatives (such as the WHO Global Network of Age-Friendly Cities and Communities, the WHO European Healthy Cities Network, the 2013 Dublin Declaration on age-friendly Cities and the European Innovation Partnership on Active and Healthy Ageing).

Composition

Based on the 4Helix approach, the Transnational Governance Board is a network of members such as public authorities at different levels of government, research centres and universities, associations, industries, individual firms, civil society organisations.

The Members must be legally established in the Alpine Space Programme Area. Existing transnational and/or thematic organisations on Active and Healthy Ageing, although based outside the Alpine Space area, are eligible.

There are two categories of Members: Full Members and Observers. Full members have full rights and duties, Observers have no responsibilities in the TGB management, and day to day operational roles, and they don't have the right to vote the decision of the TGB.



Applicants may request to enter the category of their choice provided they fulfill the eligibility criteria of the chosen category. ASTAHG Project Partners and other founding organisations are considered Full Members.

The admission of new members is approved by the Managing Committee, that can also set additional eligibility criteria.

Potential situation of conflict of interest will be checked during the admission process of a new member.

At any time, a Member may resign from the Board by notifying the Managing Committee in writing. The resignation takes effect immediately.

Organisation of the TGB

The Bodies of the TGB are:

- The TGB Managing Committee
- The TGB Coordinator
- The TGB General Assembly
- The Working Groups
- The Coordinators of WGs
- The evaluation expert group

The roles of the Bodies are as follows:

- Transnational Governance Board Managing Committee: the managing committee is in charge for the strategic decisions and the overall management; the Managing Committee executes in particular the following duties: implementation of the decisions of the General Assembly, debate on topical issues for members, adoption of positions and decisions related also to evaluation of AHA practices submitted to the TGB, preparation of the meetings of the General Assembly, preparation of the work programme and decision on membership applications; for the first three years the Managing Committee is composed by one representatives of each ASTAHG partner, and Friuli Venezia Giulia Region will act as TGB Coordinator.
- Transnational Governance Board Assembly: the assembly is composed by one representative of each organisation that has joined the Board. It is in charge of the operational soundness of the Board, it serves to identify and discuss projects, ideas and proposals as well as their further planning and implementation.
- Working groups: the TGB includes thematic working groups that are formed by members committed to address specific topics of AHA; each member organisation can decide to join a WG during the admission process or later with



a written communication to the Managing Team; WG members are representatives of the organisations that have joined a thematic activity.

- Working group coordinators: the working group coordinators are nominated by the WG members and they will support the implementation and monitoring of the thematic activities within the TGB according to the mutually agreed plans; they report to the Managing Team; WG coordinators nominate a synergy leader who is a member of the managing team in charge of the supervision and synergy of working groups' activities and results.
- Evaluation expert group: a small number of experts will be appointed by the Managing Committee to evaluate initiatives and projects proposed and developed by members.

Rules and procedures of the Transnational Board

Meetings

An Annual General Meeting shall be held. Other types of meeting could be organised based on the needs of the TGB's bodies.

Till the end of the ASTAHG project the meetings of the TGB will be held during the Project Consortium meeting. After the end of the project any meeting - of the Managing Committee or the Assembly or the WGs or the coordinators - can be held physically or online - by conference call or video conference or any other means of telecommunication -, at any time the interest of the Board so requires. Each member shall decide to participate physically or online depending on the financial resources.

The Annual General Meeting shall be set up by the Managing Committee and the Assembly meeting shall be convened by the Managing Committee. The agenda of these meetings is set by the Managing Committee.

The WGs meeting shall be set up by the coordinators.

Decision making process

The Managing Committee can validly decide if more than half of the committee members are present or represented at the meeting. Each member has one vote.

The decision of the Committee shall be adopted by a simple majority of the vote of the members. Decisions can be taken also by a simply written communication procedure (via email). In case of a tie-vote, the Coordinator will have a casting vote.



Annex 2: Founding Members of the Transnational Governance Board (TGB)

FVG | Autonomous Region Friuli Venezia Giulia

<http://www.regione.fvg.it/rafvfg/cms/RAFVG/>

Riva Nazario Sauro 8, 34124 Trieste, Italy

AREA | Area Science Park

<https://www.areasciencepark.it/>

Padriciano, 99 34149 Trieste, Italy

PAT | Autonomous Province of Trento

<http://www.provincia.tn.it/>

Via Gilli 4, 38121 Trento, Italy

ECV | European Centre for Social Welfare Policy and Research

<https://www.euro.centre.org/>

Berggasse 17, 1090 Vienna, Austria

AULSS1 | Local Health Authority n.1 Dolomiti

www.aulss1.veneto.it/

Via Feltre 57, 32100 Belluno, Italy

PLUS | Centre for Ethics and Poverty Research at University of Salzburg

<https://www.uni-salzburg.at> and <https://www.povertyresearch.org>

Kapitelgasse 4-6, 5020 Salzburg, Austria

PSP PACA | Professional network of home care service providers in Provence-Alpes-Côte-d'Azur

<http://www.psppaca.fr/>

Rue Edmond Rostand 74, 13006 Marseille, France

NIJZ | National Institute of Public Health

www.nijz.si

Trubarjeva 2, 1000 Ljubljana, Slovenia

GINA | Geneva International Network on Ageing

www.GINA.group

Rue Butini 16, 1202 Geneva, Switzerland