



ASTAHG ALPINE SPACE TRANSNATIONAL  
GOVERNANCE ON ACTIVE AND HEALTHY  
AGEING

REPORT ON GOVERNANCE MODELS  
IN THE AS

D.T 3.1.1

Trieste, December 2020

WP3



REGIONE AUTONOMA  
FRIULI VENEZIA GIULIA

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## *Executive summary*

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Population ageing is a global challenge recognized as one of the demographic “mega-trends” together with population growth, international migration and urbanization, that affect and are effected by the implementation of the *Programme of Action and the 2030 Agenda for Sustainable Development* (Commission on Population and Development, 2019). The World Health Organization argues that countries can afford to get old if governments, international organizations and civil society enact “active ageing” policies and programmes that enhance the health, participation and security of older citizens (WHO, 2002). Due to these challenges, there is a need to increase multilevel and transnational governance as well as the capacity of stakeholders (responsible for regional and national strategies and action plans) to better integrate the transnational dimension in their work in order to put in place the most suitable and appropriate policies and interventions.

Acting on policy implementation stage, ASTAHG project aims at helping local, regional and national governments in implementing a scaling up AHA strategy across regions and countries of the AS, bringing together key stakeholders and policy makers. In addition to that, by supporting a successful uptake of innovations, ASTAHG will provide important insights for the EUSALP and EIP on AHA mission.

This deliverable gives a comprehensive description of the activities of WP3 including 1) data gathering and analysis of AHA governance models and 2) identification and monitoring of the innovation in the AHA field. In detail, the macro -activity concerning “Data gathering and analysis of AHA governance models” can be broken in 2 following categories: one related to collection of governance models and the other with their assessment. As part of this framework, the present deliverable concerns the collection of information on the governance models for AHA in the Alpine Space area.



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## 1 INTRODUCTION

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### 1.1 Project concept

#### 1.1.1 Project objectives

The ASTAHG project is part of the Priority 4 “*Well-Governed Alpine Space*” of the Alpine Space programme that has as specific objective: increasing the application of multilevel and transnational governance in the Alpine Space.

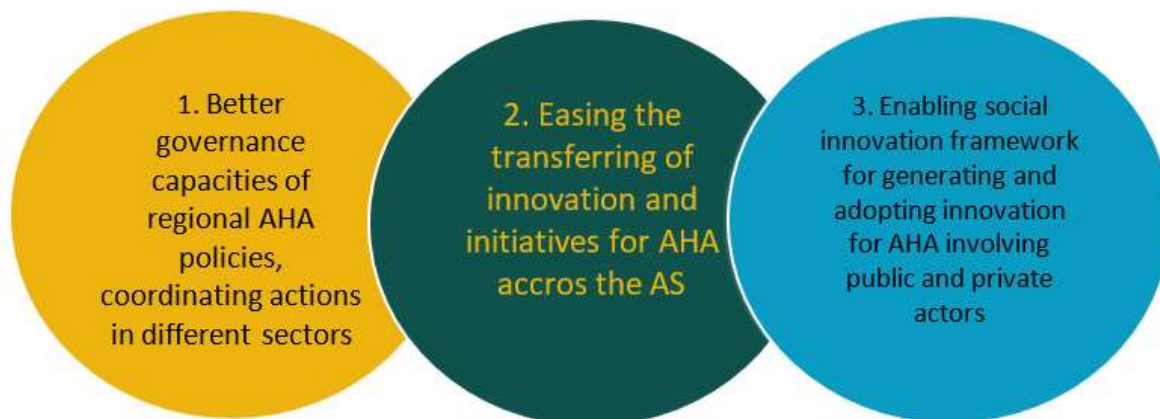
The overall objective of the ASTAHG project is to foster innovations in public administration and relevant public authorities which tackle the challenges arising from population ageing in the Alpine Space:

- 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 (*ASTAHG MoU, 2019*).

The specific objectives of the project, as reported on the ASTAHG application form, deal with:

- better governance capacities,
- cross-fertilization of initiatives and innovations,
- enabling social innovation framework for generating and adopting innovation by involving the most relevant public and private players (Figure 1).

**Figure 1. Project specific objectives**



*Source: Own drawing based on ASTAHG AF (2018).*

### 1.1.2 Project outputs

To reach these specific objectives the project will produce 4 concrete outputs as listed in the scheme below (Figure 2). A Transnational governance board will be established (OT1.1) engaging multisector 4Helix actors to share regional perspectives and define a platform of common policies on AHA. The board will strategically engage with AS Regions, EUSALP and international AHA networks for the efficacy, impact and sustainability of governance approaches and AHA policies. There will be developed a framework for AHA innovation (OT2.1) based on the 4Helix model that will help engaging public actors with R&I, social business actors and citizens for the co-creation of innovation making the best use of new available technologies and services for the elderly. Within the WP3 will be developed two outputs, Analysis of AHA governance applications and good practices portfolio (OT3.1) and an Observatory of innovation for AHA (OT3.2) that will be populated with the most innovative AHA initiatives and technologies in the AS.



**Figure 2. Project outputs**



*Source: Own drawing based on ASTAHG AF (2018).*

### 1.1.3 Work package structure

The overall structure of the project will run for 36 months and consists of 5 work packages (see Figure 3). Each work package has a WP Leader (responsible partner), respective budget and a planned start and end date. In the preparation phase of the project, WP P was included as a separate WP. The structure of project work packages is shown in the scheme below. WP M is responsible of project planning, controlling and coordination of the partnership and internal communication, as well as evaluation of project results and contribution to the AS programme and EUSALP strategy. WP1 is concerned with the creation and coordination of a Transnational Governance Board involving multilevel policymakers and stakeholders of different regions and European networks and initiatives giving a contribute on the activities of WP3 (AT3.1; AT3.2). The main activities of WP2 deal with “AHA governance models logic classification” and “Methodology for AHA governance assessment”. These activities are related with the activities of WP3 that concern on “Data gathering and analysis of AHA governance models” as well as “Identification and monitoring of the innovation in the AHA field”. All the activities related to communication, are horizontal to all WPs, involve all project partners and the responsible of those activities is WP C.



**Figure 3. Overall project structure**

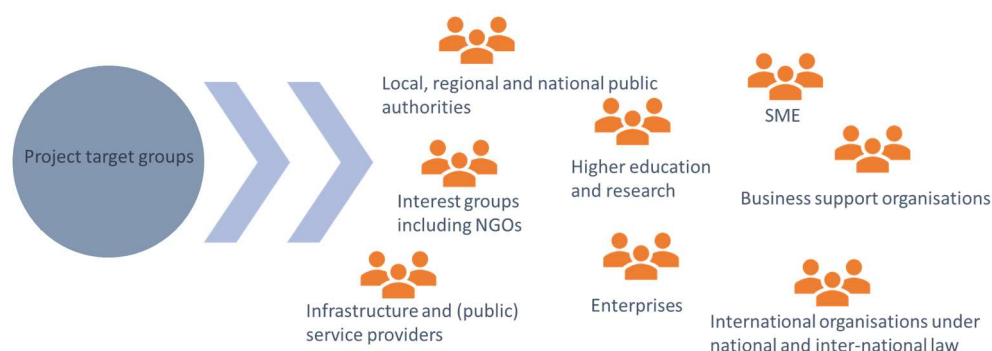


Source: Own drawing.

#### 1.1.4 Project target groups

The direct target groups of the project are AHA policymakers such as local, regional, and national public authorities of different sectors from healthcare, welfare, mobility and transport, R&I, industry and culture as well as organizations promoting the silver economy. All the interest groups will be engaged during the transnational governance board meetings bringing their perspective, expertise, and experience in the AHA field (Figure 4).

**Figure 4. ASTAHG target groups**



Source: Own drawing based on ASTAHG AF (2018).



## 1.2 Contribution of WP3

The aim of WP3 “AHA mapping in the Alpine Space” is to understand how the AS regions deal with the population ageing challenge and which are the governance models that have an outstanding impact on AHA. There are two macro-groups of activities within the WP3 that consist of “Data Gathering and analysis of AHA governance models” (Activity A.T3.1) and “Identification and monitoring of the innovation in the AHA field” (Activity A.T3.2). Both of activities must deal with data collection and analysis. The Activity A.T3.1 is concerned with “AHA Governance models”. It aims to gather information on AHA governance models in the AS from relevant actors at different territorial levels and sectors. Regional and transnational (public/private) actors are joined to work together within the transnational governance board. The ideas and recommendations coming from the board thematic group meetings and local events will be part of the final versions of WP3 deliverables, as well as contribution and input from relevant stakeholders and observers of the project. In the context of A.T3.1, the deliverable D.T3.1.1 “Governance models in the AS”, is concerned with data collection of governance models, whilst the deliverable D.T3.1.2, with the assessment of governance models for AHA in the AS. The tool for information collection (ASTAHG survey), an agreed template for data collection developed based on the classifications in A.T2.1, will be provided by WP2. The aim is to gather relevant information on AHA policies, initiatives and innovations on the AHA field. The assessment of the governance models collected will be done using the methodological framework provided by AT 2.2 (DT2.2.1, DT2.2.3). By following the multisectoral and multilevel approach of the project, the governance models will be assessed in all sectors and at different levels. Based upon the analysis of the models collected, will be proposed a portfolio of approaches in order to coordinate efforts on AHA strategies in different sectors involving all territorial stakeholders in a multilevel cooperation (O.T3.1 AHA governance good practice portfolio).

The activity A.T3.2 “Identification and monitoring of the innovation in the AHA field” is concerned with data collection and analysis of initiatives and innovations of AHA in the AS. In specific, the deliverable D.T3.2.1 “Initiatives on AHA in the AS” will gather all the initiatives and innovations collected by different actors (partners, stakeholders, observers, governance



board members, EUSALP members) on the respective territory. The information collected will be structured in a framework and the most promising AHA innovative initiatives will be part of a transnational observatory (O.T3.2 AHA innovation observatory). The aim is to facilitate the transferring of innovation and initiatives across the AS helping public/private actors and policy makers to understand the feasibility of initiatives in their territory. Inputs and feedback for the observatory will then be provided during local events and thematic group meetings of the transnational governance board.

### 1.3 Deliverable description

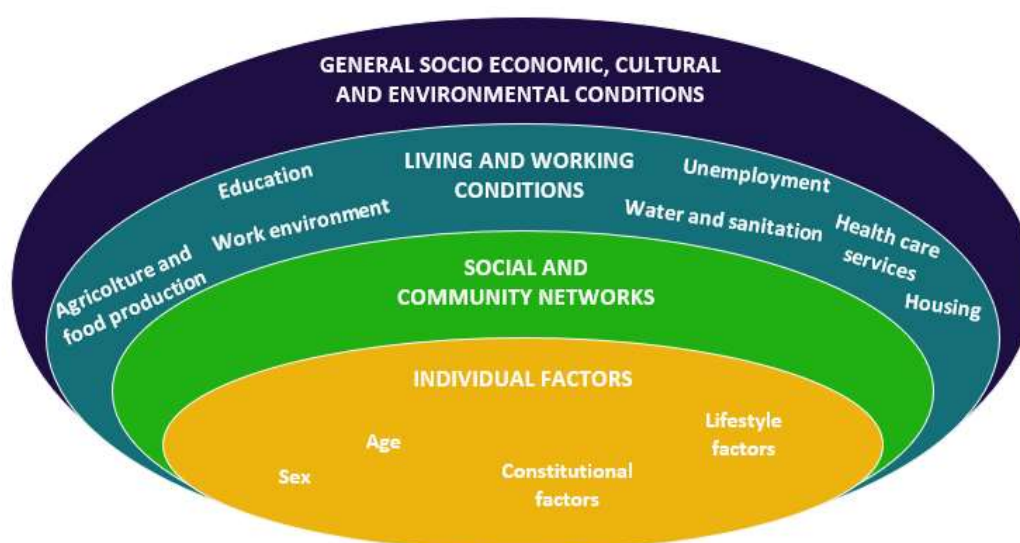
The scope of the deliverable D.T3.1.1 is to give a picture of the AHA good practices collected by project partners in the AS. In specific, this deliverable focuses on AHA policies, considered the first level of governance implementation, and their first analysis.

This report is structured in five main sections. The first section is an introduction to the project along with an overview of WP3 objectives, activities, and outputs. The second section addresses A) the AHA as a demographic change and a political challenge and B) the governance models and their relations to policymaking. The third section provides an overview of the data collection methodology, describing the ASTAHG information survey used to gather AHA good practices in the AS as well as the different stages of data collection. Section 4 reports the results of the analysis of good practices collected, focusing on AHA policies. The deliverable report, therefore, concludes with a summary of the main points emerging from the analysis, contextualising and linking them within the whole WP3 activities of ASTAHG project.

## 2 A MULTIDIMENSIONAL PERSPECTIVE ON ACTIVE AND HEALTHY AGEING

The World Health Organization (WHO) has defined health as «*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*» (WHO, 1948). In line with this definition, health is a multi-dimensional concept in which environmental, social, physiological and psychological factors come into play, interacting and overlapping with each other, to produce health, as well as capturing how people feel and function both individually and in society (Bousquet et al., 2015). Consequently, many determinants of health are found in sectors other than health itself (see Figure 5).

**Figure 5. An overview of health determinants in line with the ASTAHG project approach**



Source: Own drawing based on Dahlgren & Whitehead (2006).

In the field of health, in the 1990s, the WHO developed the broad concept of Active and Healthy Ageing (AHA) as «*the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age*», with a focus on the link between activity and health (Malva & Bousquet, 2016; WHO, 1994). This definition is worthwhile for both individuals and population groups and involves environmental and social determinants. In this context, the word «*active*» means «*continuing participation in social, economic,*



*cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force» (WHO, 2012, p.12).*

It follows that, the adoption of an AHA approach dismantles the traditional concept that associates the oldest phase of life with inactivity (Boudiny & Mortelmans, 2011) as well as elderly with dependency and passivity. Rather, AHA perspective encourages the participation of older people in society and the improvement of their autonomy, considering them a resource for the entire community and emphasizing the knowledge and experience they have accumulated over time. From this point of view, retirement from work is not equivalent to withdrawal from all forms of activity and the ageing of population and, on the contrary, population ageing must be perceived as a social advancement. In line with the complexity of health concept, an AHA approach requires to consider aging in a more holistic and life course-oriented perspective focusing on different aspects of quality of life, such as physical and mental well-being, social connectiveness, participation and activities, maintaining autonomy, independence and mobility, general life satisfaction (Foster & Walker, 2013; Walker, 2002).

In a broader sense, understanding the factors involved in the trajectories of AHA across life course is crucial to achieve the following key goals in the health, economic and social fields (see Bousquet et al., 2015):

- developing effective prevention strategies, programs or interventions;
- developing new strategies, programs or interventions taking into account socio-demographic changes and gender-related characteristics or differences associated to a specific geographic and socio-cultural context;
- implementing strategies, programs or interventions for reducing individual and societal costs of an ageing population;
- reducing health and societal inequities.

## 2.1 Global demographic change: challenges and opportunities

Population ageing, consisting in the process leading to increases in the representation of older people in the total population, was a substantial trend in Europe in twentieth century, and



will rise over the course of the current century. Data show that the numbers and proportions of older people increased significantly between 1950 and 2000 and are projected to grow further by 2050, in which it is estimated that more than a quarter of the European population will be aged 65 and over (Grundy & Murphy, 2017). Furthermore, by 2050, it is estimated that elderly aged 80 and over will represent at least one in ten of the general population in almost all major European countries (Eurostat, 2014).

Going beyond its definition, population ageing is configured as a multidimensional process involving various aspects and lending itself to different readings. At a more general level, the growing presence of the elderly in Europe may be viewed as the self-evident outcome of ongoing demographic changes, such as increased life expectancy or low fertility, which have resulted in sweeping shifts in the age composition of population, labour force and general population ageing. A more thorough analysis of this process suggests that population ageing may be considered as a successful outcome of improved health and living conditions and effective policies in the social and health field. Accordingly, the ageing of population may be viewed as 1) a demographic process requiring institutional, social, economic and policy actions, interventions and adaptations, that will affect the lives of citizens of all ages and 2) a developmental process that people go through when they grow up and associated with an active way of life (Avramov & Maskova, 2003).

Moreover, the rise in the numbers of European elderly has direct relevant implications at different social, economic and individual levels, and, at the same time, has to face several ongoing modifications in socio-demographic structures:

- a reducing working-age population: a contraction in labour force increases pressures in the workplace and may pose a threat to the maintenance of a good work–life balance in the coming years. The upset of this balance may change contributions of men and women to the family management as well as undermine fertility levels and further encourage population ageing (Bloom et al., 2010);
- increasing number of consumers relative to the effective number of producers, as a consequence of the growth of the population in non-productive ages;



- changing proportions between different generations (i.e., children, young people, adults, elderly);
- modifications of family structure and organization: families are becoming smaller (with less siblings) and increasingly de-institutionalised (more non-marital unions) or non-co-resident;
- modifications of kinship networks (increasingly “tall and lean”) (Sareceno, 2008).

Overall, the abovementioned changing patterns in the socio-demographic context contribute to making relational dynamics in the family, in kinship and, in general, in the community more diversified, fluid and complex (Chłoń-Domińczak, 2014).

## 2.2 Active and healthy ageing as a political challenge

Considering all the described aspects related to population ageing in Europe, it is evident that this multidimensional process leads to a radically changed demographic, economic and socio-cultural context and to a new policy framework in the upcoming decades, with widespread implications for current and future policies across countries. From this perspective, desirable AHA governance models could be distinguished by the implementation of some strategic aspects:

- to develop and exploit opportunities stemming from demographic change occurring in Europe;
- to be life-course oriented, with a focus on multiple generations and their life histories as well as on maintaining a balance between and within generations at different times in life;
- to be addressed to multiple sectors, beyond the purely health one (e.g., work, welfare, care): it is crucial to adopt a wide and comprehensive perspective to promote quality of life and well-being of the elderly;
- to cover changes at different levels (e.g., local, regional, national, international);
- to involve different social actors (e.g., public institutions, policy makers, social and health professionals, industry, academia, citizens);
- to affect both sides of the labour market: supply and demand.





The above mentioned aspects may be considered as a pre-condition for reaching the goal of an inclusive, smart, cohesive and sustainable growth in Europe, over the long term and with the new demographic context (for an in-depth examination see Boudiny, 2013; Foster & Walker, 2015).

Considering the general framework outlined up to this point, AHA represents the main policy response to demographic changes emerging over the past ten years. Therefore, a supportive policy framework is needed to pursue actions and adopt multisectoral strategies, enabling older people to realize their potential, continuing to be a resource for their families, communities, and economies. Since AHA focus on individual as well as on social involvement and responsibility, it should configure not only as an end but also as a mean to enable different countries to successfully meet the challenges posed by population ageing.



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## 3 GOVERNANCE MODELS

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### 3.1 Definitions of governance: a framework

There is not a universally recognised definition for 'governance', that represents a complex concept characterised by several crucial aspects. It is described as *“the sum of the many ways individuals and institutions, public and private, manage their common affairs”* (Commission on Global Governance, 1995) as well as *“the systematic, patterned way in which decisions are made and implemented”* (WHO, 2016) and also as *“the process through which governments and other social organizations interact, relate to citizens and take decisions in an increasingly complex and interdependent world”* (Kickbusch & Behrendt, 2013). Therefore, governance includes both formal institutions and informal arrangements but also the management rules for design, decision making and implementation processes. ‘Governance’ requires the creation of a balance between competing influences and demands and differs across political systems. In a nutshell, governance is a continuing political process through which conflicting or different interests may be accommodated and cooperative actions may be taken (Commission on Global Governance, 1995; WHO, 2020).

As highlighted by WHO (2020), to pursue these goals governance includes:

- the maintenance of the strategic direction of policy development and implementation;
- the identification and correction of undesirable trends or distortions;
- the coordination of the actions of a large range of actors and stakeholders;
- the definition and application of effective and transparent accountability mechanisms.

Governance for AHA promotes joint actions in many different sectors among public and private actors and citizens to pursuit common objectives and interests. It requires a synergistic set of policies at all levels of governance, many of which act on multiple sectors and involve stakeholders outside government, that need to be supported by mechanisms and structures

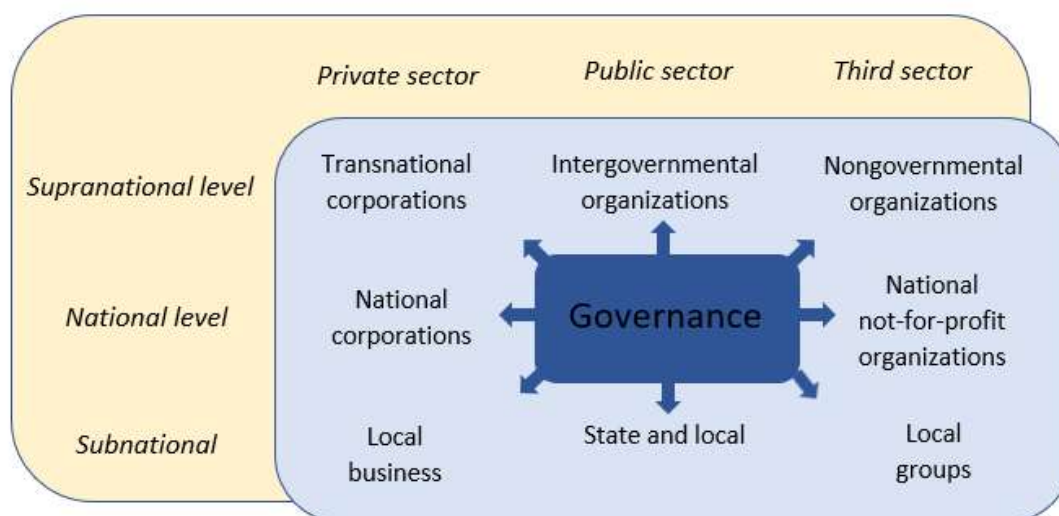


promoting collaboration (Kickbusch & Behrendt, 2013). These key elements offer a useful perspective on how to develop and implement AHA governance models across the AS. The latter is indeed a transnational region characterised by the presence of heterogeneous geographic areas belonging to different countries and showing specific and distinctive territorial characteristics (Bausch, 2014) which manifest somewhat common needs that require coordinated and targeted interventions.

### 3.2 Multiactor and multilevel aha governance models

The development of new governance approaches is driven by the changing nature of the challenges faced by 21st century societies, such as population ageing, many of which have significant impacts on health. The complexity of these critical issues requires a collaborative network, based on all levels and force policymakers that have to move out of their conventional silos compartments (Kickbusch & Gleicher, 2012). This approach goes in the direction of a diffusion of governance beyond government to various actors in society (Nye & Kamarck, 2002), crossing the boundaries of organizations and creating network-based public service production systems, which draw on new pools of resources (Moore & Hartley, 2008). Governance is, indeed, increasingly conducted across levels, from local to supranational level, demonstrating that an effective multilevel approach is as important as a cross-sectoral and participatory governance (see Figure 6).

**Figure 6. Diffusion of governance**



*Source: Own drawing based on Kickbusch & Gleicher (2012).*

However, different governance levels have more or less relevance depending on the specific territorial challenges, objectives and needs they have to address. Consequently, a functional and flexible approach, that can be adapted to the geography and the specificities of different territorial scales, should be preferred, as in ASTAHG project. Nevertheless, the promotion of AHA is and must be a shared responsibility between supranational, national and local/territorial jurisdictions.

In ASTAHG project, governance refers specifically to the attempts of governments or other actors to steer communities in the pursuit of AHA through both whole-of-government (WHO, 2015) and whole-of-society (WHO, 2012) approaches, characterized by an integrated government response, the involvement and the coordination of all relevant stakeholders, in order to achieve shared goals and improve the effectiveness of the efforts. These approaches are based on strategies that enhance joined-up government, intersectoral action, improved coordination and integration and diffusion of responsibility for health throughout government and society.

One of the fundamental aspects of whole-of-government and whole-of-society approaches resides in negotiation, since different sectors and organizations can be expected to express



different priorities, interests and attitudes. It is therefore crucial for policy makers to acquire the negotiating skills necessary to enable AHA promotion and improvement, looking for opportunities and planning solutions to incentivize stakeholders to find common ground (Kickbusch & Behrendt, 2013). This logic is consistent with the multisectoral, transnational, and multilevel approach of the project in which AHA is considered in its complexity, considering all relevant domains and stakeholder categories for its improvement.

### 3.3 From governance models to policy-making

Governance has been defined, in short, as the formulation and implementation of public policies for the development of a territory/country based on five main actions (Rivolin et al., 2014):

- 1) coordinating actions of different actors;
- 2) integrating multiple policy sectors;
- 3) promoting stakeholder participation;
- 4) being adaptive to changing contexts;
- 5) producing territorial/context-based specificities and impacts.

Consequently, the improvement of the governance has the aim to ameliorate policy performance, that means to formulate and to implement better policies (WHO, 2016). With this in mind, we decided to assess AHA governance models through an evaluation of AHA policies collected through the survey, since they represent the first level of implementation of the governance itself (see Table 1).

**Table 1. Governance levels in ASTAHG**

LEVEL	ROLE	KEYWORDS	ENTITIES
<b>Governance</b>	strong political commitment	PLANNING the policy lines	Regional health authorities
<b>Policy Maker</b>	governance application	SHARING and NEGOTIATING the policy with civil society for the implementation in the context	Municipalities, local health authorities...
<b>3<sup>rd</sup> level</b>	policy application – civil society empowerment	policy ACCEPTED and AGREED	Non-governmental organizations, public institutions that pursue social and health purposes, ...

As long as this perspective is considered, policy analysis can be a structured, pragmatic and useful starting point for the assessment of governance models. The combination of such analysis with other data such as information provided by context analysis, allows to define potential internal strengths and/or weaknesses of a governance model as well as external opportunities and threats related to each specific territory. The policy process (Figure 7) in this sense could represent a useful source of information for identifying peculiarities or possible rooms for improvement associated to different topics, issues or sectors, such as AHA, in a specific context. In this regard, the good governance principles, that should be applied when designing AHA policies (Kickbusch & Gleicher, 2012), could also be used as criteria for the analysis, measurement and evaluation of the policy itself (see Table 2).

**Figure 7. The policy process**



Source: Own drawing based on Bridgman & Davis (2003).

**Table 2. Good governance principles as a key to understanding policies**

Good governance principles	
<b>Innovative</b>	Questioning established methods and promoting new ideas
<b>Joined-up</b>	Horizontal and vertical integration
<b>Informed by evidence</b>	Based on evidence gathered using reliable and accredited sources
<b>Adaptive</b>	Learning from experience and being suitable to changing contexts
<b>Inclusive</b>	Taking account of the impact and both direct and indirect effects of the policy on all the actors involved
<b>Accountable</b>	Being transparent and responsive to the demands of citizens
<b>Evaluative</b>	Providing systematic evaluation methods and tools
<b>Forward looking</b>	Long-term view based on statistical trends and evidence-based predictions of the possible impacts of the policy

Source: Own drawing adapted on Kickbusch & Behrendt (2013).

Since AHA policies in the AS, as all other types of policies in all territories, are influenced by the context and are embedded in specific national, economic, political, cultural as well as

*This project is co-financed by the European Regional Development Fund through the Interreg Alpine Space programme.*





social structures (Parag, 2006), it is evident that there is a great diversity in how they are developed, adopted and implemented in each political systems and geographic contexts. However, the fact that policies are linked to specific actors, territorial contexts, sectors and issues does not preclude the possibility to define overall-validated key elements that can be used to define and develop an assessment governance model for AHA in the AS. Conversely, contextual analysis of policies implemented in different geographical areas can provide experienced policymakers with a more analytical and formalized approach that can be functional to the development and implementation of effective and efficient AHA policies in the AS.



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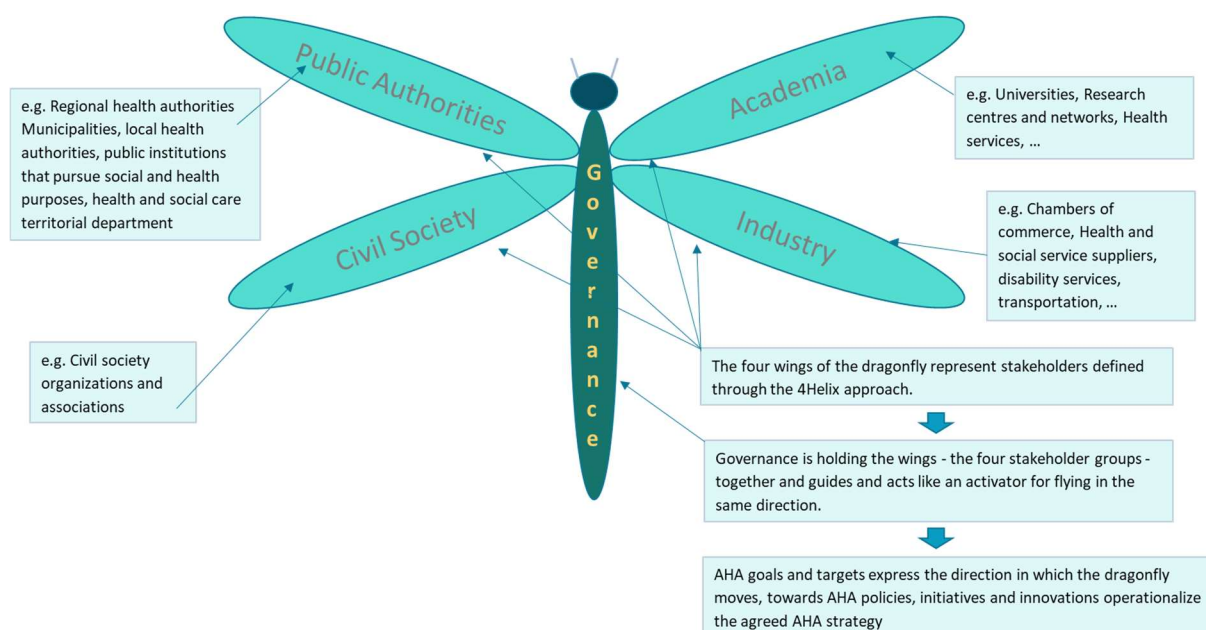
## 4 DATA COLLECTION METHODOLOGY

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The good practices were gathered from the project partners that collected information from stakeholders on their respective territory (observers, governance board members, EUSALP members, and other stakeholders) grouped in Public Authorities (e.g. Regional health authorities, Municipalities, local health authorities, public institutions that pursue social and health purposes, health and social care territorial department), Academia (e.g. Universities, Research centres and networks, Health services, ...), Civil Society ( e.g. Civil society organizations and associations) and Industry (e.g. Chambers of commerce, Health and social service suppliers, disability services, transportation, ...), as in the Quadruple Helix approach.

As ASTAHG is essentially concerned with the spread of AHA innovation the AS, the Quadruple-Helix model also ensures that, at least in principle, all relevant stakeholders within the AS are targeted. We therefore discussed the use and application of the Quadruple Helix model for the purposes of the project and developed a project specific adaptation of the model that was proposed to all project partners during the 2° PSG meeting of the project in Vienna (11-12 December, 2018). The model was then adapted after the feedback of project partners (Figure 8).

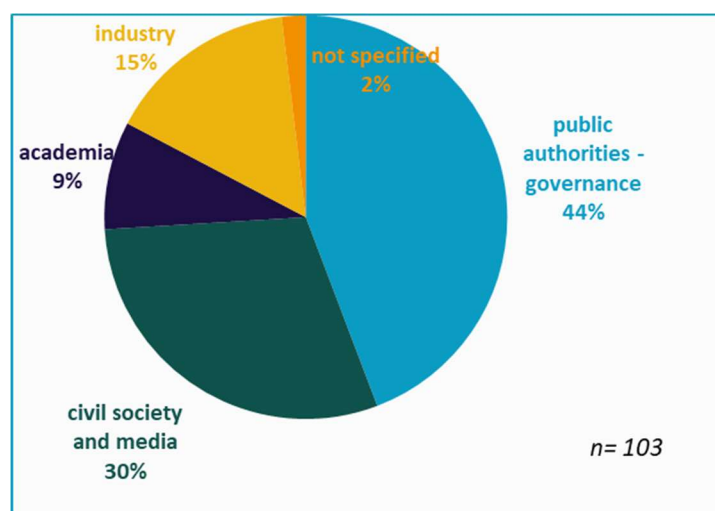
**Figure 8. Quadruple Helix model adaptation**



Source: ASTAHG WP2 DT2.1.1.

The model is represented by a dragonfly, where governance is the body that holds the wings represented by the stakeholder groups and guide as an activator for flying in the same direction. 103 relevant stakeholders were identified and classified as follows (see Figure 9).

**Figure 9. Stakeholder's distribution according to the Quadruple Helix model**



Source: Own drawing.



## 4.1 AHA information survey

The survey template was developed by Area, ECV and PLUS with the contribution of all the project partners in order to identify and describe available and promising AHA policies (expression of governance models), initiatives and innovations, as follows:

1. *AHA policies*, that may be implemented in ASTAHG project regions (and potentially beyond)
2. *AHA initiatives*, which are not formalized as official policies but may serve or relate to a policy in some way
3. *AHA innovations*, which may introduce new technologies / products, services, or processes of some kind and which may be piloted or implemented for routine use in any of the project regions

The survey consists of 73 questions on AHA policies, initiatives and innovations, grouped in the following dimensions:

- *General characteristics & context*
- *Description of AHA activity*
- *Innovation level*
- *Target population & time frame*
- *Stakeholders & governance*
- *Design, decision making & operational process*
- *Evaluation & budget*
- *Respondents' information*

All the project partners were involved in the data gathering and different ways of data collection were recommended:

- literature review
- Transnational Governance Board meetings (AT1.2)
- independent meetings
- local Events (C3.2)



The data gathering was organized in four different rounds. Area Science Park sent the indications to all the project partners and performed the analysis of data collected. All the analysis was then shared with the project partners during different PSG meetings.

Pre-selection criteria were agreed with partners to help them during data gathering, selecting good practices that:

- are effective (i.e. achieves its objectives)
- have impact (i.e. achieves changes in the respective target population)
- are cost-effective (i.e. is regarded to provide good value for money, compared to a suitable alternative)
- are transferable to other AS regions participating in the project (or at least there are no critical “knock-out-factors” that would hinder the transfer to another context)
- are multisectoral (e.g. healthcare + social care + mobility or culture and tourism + social care, etc.).

## 4.2 Collection of aha practices

The collection of policies, innovations and initiatives among ASTAHG project partners has been conducted in 4 phases:

- 1<sup>st</sup> phase: May 2019
- 2<sup>nd</sup> phase: From July to November 2019
- 3<sup>rd</sup> phase: From January to May 2020
- 4<sup>th</sup> phase: From June to July 2020



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## 5 DATA ANALYSIS AND RESULTS

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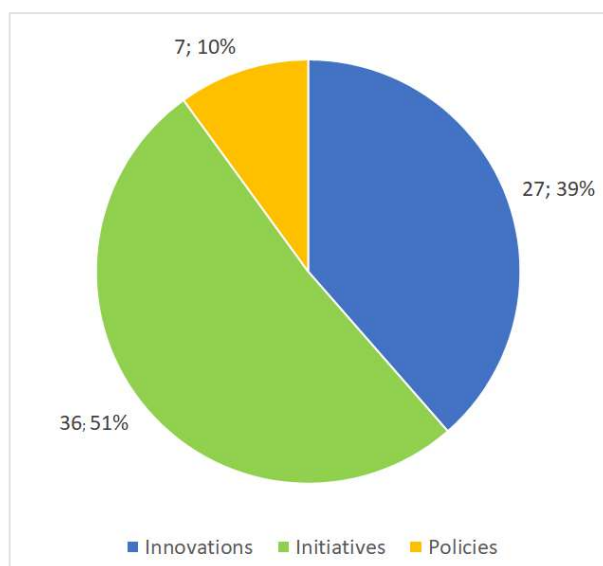
In this chapter, we discuss the descriptive results from the ASTAHG survey data analysis, with a focus on reported AHA policies as the first level of governance implementation. Data related to AHA initiatives and innovations (explained in detail in DT3.2.1) are reported in the present work only for comparative description purposes, since some peculiarities can only emerge and be highlighted through direct comparison among policies and initiatives/innovations as different categories of good practice for AHA.

With regard to the results reported below, it should be noted that in some cases, not all information required in the AHA information survey have been reported; for this reason, the exact number of AHA good practices utilized in the following analysis has been indicated for each figure in the text.

## 5.1 Survey data analysis

A total of 70 AHA good practices were collected through the ASTAHG survey, including 7 policies, 27 innovations\* and 36 initiatives (Figure 10).

**Figure 10. Level of reported AHA good practices (N=70)**



*Source: Own drawing based on AHA information survey data.*

Table 3 provides a complete overview of the policies reported by partners, representing 10% of all AHA good practices collected through the survey. The amount of information reported for each policy varies depending on the data reported by each partner during the process of survey filling. Please note that a detailed description and analysis of collected AHA innovations and initiatives is provided in DT3.2.1 (Tables 1 and 2).

\*one of them was not submitted and implemented by the promotor.

*This project is co-financed by the European Regional Development Fund through the Interreg Alpine Space programme.*



**Table 3. Brief description of collected AHA policies (N=7)**

Name	Short description of the AHA policy reported	Maturity level	Country	Region	Priority sector	Other sectors involved
Active and Healthy Ageing in Slovenia (AHA.SI)	<p>The project started with the analysis of the present situation to define the specific national challenges in the area of AHA; it had proceeded with the identification of the models, best practices and regulatory solutions, provided by international organizations (OECD, WHO, and others) and Member States (Austria, Poland, and others) and analysis of their potential applicability to promote active ageing in Slovenia. Based on this analysis, measures had been proposed that can contribute to improve the conditions for active ageing in Slovenia. Proposed measures had also been checked for feasibility of their implementation and institutionalized solutions had been favoured with the aim of assuring sustainability.</p> <p>This project leads to (1) a sustainable network of relevant sectors and stakeholders in the area of AHA; (2) a higher level of awareness amongst the general public as well as amongst specific target groups of the urgent need to adopt an AHA strategy; (3) an analysis of the situation and specific challenges, and an overview and comparative analysis of possible solutions (best practices, models, legislative measures, etc., with the involvement of selected Member States and international organizations as OECD and WHO).</p> <p>The project also resulted in an agreed set of measures and reforms with recommendations, together with a proposed set of Active Ageing Index harmonized indicators for an AHA strategy for Slovenia. These measures, recommendations and indicators</p>	Pilot stage	Slovenia	Slovenia	Health care	Social care

*This project is co-financed by the European Regional Development Fund through the Interreg Alpine Space programme.*

	<p>were based on work undertaken in the following three areas: 1) promotion of senior's employability and postponed retirement decisions; 2) AHA for active and healthy old age; 3) assisted independent living and long-term care (LTC). All project outputs and outcomes assured sustainable implementation of the AHA strategy.</p> <p>The objective of the project is to support the development of the new comprehensive Slovenian AHA strategy aimed at promoting and improving the conditions for active ageing. The long-term goal of the project is to show better functioning at a healthy age to all residents of Slovenia with various measures that have also been solved through better integration of the health system in the social systems of local communities.</p>					
Free public transport for seniors	<p>This policy, which is part of the Road Transport Act, provides for free public transport for bus and train for seniors older than 65 years, retirees, disabled people, and war veterans from 1 July 2020. The aim is to promote sustainable mobility and enable beneficiaries to use public transport in a simple, transparent, and efficient manner, irrespective of the service provider.</p>	Routine use	Slovenia	Slovenia	Mobility & transport	Independent living, culture & tourism
<p>Regional Law 22/2014</p> <p>"Promotion of active ageing"</p>	<p>Law 22/2014 contrasts all phenomena of prejudice and discrimination towards the third age, through the planning and implementation of coordinated and integrated interventions in favour of the elderly and their inclusion in the areas of health and safety, participation, lifelong learning, work, culture and social tourism, sport and leisure time, civil commitment, and volunteering.</p> <p>The Law pursues an advanced model of social policy that aims at strengthening the opportunities for the contribution of the</p>	Routine use	Italy	Friuli-Venezia Giulia Region	Social care	Health care, long term care, independent living, wellbeing, culture & tourism, mobility & transport



	<p>elderly to society and incorporates the most recent legislative and planning guidelines of the European Union.</p> <p>The innovative nature of this law is inspired by a "rationale" that, overcoming a focus only on welfare and healthcare, promotes autonomy and independent living through initiatives on education, training, culture and knowledge with the support of research and innovation.</p> <p>The Law enhances the role of citizens, older people and others, in determining a change in the old social policy models, orienting them towards a range of personal care services that guarantee the right to awareness and free choice, the respect for self-realization needs and a response focused on the habitual living places.</p> <p>This regional law is implemented through "three-year programs" and the FVG Region FVG established an inter-directorate technical table promoting an innovative system to create a collaboration amongst seven Directorates and the Liaison Office of FVG Region in Bruxelles on Active Ageing.</p>					
<p>Regional Law 23/2017</p> <p>"Promotion and enhancement of active aging"</p>	<p>Law 23/2017 concerns the definition of initiatives to promote active ageing, the institution of an active ageing board and the definition of priorities in AHA field. Law aims to enhance AHA, tackle social exclusion of older people and coordinate initiatives in active ageing sector.</p>	Routine use	Italy	Veneto	Wellbeing	Culture & tourism, social care, health care
<p>Conference of financers of the prevention of loss of autonomy</p> <p>(CFPPA)</p>	<p>The Conference is a mandatory body that represents one of the key provisions of Act No. 2015-1776 of 28 December 2015 on the Adaptation of the Society to Aging. It is an institutional coordination body whose mission is to define in each department (geographic and administrative scale) a coordinated programme for financing individual and collective prevention</p>	Routine use	France	France	Long term care	Wellbeing, independent living, mobility & transport



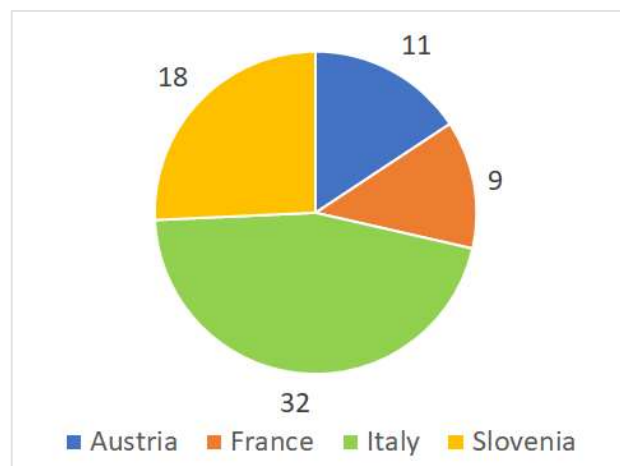
	<p>actions, in addition to legal or regulatory services. In other words, the objective of the conference is to coordinate funding for loss of autonomy prevention around a common strategy.</p> <p>It brings together the actors of the sectors intervening on prevention around shared strategies and actions to build more readable and coherent responses for people. The success of the conference in each departmental territory is the result of the commitment of all the actors concerned in a common strategy to prevent loss of autonomy.</p> <p>The conference of funders is not a funding management body but a governance and strategy development framework.</p> <p>Each conference shall define its own rules of procedure and the members of the conference are different in each territory, but all contribute to the financing of prevention actions.</p>					
Personalized Autonomy Allowance (APA)	<p>The Personalized Autonomy Allowance is an allowance, paid by the departmental council, for people aged 60 and over who are losing their autonomy, who need help to perform the essential acts of daily life (e.g., getting up, washing, dressing, ...) or whose condition requires regular supervision.</p> <p>APA can be attributed to individuals who live at home (home APA) or in a residential facility for dependent elderly people (institutional/residential APA). In detail, while home APA helps to pay the expenses necessary to stay at home despite the loss of autonomy, that are included in an assistance plan, residential APA helps the resident to pay the dependency rate.</p>	Routine use	France	France	Long term care	

Regional Health Project 2018-2023 - Elderly Path  (PRS)	<p>The Regional Health Project 2018-2023 is part of a logic of planning and programming of means. It defines, in line with the national health strategy and in compliance with the social security financing laws, the agency's five-year objectives and the measures to achieve them.</p> <p>The project comprises: 1) the Strategic Orientation Framework (SOF), which sets out the general objectives and expected results over a 10-year horizon; 2) the regional health plan (SRS) established for 5 years, based on an assessment of health, social and medical-social needs; 3) the regional programme on access to prevention and care for the most deprived persons (PRAPS).</p> <p>The Elderly Path of the regional health strategy contains six objectives: 1) prevent loss of autonomy and anticipate disruptions; 2) strengthen, adapt and secure home care; 3) improve the coordination of professionals and information for seniors and their caregivers on the territory; 4) improve city - hospital interfaces; 5) continue to adapt health care institutions to the specific needs of the elderly; 6) rethink the place of the 'EHPAD' and all the reception, support and accommodation services/arrangements within the pathway.</p>	Routine use	France	Provence-Alpes-Côte d'Azur	Health care	Long term care
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### 5.1.1 Geographic distribution

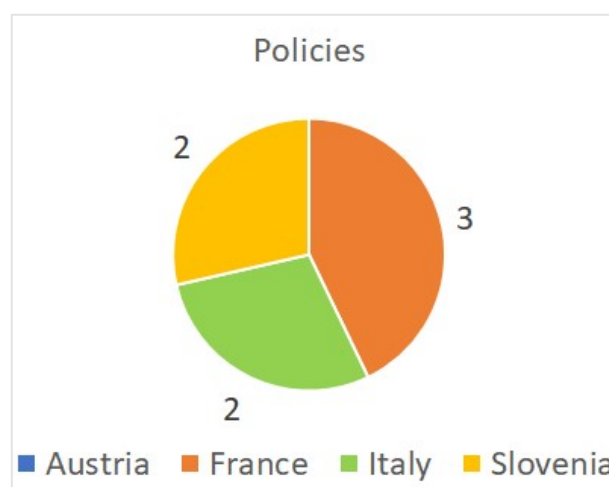
Of the 70 reported good practices (policies, initiatives and innovations), 11 refer to an Austrian context, 9 are implemented in the French project region, 32 in Italy (gathered by the four Italian partners) and another 18 in Slovenia (Figure 11). Regarding policies collected by partners, 3 are related to the French context, 2 are Italian policies and the remaining 2 concern Slovenia. No policies were reported for the Austrian context (Figure 12).

**Figure 11. Geographic origin of total reported AHA good practices (N=70)**



Source: Own drawing based on AHA information survey.

**Figure 12. Geographic origin of reported AHA policies (N=7)**

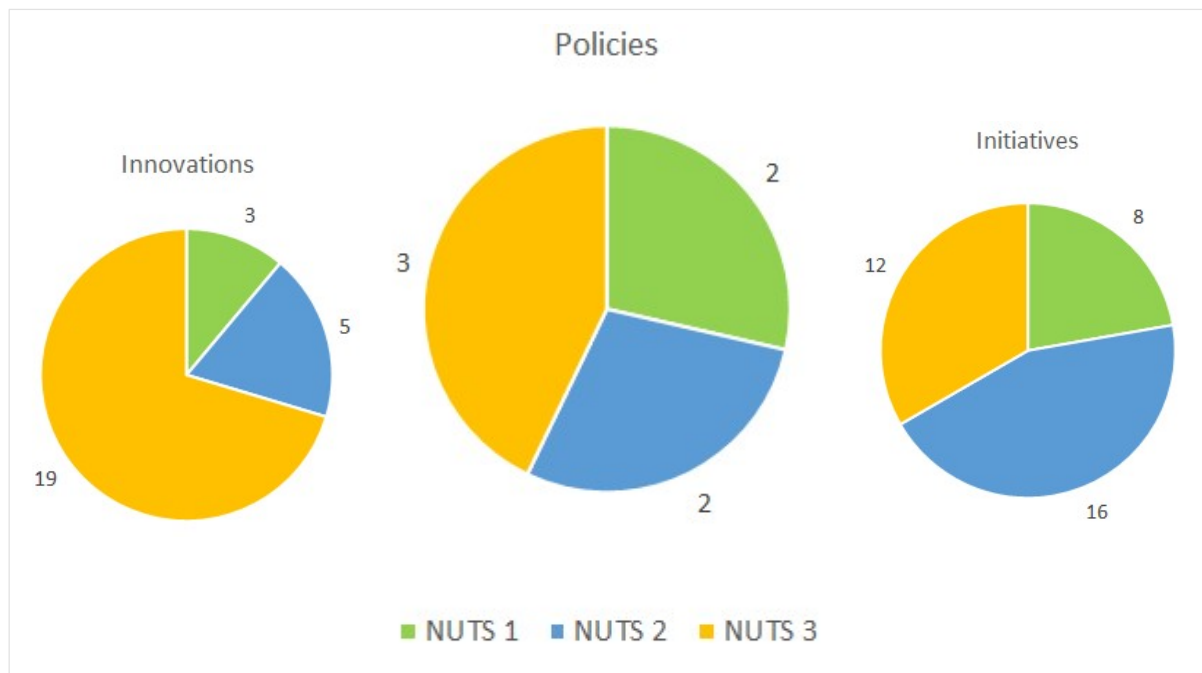


Source: Own drawing based on AHA information survey.

### 5.1.2 NUTS level

Concerning policies, 2 are implemented at the National level (NUTS1), while 2 refer to each NUTS2 and NUTS3-level. Overall, while policies are implemented to a comparable extent on all three levels, on the other side innovations in most cases refer to NUTS3-level and initiatives relate mostly to both NUTS2-level and NUTS3-level (Figure 13). Looking at each of the three countries involved in policy collection, it is noteworthy that in France all the policies refer to NUTS3 level, in Italy they all relate to NUTS2 level, while in Slovenia they are all implemented at NUTS1 level (Figure 14).

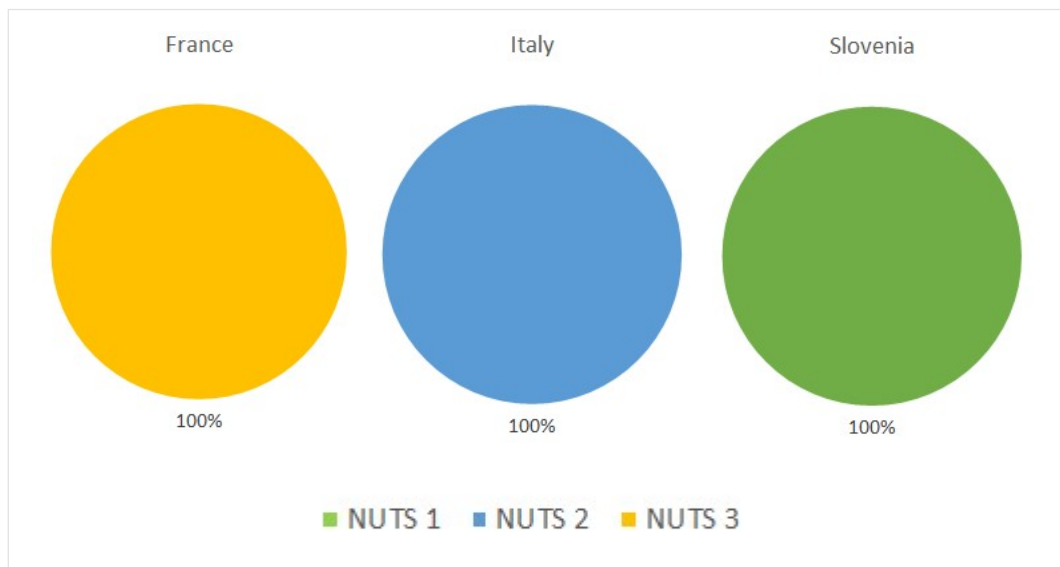
**Figure 13. NUTS-level of reported AHA policies, innovations and initiatives (N=70)**



Source: Own drawing based on AHA information survey.



**Figure 14. NUTS-level of AHA policies reported in different countries (N=7)**



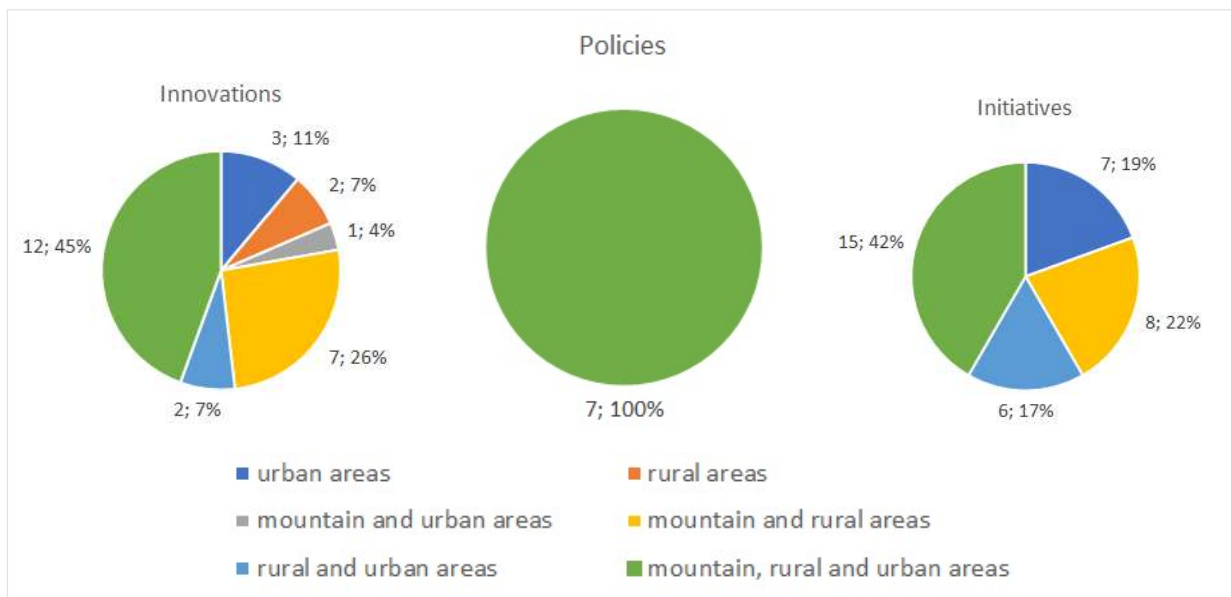
*Source: Own drawing based on AHA information survey.*

### 5.1.3 Geographic context

All the reported policies refer to mountain, rural or urban areas without distinction. On the one hand, this aspect highlights the large territorial extension of policies, which manage to cover and reach territorial areas with very different characteristics and needs. On the other hand, this point focuses attention on the lack of policies reflecting geographical specificities of each type of territory of AS region and therefore tailored to their peculiarities.

On the contrary, both innovations and initiatives show a greater differentiation and characterization according to the geographic context in which they are implemented although, even in these two cases, the majority of them are designed for mixed contexts, including mountain, rural and urban areas . More in detail, the category of AHA good practices with the greatest diversification is that of innovations, implemented in both mixed and specific geographical contexts (Figure 15).

**Figure 15. Geographic context of reported AHA policies, innovations and initiatives (N=70)**



Source: Own drawing based on AHA information survey.

#### 5.1.4 Type of innovation

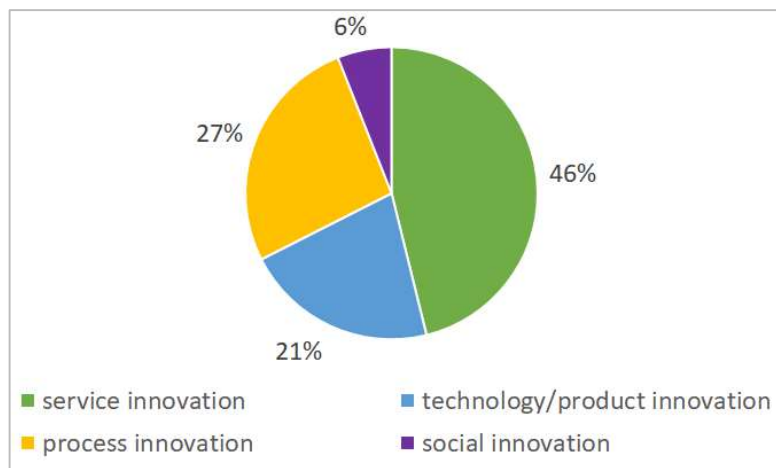
Most reported AHA good practices fall into the category of service innovation ( $n = 54$ ), followed by process innovation ( $n = 31$ ), technology/product innovation ( $n = 25$ ) and finally social innovation ( $n = 7$ ) (Figure 16).

With specific regard to policies, 5 of them consist of service innovation and other 5 are related to process innovation. Only one policy concerns technology/product innovation, and no one of the collected policies concerns social innovation.

Most of the innovations and initiatives also relate to service innovation (46%, respectively), with a smaller number of good practices referring to the other categories. Predictably, a large number of innovations fall into the category of technology/product innovation ( $n = 15$ ), while the remaining part refers to process innovation ( $n = 7$ ). Regarding initiatives, many of them are associated to process innovation ( $n = 19$ ), while the rest are fairly equally distributed between technology/product innovation ( $n = 9$ ) and social innovation ( $n = 7$ ). The category of social innovation is therefore found only among the initiatives (Figure 17).

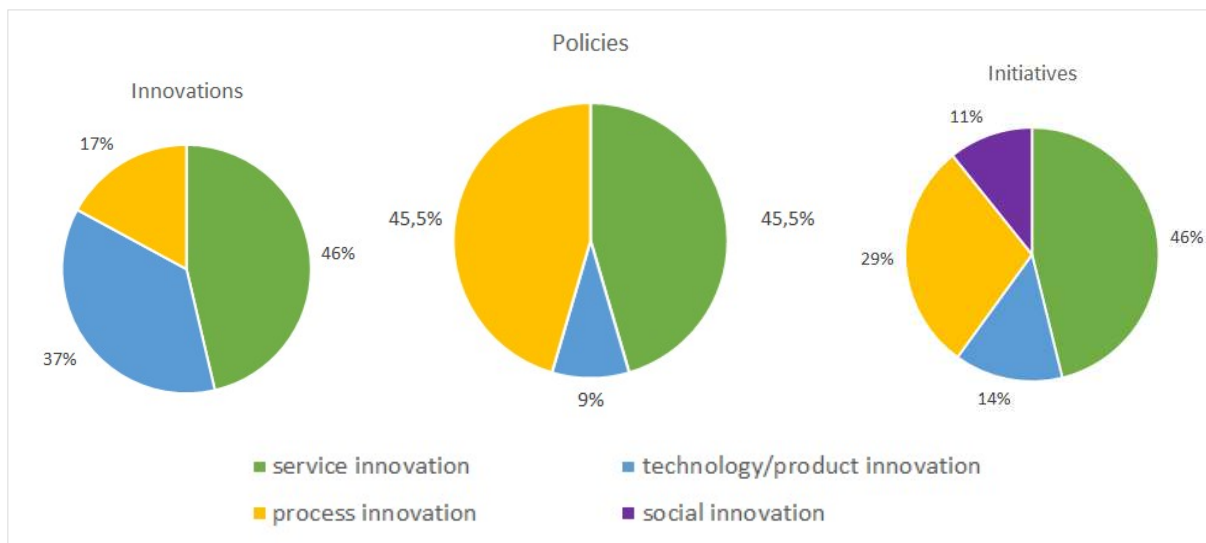
By focusing on the distribution of the policies reported in the three countries, the situations in Italy and Slovenia are overlapping, with a prevalence of policies related to process innovation ( $n = 2$ ) and the rest concerning service innovation ( $n = 1$ ) in both countries. France, on the other hand, is in line with the general trend, with the majority of policies associated with service innovation ( $n = 3$ ) and the remaining part equally pertaining to the categories of process innovation ( $n = 1$ ) and technology/product innovation ( $n = 1$ ) (Figure 18).

**Figure 16. Type of innovation of reported AHA good practices (N=69)**



Source: Own drawing based on AHA information survey.

**Figure 17. Type of innovation of reported AHA policies, innovations and initiatives (N=69)**

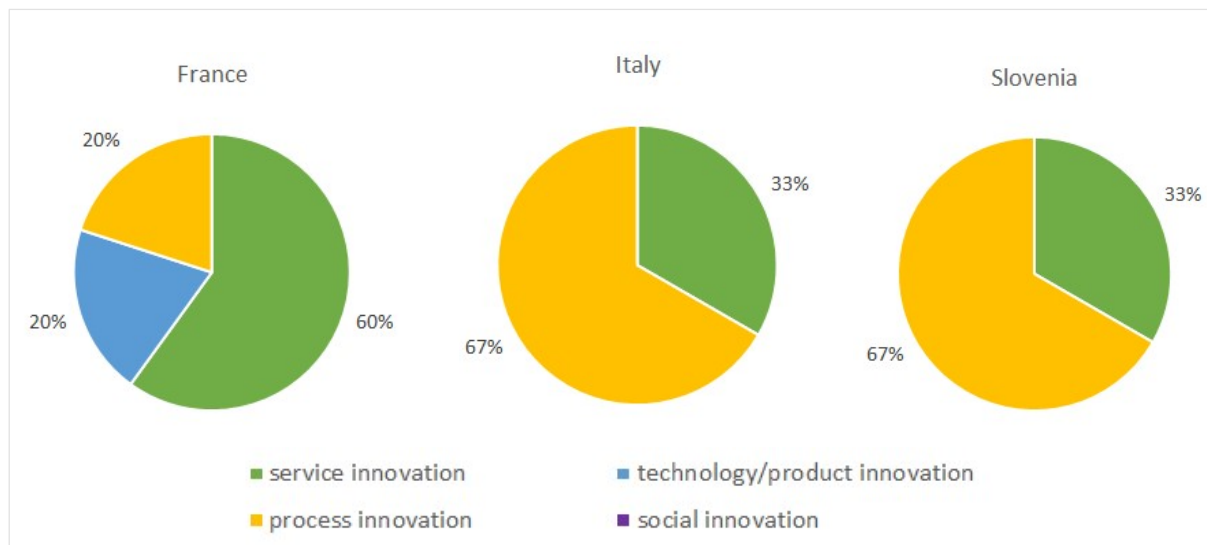


Source: Own drawing based on AHA information survey.

This project is co-financed by the European Regional Development Fund through the Interreg Alpine Space programme.



**Figure 18. Type of innovation of AHA policies reported in different countries (N=7)**



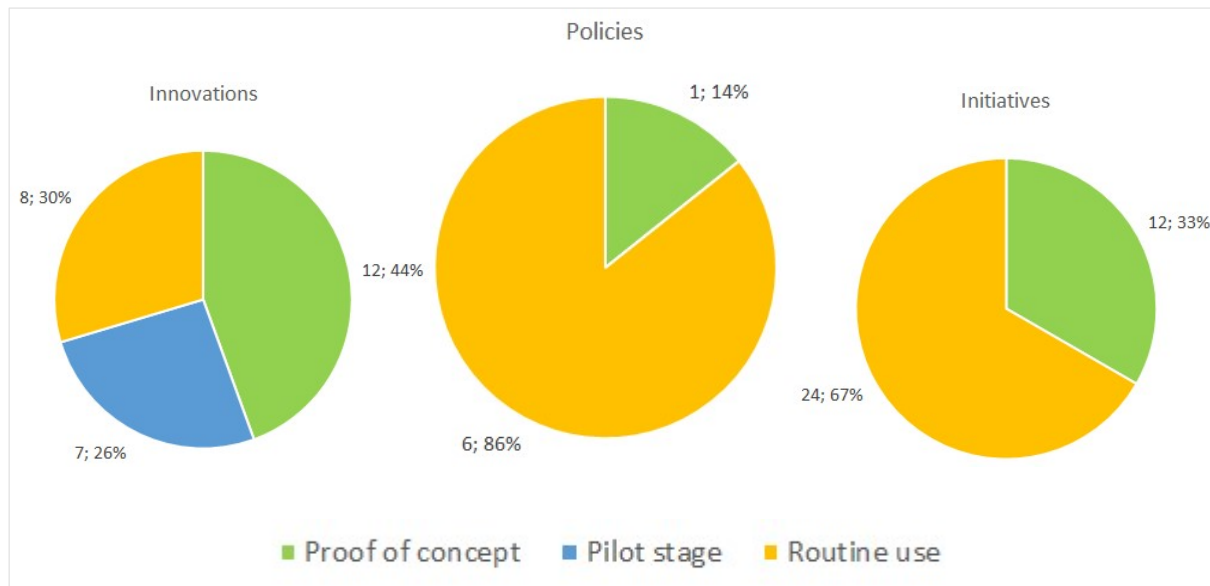
Source: Own drawing based on AHA information survey.

#### 5.1.5 Maturity level & duration

Concerning the maturity level, all policies are in routine use, except one referring to Slovenia that is in a proof of concept stage. Both innovations and initiatives, in contrast, show greater diversification in terms of maturity. More in detail, innovations are distributed, in descending order, among proof of concept stage, routine use and pilot stage, while initiatives are mostly in routine use, with a minority of them at proof of concept stage (Figure 19). The pilot stage is, therefore, only found in the case of innovations. Overall, in percentage terms, the policies are characterised by a higher level of maturity than innovations and initiatives.



**Figure 19. Maturity level of reported AHA policies, innovations and initiatives (N=70)**

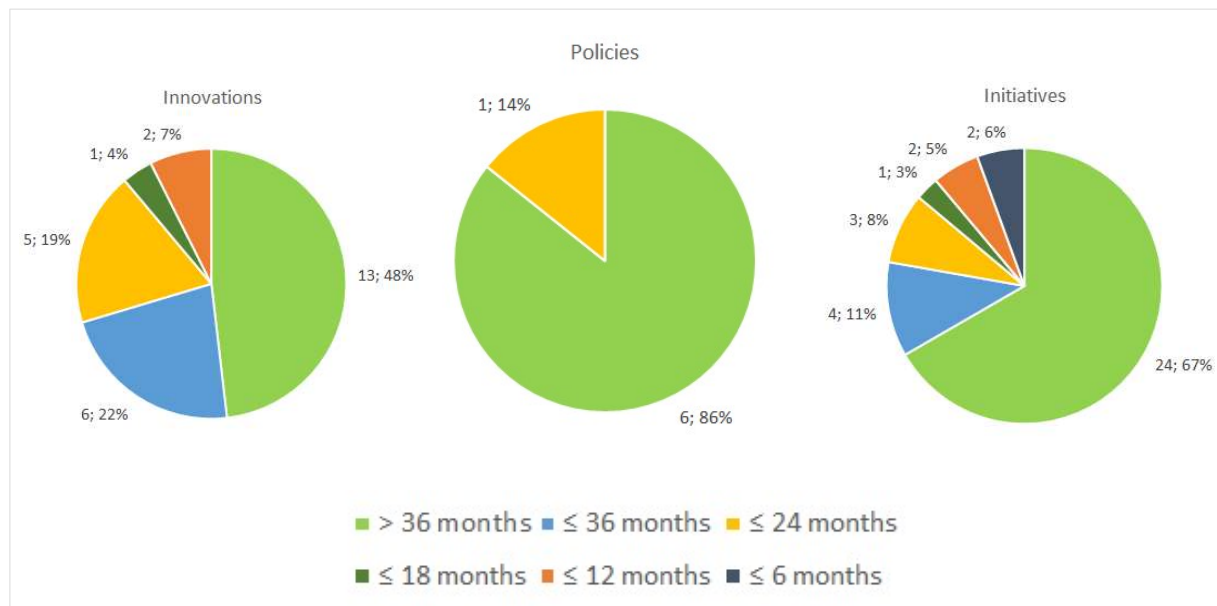


*Source: Own drawing based on AHA information survey.*

The duration of implementation of all policies is above 36 months except for the Slovenian policy which is at proof of concept stage and whose duration is below (or equal to) 24 months. Regarding both innovations and initiatives, their duration of implementation is much more diversified. The majority of both innovations and initiatives are indeed implemented above 36 months, but some of them have a much shorter duration. Specifically, 2 good practices (1 for each category) have a duration below 18 months, 4 (2 for each category) are implemented below 12 months and 2 innovations below 6 months (Figure 20).

Overall, in percentage terms, policies are more long-lasting, and therefore consolidated, than innovations and initiatives. These results are consistent with those related to the maturity level of the AHA good practices. The six policies in routine use are, indeed, the same policies that have a duration of implementation above 36 months.

**Figure 20. Duration of reported AHA policies, innovations and initiatives (N=70)**



Source: Own drawing based on AHA information survey.

#### 5.1.6 Good practice sectors

Six of the 7 reported policies touch on at least 2 AHA sectors up to a maximum of seven different sectors, which is well in line with the multisectoral approach of the project (Figures 21 and 22). While considering all the primary and other sectors involved in the delivery of the respective AHA policy, it is noteworthy that the reported policies fall into all AHA-sectors covered by the survey. The most affected sectors are health care and long-term care, followed by social care, wellbeing, mobility & transport, culture & tourism and independent living. Among them, culture & tourism and independent living are only reported as secondary or other AHA-sectors (Figure 23). More specifically, as primary sectors, policies involve health care and long-term care, followed by mobility & transport, social care and wellbeing.

Both innovations and initiatives show an even greater diversification of primary target sectors. The former also involve independent living and culture & tourism, but not social care, while the latter touch on all seven sectors considered in the survey as primary sectors, although



some in very small percentages, in particular mobility & transport and long-term care (Figure 24).

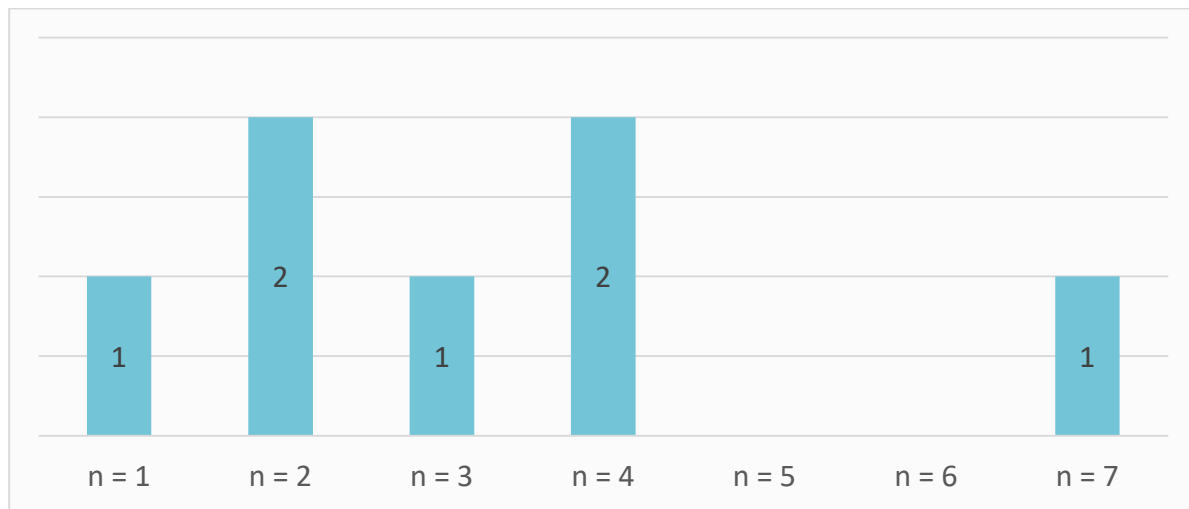
Comparing the three countries where policies have been collected, reveals that in France the most represented primary sector is long term care ( $n = 2$ ), followed by health care ( $n = 1$ ), while in Italy wellbeing and social care are equally represented ( $n = 1$  respectively), as well as mobility & transport and health care in Slovenia ( $n = 1$ ) (Figure 25).

Regarding other sectors, policies affect all sectors considered in the survey to an almost equal degree. More in detail, the most covered other sectors are culture & tourism, independent living and mobility & transport, followed by health care, long term care, social care and wellbeing. Innovations and initiatives also show the same diversification in terms of sub-sectors, with innovations mostly affecting social care, health care and wellbeing, while initiatives being mostly related to wellbeing, independent living, social care and health care (Figure 26).

Comparing the three countries where policies have been collected, a significant diversification of reported sectors can be observed in Italy, covering all the other sectors considered in the survey. More in detail, the more represented other sectors are health care and culture & tourism ( $n = 2$  respectively), followed by independent living, long term care, mobility & transport, social care and wellbeing ( $n = 1$  respectively). Concerning France, four other sectors are equally represented, that is independent living, long term care, mobility & transport and wellbeing ( $n = 1$  respectively). Finally, three other sectors are most represented in Slovenia, i.e., culture & tourism, independent living and social care ( $n = 1$  respectively) (Figure 27).

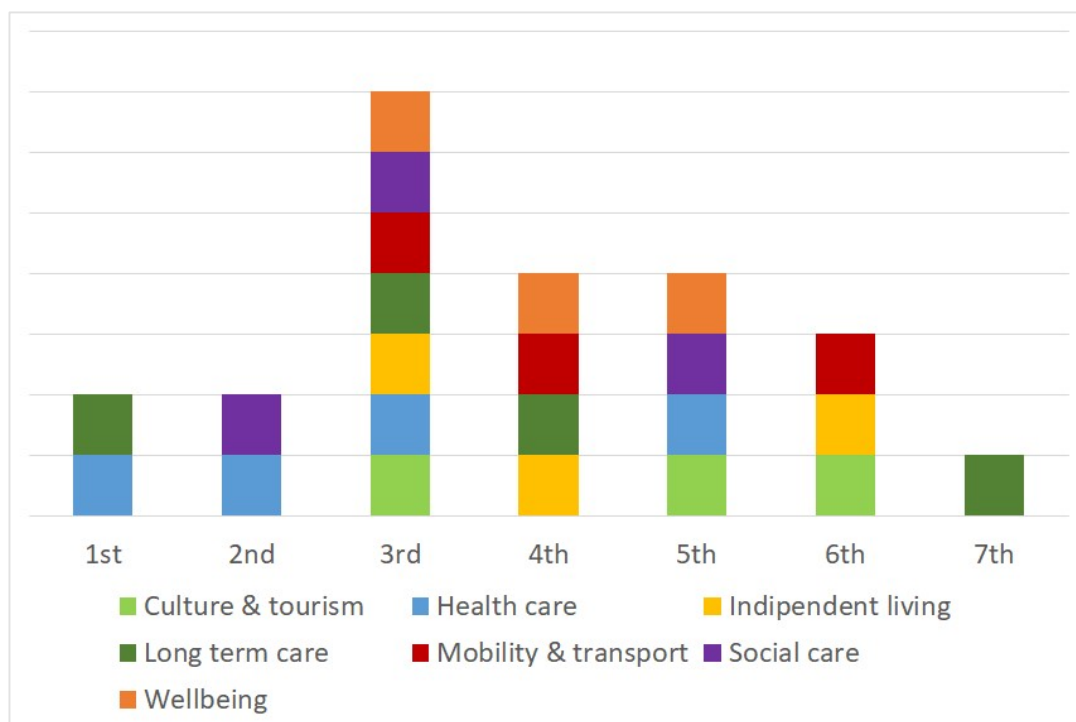


**Figure 21. Number of AHA-sectors involved in reported policies (N=7)**



Source: Own drawing based on AHA information survey.

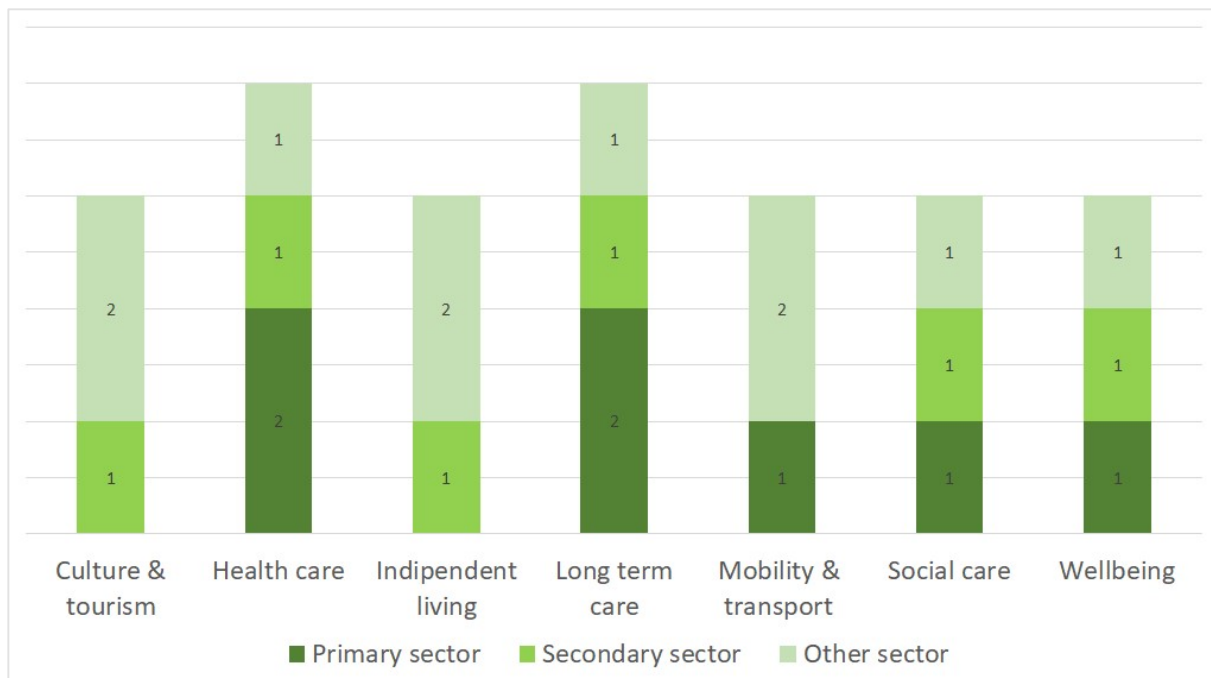
**Figure 22. AHA-sectors involved in each reported policy (N=7)**



Source: Own drawing based on AHA information survey.

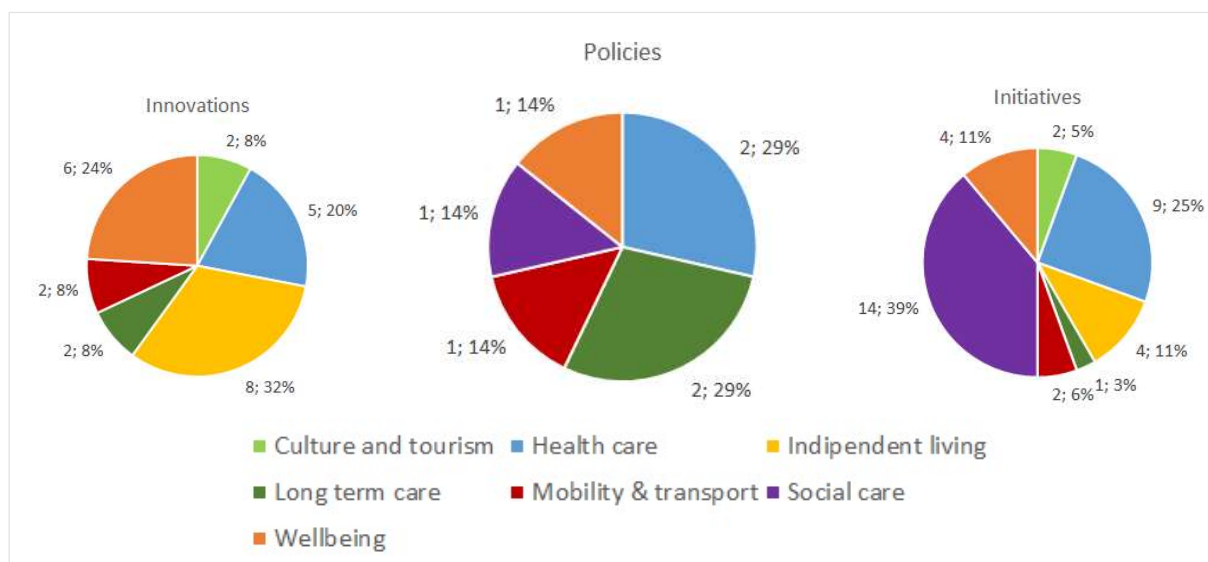


**Figure 23. AHA-sectors involved in reported AHA policies (N=7)**



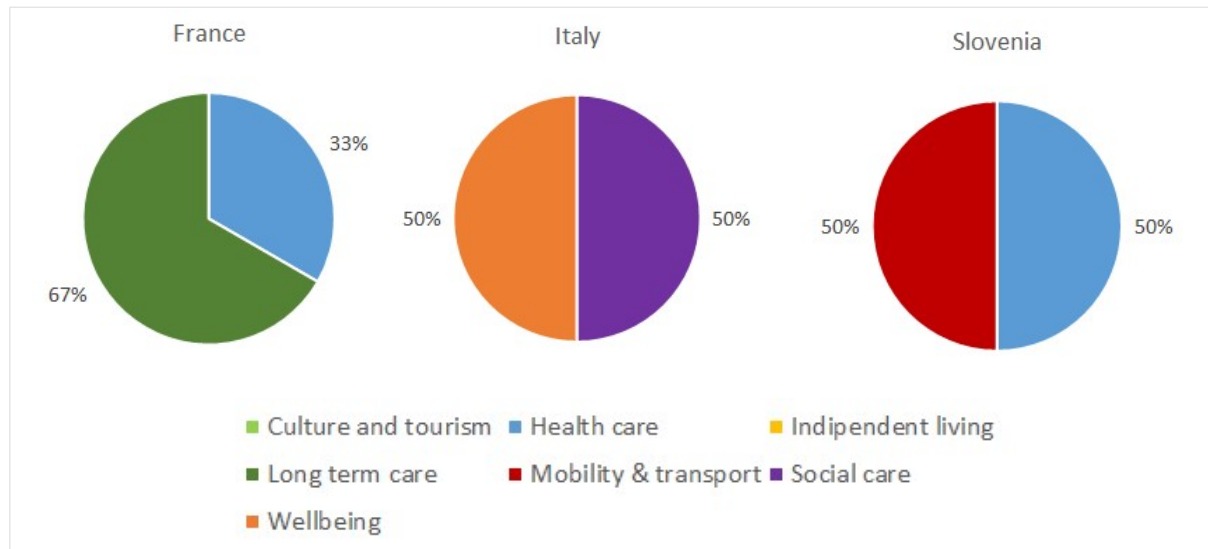
Source: Own drawing based on AHA information survey.

**Figure 24. AHA-primary sectors involved in reported AHA policies, innovations and initiatives (N=68)**



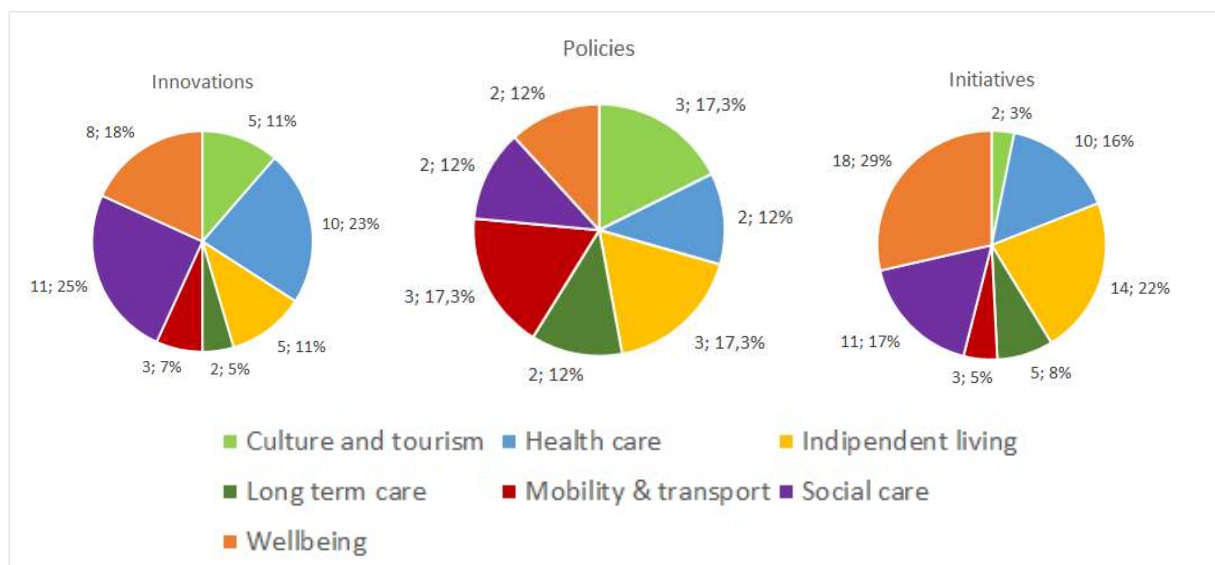
Source: Own drawing based on AHA information survey.

**Figure 25. AHA-primary sectors involved in AHA policies reported in different countries (N=7)**



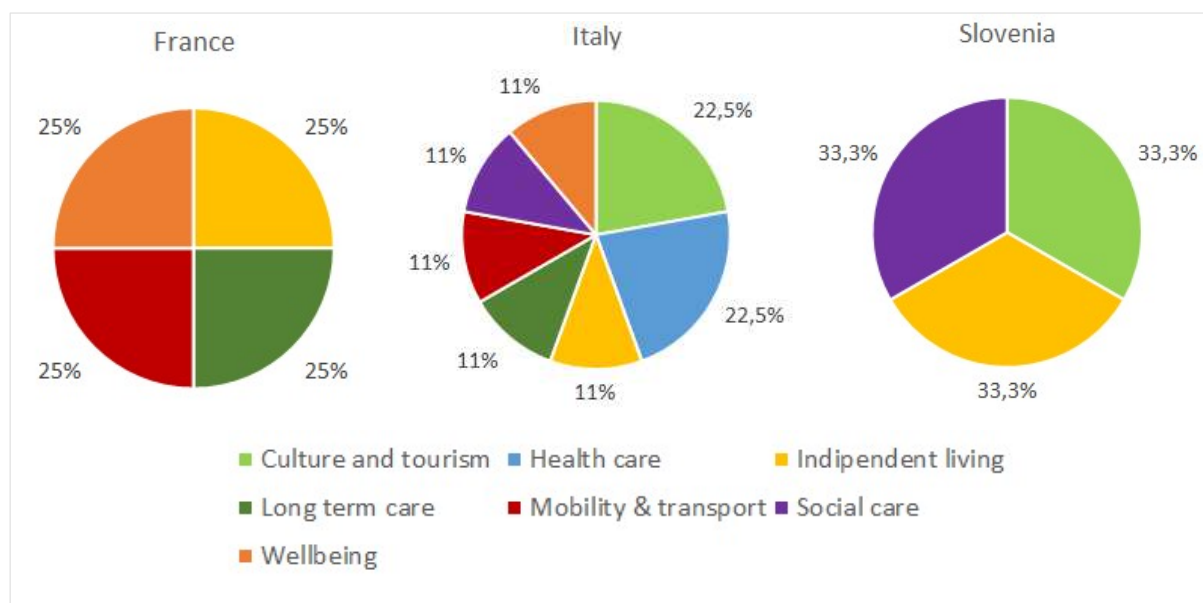
Source: Own drawing based on AHA information survey.

**Figure 26. AHA-other sectors involved in reported AHA policies, innovations and initiatives (N=60)**



Source: Own drawing based on AHA information survey.

**Figure 27. AHA-other sectors involved in AHA policies reported in different countries (N=7)**



Source: Own drawing based on AHA information survey.

#### 5.1.7 Primary and secondary users groups

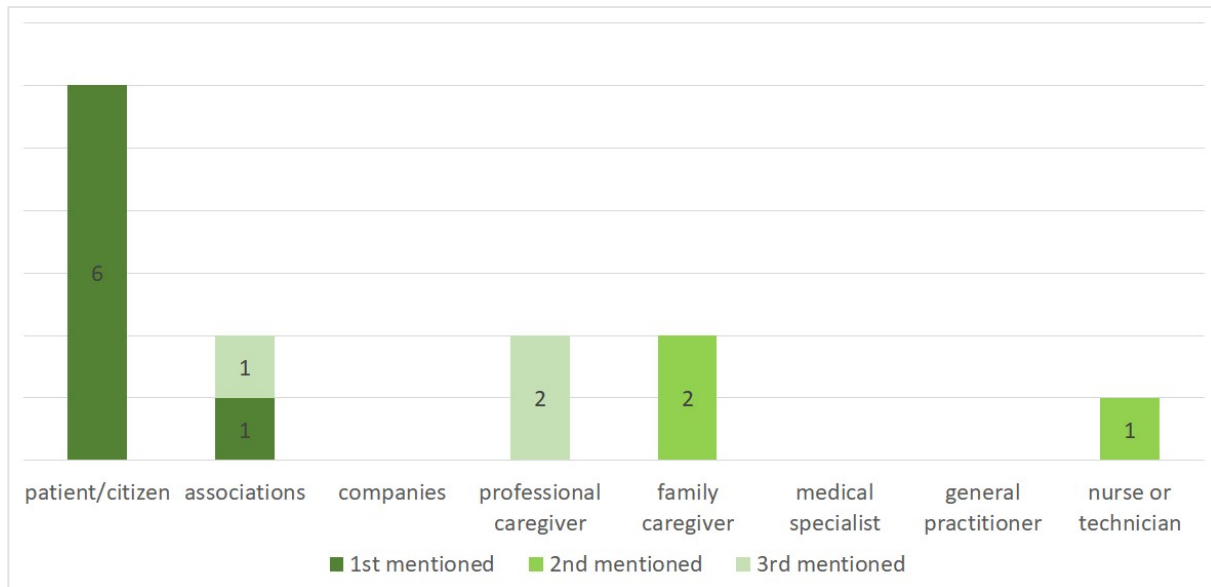
Figures 28 and 30 depict primary user groups of the reported AHA policies. In terms of primary users, most policies focus on patients/citizens, followed by associations, professional caregivers and family caregivers. Only one policy is targeted at nurses or technicians.

Analysing each policy, it is possible to notice that more than half of them target multiple primary user groups (Figure 29). Compared to policies, both innovations and initiatives show a greater diversification of primary users. In both cases, most of the AHA good practices are also targeted at patients/citizens, with a minority of them focused on companies, medical specialists and general practitioners, categories of primary users that are not included in the case of policies (Figure 30).

Comparing the different countries where policies have been collected, it can be noticed that in all three cases, patients/citizens represent a substantial percentage of primary users ( $n = 3$  in France,  $n = 2$  in Italy and  $n = 1$  in Slovenia). Moreover, part of the policies in Slovenia and France is targeted at professional caregivers ( $n = 1$ , respectively), while another part is focused on associations in both Slovenia and Italy ( $n = 1$ , respectively). Regarding territorial specificities

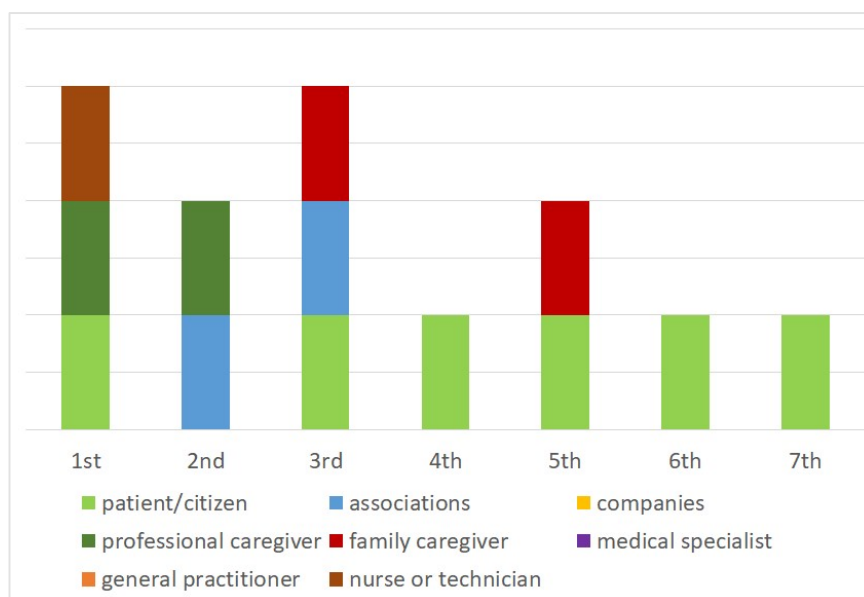
of each of the countries involved in AHA-policies collection, a large percentage of Italian policies is targeted at family caregivers ( $n = 2$ ), while a minority of French ones is focused on nurses or technicians ( $n = 1$ ) (Figure 31).

**Figure 28. Primary user groups targeted with reported AHA policies (N=7)**



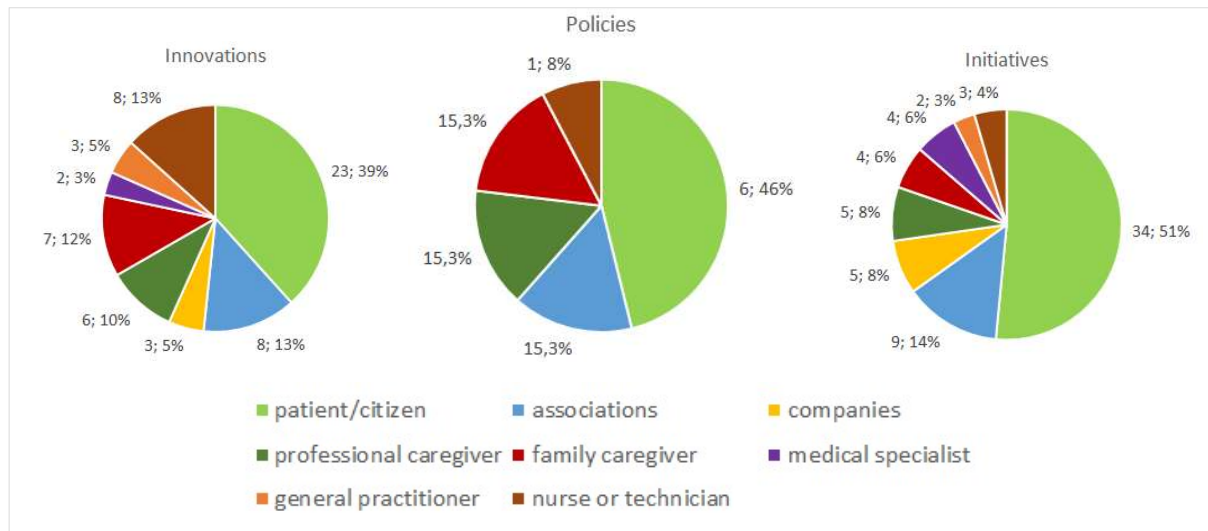
Source: Own drawing based on AHA information survey.

**Figure 29. Primary user groups targeted with each reported AHA policy (N=7)**



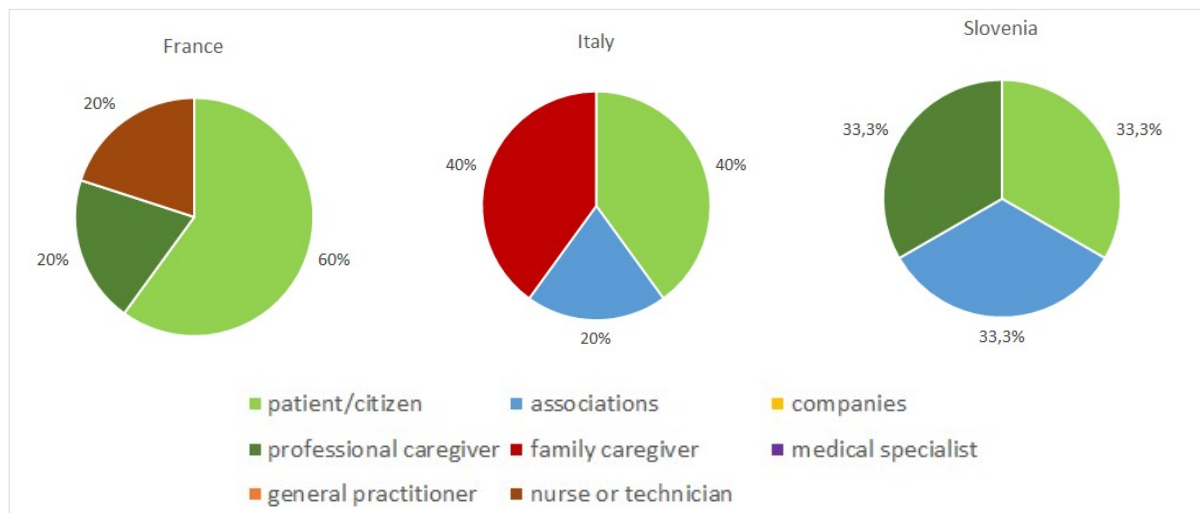
Source: Own drawing based on AHA information survey.

**Figure 30. Primary user groups targeted with reported AHA policies, innovations and initiatives (N=68)**



Source: Own drawing based on AHA information survey.

**Figure 31. Primary user groups targeted with AHA policies reported in different countries (N=7)**



Source: Own drawing based on AHA information survey.

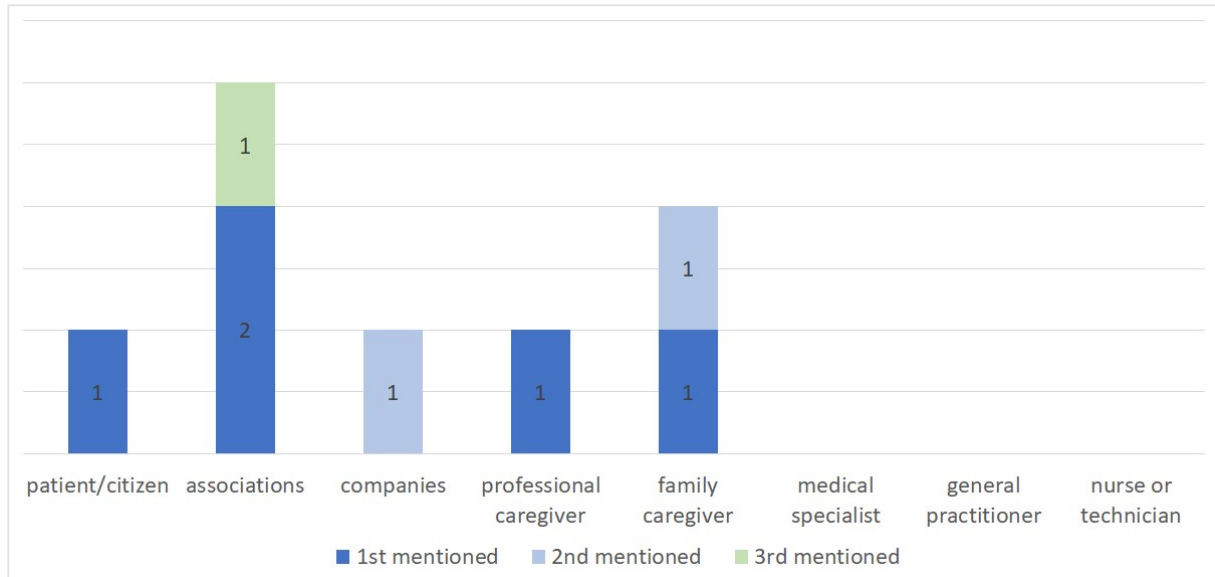
As for secondary user groups, the categories on which AHA policies focus most are associations, followed by family caregivers, patients/citizens, companies and professional caregivers (Figures 32 and 34). Analysing each policy, it can be noticed that two of them target multiple secondary user groups, three others focus on a single category of secondary users and, finally, in two cases no secondary users have been reported (Figure 33).

As for primary users, compared to policies, both innovations and initiatives show a greater diversification of secondary users, targeting at all the groups reported in the survey. More in detail, most innovations focus on companies and professional caregivers, followed by associations and medical specialists, and finally by patients/citizens, family caregivers, general practitioners and nurses or technicians. Regarding initiatives, most of them focus on associations, another part on professional caregivers, nurses or technicians and medical specialists, with a minority targeting at patients/citizens, family caregivers and general practitioners as secondary user groups. Therefore, also in this case, as for primary use groups, both innovations and initiatives target at categories of secondary users that are not included in the case of policies, that is medical specialists, general practitioners and nurses or technicians (Figure 34).

Comparing the different countries where policies have been collected, it can be seen that in all three cases, associations represent a substantial percentage of secondary users ( $n = 1$  in France,  $n = 1$  in Italy and  $n = 1$  in Slovenia), while the remaining part of French policies as well as some of the Slovenian ones target at family caregivers ( $n = 1$ , respectively). Regarding territorial specificities of each of the countries involved in AHA-policies collection, the rest of Slovenian policies focus on patients/citizens ( $n = 1$ ), while the remaining percentage of Italian ones targets at companies and professional caregivers ( $n = 1$ , respectively) (Figure 35).

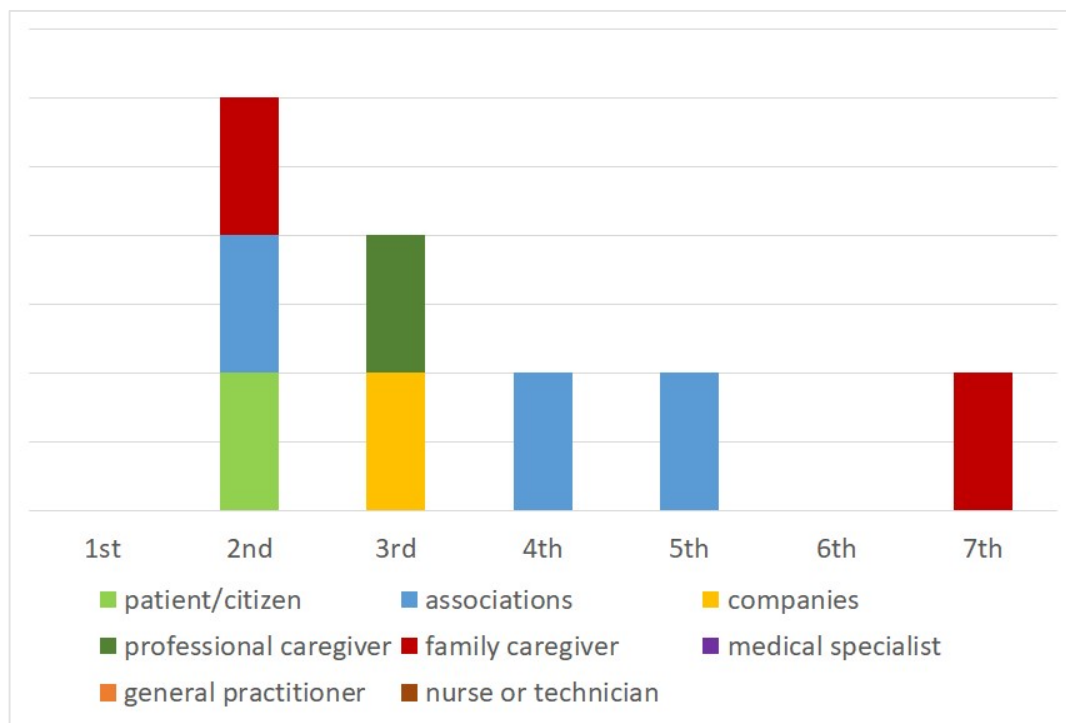


**Figure 32. Secondary user groups targeted with reported AHA policies (N=5)**



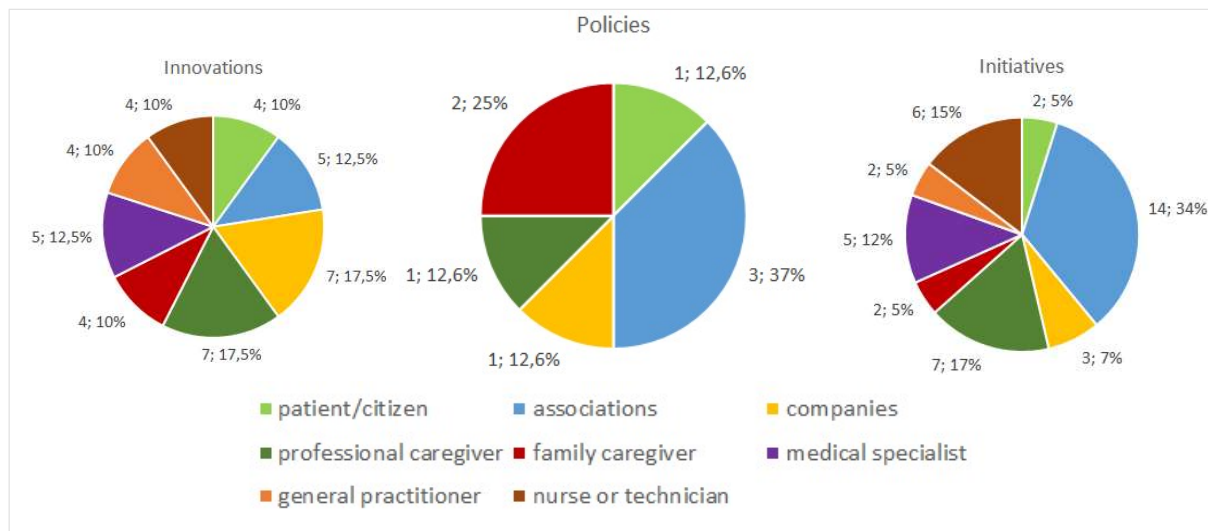
Source: Own drawing based on AHA information survey.

**Figure 33. Secondary user groups targeted with each reported AHA policy (N=5)**



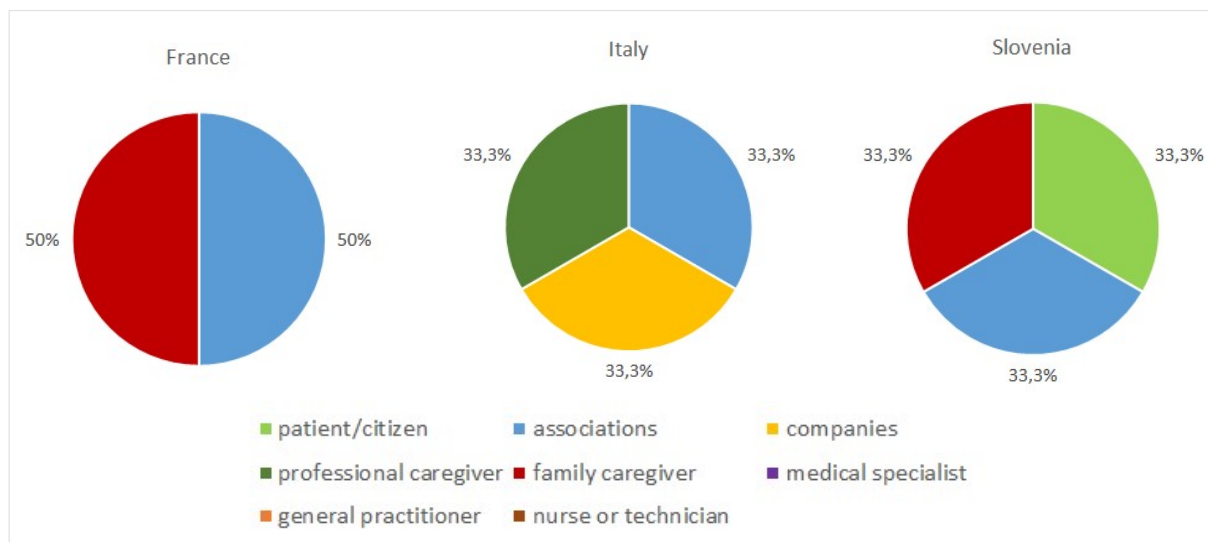
Source: Own drawing based on AHA information survey.

**Figure 34. Secondary user groups targeted with reported AHA policies, innovations and initiatives (N=48)**



Source: Own drawing based on AHA information survey.

**Figure 35. Secondary user groups targeted with AHA policies reported in different countries (N=5)**



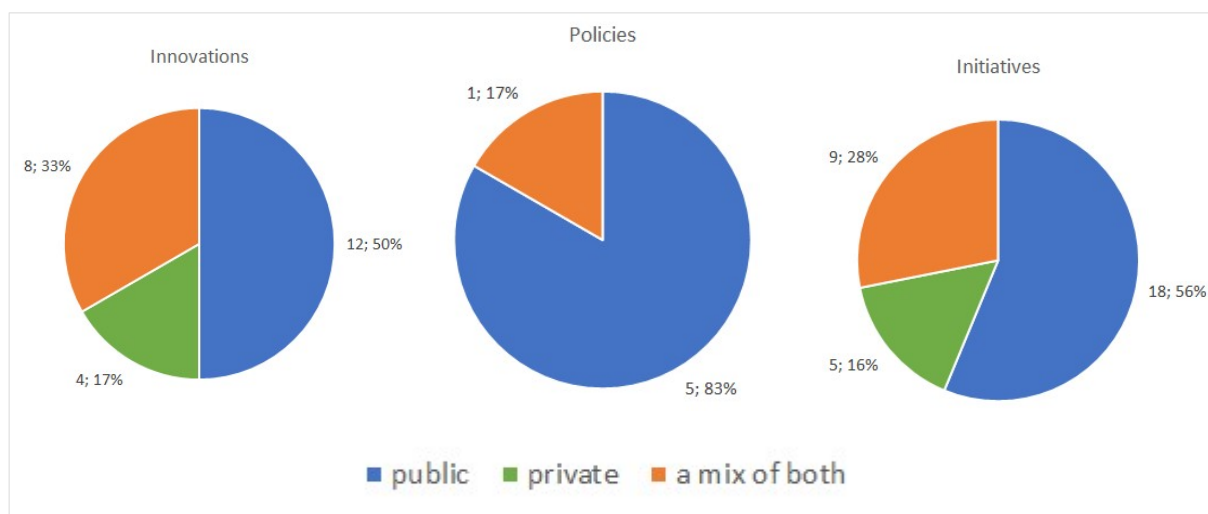
Source: Own drawing based on AHA information survey.



### 5.1.8 Responsible stakeholder

The responsible stakeholder is public in 5 of the 7 policies reported, only one policy shows a responsible stakeholder as a mix of public and private. Also in the case of innovations and initiatives the prevailing organisational form of the responsible stakeholder is public, however, a minority of them have a private responsible stakeholder, and the remaining large percentage of both innovations and initiatives have a responsible stakeholder which is a mix of public and private (Figure 36). It is relevant to point out that the private organisational form, which appears in the case of some innovations and initiatives, is not included in the case of collected policies.

**Figure 36. Organisational form of the responsible stakeholder of reported AHA policies, innovations and initiatives (N=62)**



Source: Own drawing based on AHA information survey.

### 5.1.9 Actors involved in the design, decision-making and operational processes

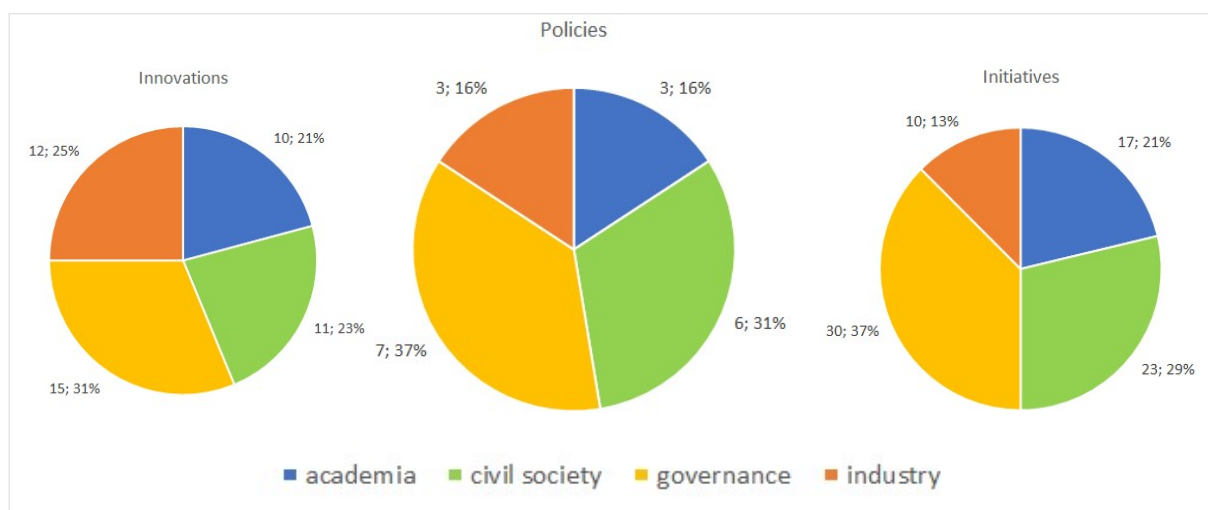
As for the design process (Figure 37), governance (i.e., public authorities) is the dominant group of Quadruple Helix actors for reported AHA policies, followed by civil society, academia and industry. A similar picture can be found in the case of both innovations and initiatives. In both cases, the actor most involved is governance with some differences regarding the involvement of other actors.

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In the case of innovations, indeed, the second most influential Quadruple Helix actor is industry, followed by civil society and academia. Concerning initiatives, the second most relevant actor is civil society, followed by academia and industry.

Comparing the different countries where policies have been collected, it can be noticed that in Italy the most represented actors are governance and civil society ( $n = 2$ , respectively), followed by academia ( $n = 1$ ). Stakeholders from industry, on the other hand, are not involved in the design process of Italian reported policies. On the contrary, in both France and Slovenia all four Quadruple Helix actors come into play with a prevalence of governance ( $n = 3$  and  $n = 2$ , respectively) and civil society ( $n = 2$ , respectively) (Figure 38). As regards the other two actors, while in Slovenia they appear equally relevant ( $n = 1$ , respectively), in France the most third influential is industry ( $n = 2$ ), followed by academia ( $n = 1$ ). Considering policies one by one, six out of seven involve at least two Quadruple Helix actors in the design process, up to a maximum of four ( $n = 2$ ), whereas only one policy involves a single actor at this stage (Figure 39). Moreover, it is noteworthy that governance is present as an actor of designing process in all the reported policies, while civil society intervenes in six out of seven cases.

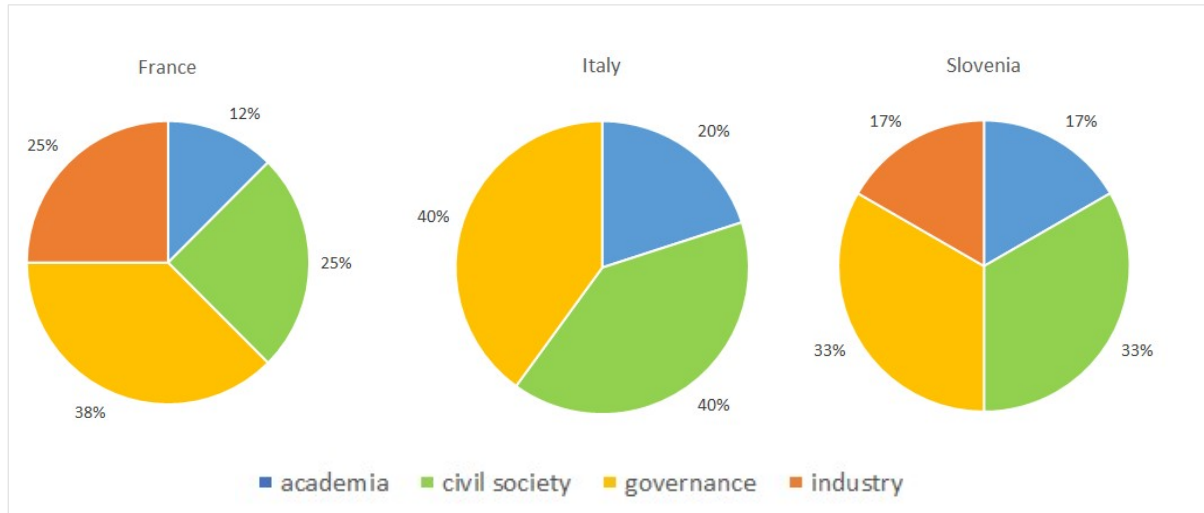
**Figure 37. Quadruple Helix actors involved in the design process of policies, innovations and initiatives (N=66)**



Source: Own drawing based on AHA information survey.

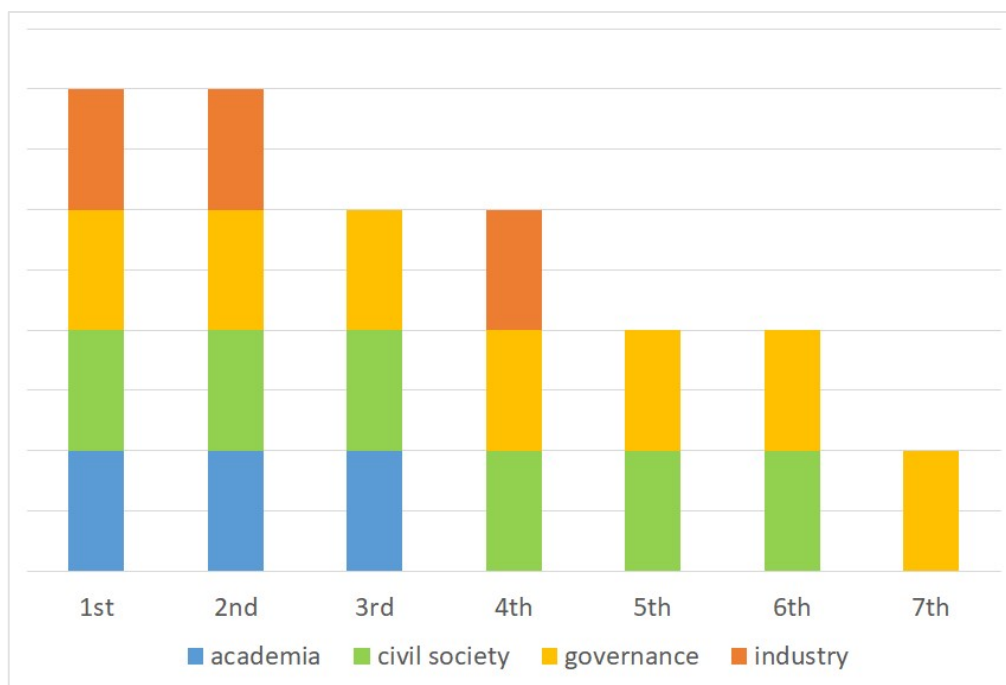
This project is co-financed by the European Regional Development Fund through the Interreg Alpine Space programme.

**Figure 38. Quadruple Helix actors involved in the design process of AHA policies reported in different countries (N=7)**



Source: Own drawing based on AHA information survey.

**Figure 39. Quadruple Helix actors involved in the design process of each reported AHA policy (N=7)**



Source: Own drawing based on AHA information survey.

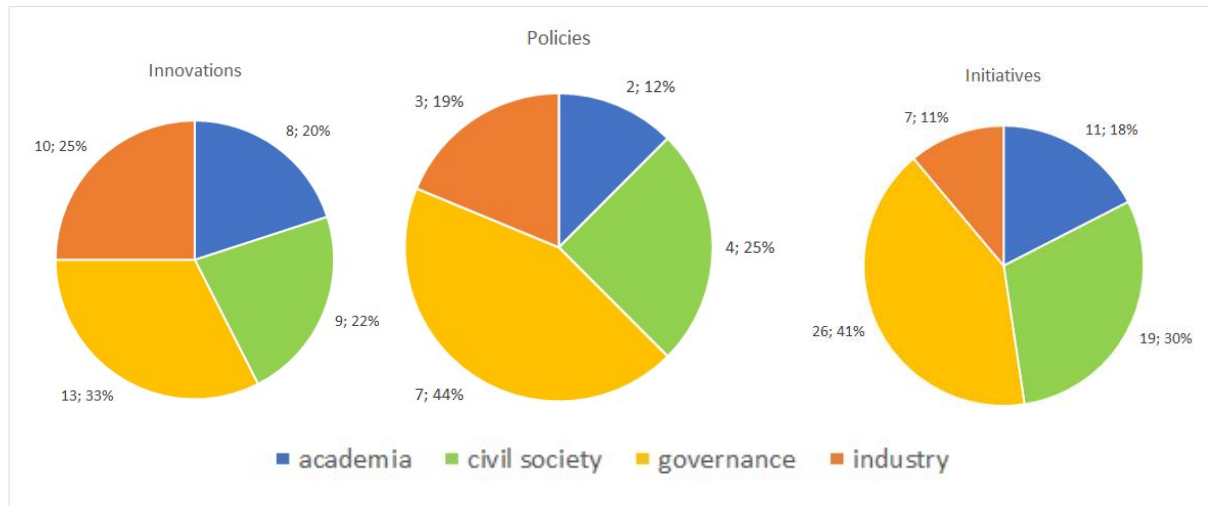


Also with regard to the decision-making process (Figure 40), governance is the dominant group of Quadruple Helix actors for AHA policies reported, followed by civil society, industry and academia.

A similar picture can be found in the case of both innovations and initiatives. In both cases, the most involved actor is governance with some differences, however, regarding the involvement of other actors. In the case of innovations, indeed, as for design process, the second most influential Quadruple Helix actor is industry, followed by civil society and academia. Concerning initiatives, as for design process, the second most relevant actor is civil society, followed by academia and industry.

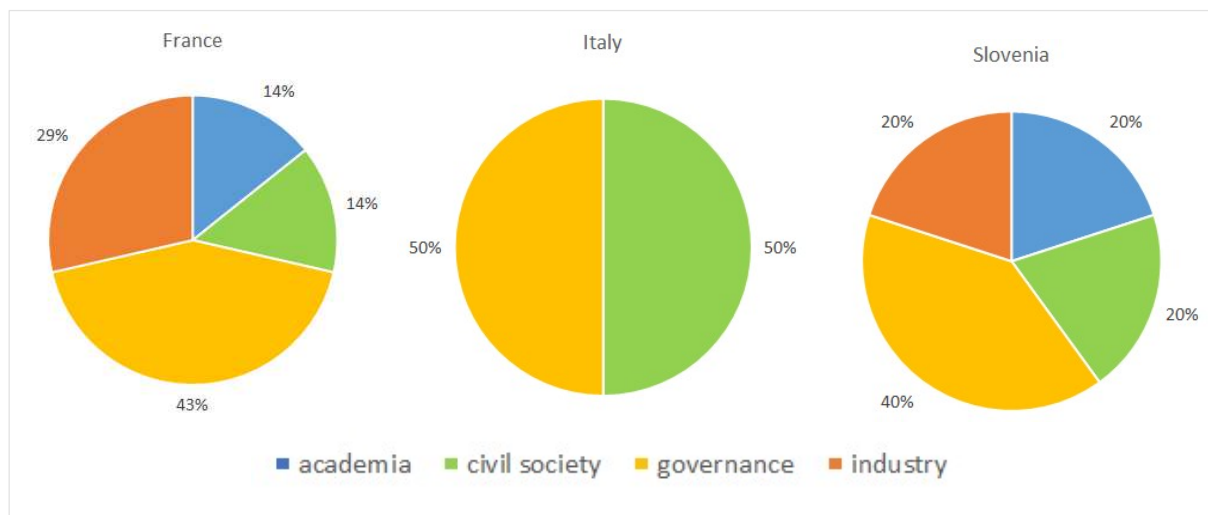
Comparing the different countries where policies have been collected, it can be seen that in Italy stakeholders from both academia and industry are not involved in the decision-making process of the reported policies. The dominant actors in this phase are both governance and civil society ( $n = 2$ , respectively). On the contrary, as for design process, in both France and Slovenia all four Quadruple Helix actors come into play with a prevalence of governance ( $n = 3$  and  $n = 2$ , respectively). As regards the other three actors, while in Slovenia they appear equally relevant ( $n = 1$ , respectively), in France the second most influential is industry ( $n = 2$ ), followed by academia and civil society ( $n = 1$ , respectively) (Figure 41). Considering policies one by one, as for the design process, six out of seven involve at least two Quadruple Helix actors in the decision-making process, up to a maximum of four ( $n = 1$ ), whereas only one policy involves a single actor at this stage (Figure 42). Moreover, it is noteworthy that governance is present as an actor of decision-making process in all the reported policies.

**Figure 40. Quadruple Helix actors involved in the decision-making process of policies, innovations and initiatives (N=64)**



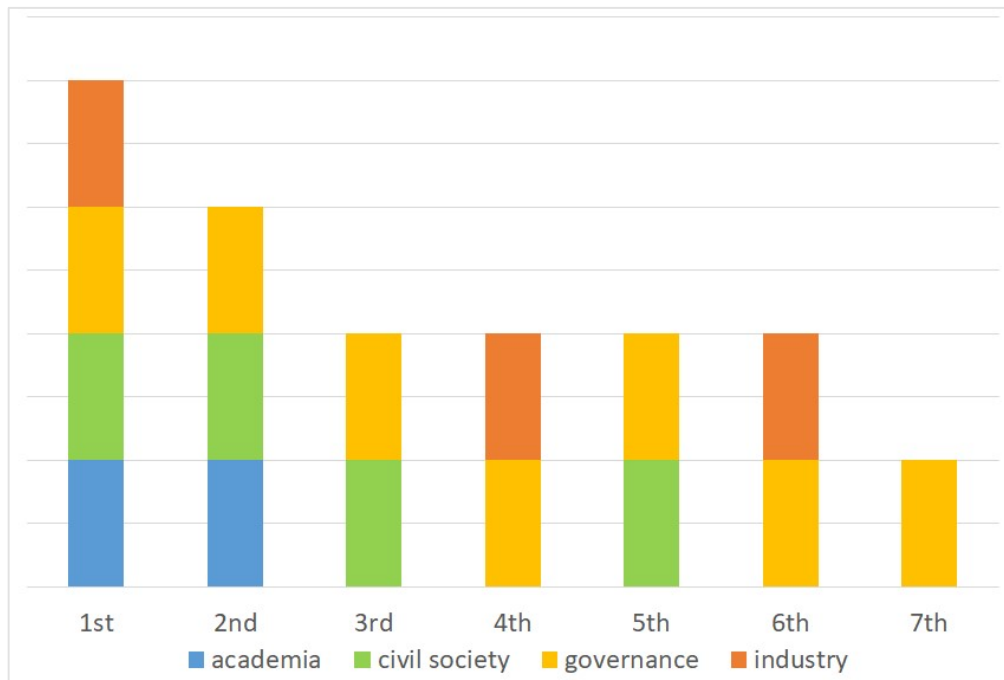
Source: Own drawing based on AHA information survey.

**Figure 41. Quadruple Helix actors involved in the decision-making process of AHA policies reported in different countries (N=7)**



Source: Own drawing based on AHA information survey.

**Figure 42. Quadruple Helix actors involved in the decision-making process of each reported AHA policy (N=7)**



Source: Own drawing based on AHA information survey.

As for design and decision-making processes, also in the case of the operational process (Figure 43), governance is the dominant group of Quadruple Helix actors for the reported AHA policies, followed by civil society, academia and industry.

A similar picture can be found in the case of both innovations and initiatives, although in both cases there is a more choral involvement of Quadruple Helix actors without a markedly predominant role for governance. More in detail, innovations equally involve governance and civil society, whereas initiatives involve them almost equally. Furthermore, both innovations and initiatives involve stakeholders from industry and academia much more than policies in the operational process.

Comparing the different countries where policies have been collected, it can be noticed that only governance ( $n = 3$ ) and industry ( $n = 1$ ) are involved in the operational process of French policies, while stakeholders from civil society and academia are excluded from this phase (Figure 44). Conversely, industry is excluded from the operational process of both Italian and

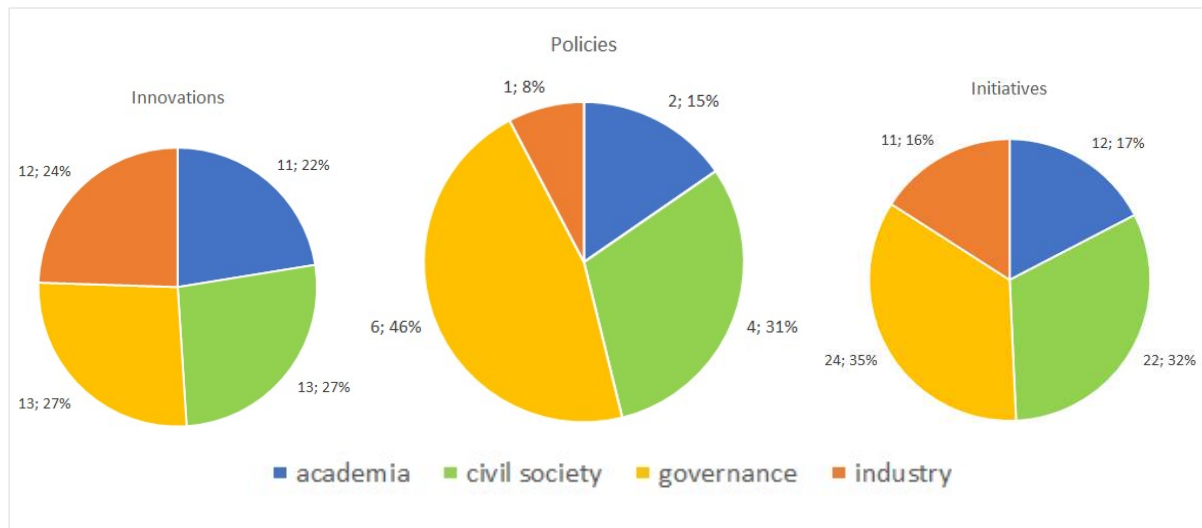


Slovenian reported policies. The latter, indeed, involve only civil society ( $n = 2$  and  $n = 2$ , respectively), governance ( $n = 1$  and  $n = 2$ , respectively) and academia ( $n = 1$  and  $n = 1$ , respectively) to a comparable extent in the two countries, with a more substantial difference only as regards governance, which is more involved in Italy. Considering policies one by one, it can be seen that five of them involve at least two Quadruple Helix actors in the operational process, up to a maximum of three ( $n = 1$ ), whereas only two policies involve a single actor at this stage (Figure 45). Moreover, it is noteworthy that governance is present as an actor of operational process in six of the seven reported policies, while industry only comes into play in one case.

Overall, going into the specifics of actors, governance plays a dominant role in all three processes (i.e., design, decision-making and operational) of all collected AHA good practices, except in the case of the operational process of innovations, in which governance and civil society have the same influence. Industry, on the other hand, is more influential in the case of innovations, coming into play substantially in all three processes. In a nutshell, stakeholders from governance and civil society play a leading role in the design, decision-making and operational processes of reported AHA policies, in which both academia and industry play a more marginal role. More specifically, governance is involved in the design, decision-making and operational processes of all the AHA policies examined, except in one case where it is not foreseen in the operational process. The dominant presence of governance in all processes is consistent with the results concerning the organisational form of the stakeholders responsible for the policies, which in almost all cases is public. In contrast, in the case of innovations and initiatives, a more balanced involvement of the Quadruple Helix actors can be observed, especially for innovations.

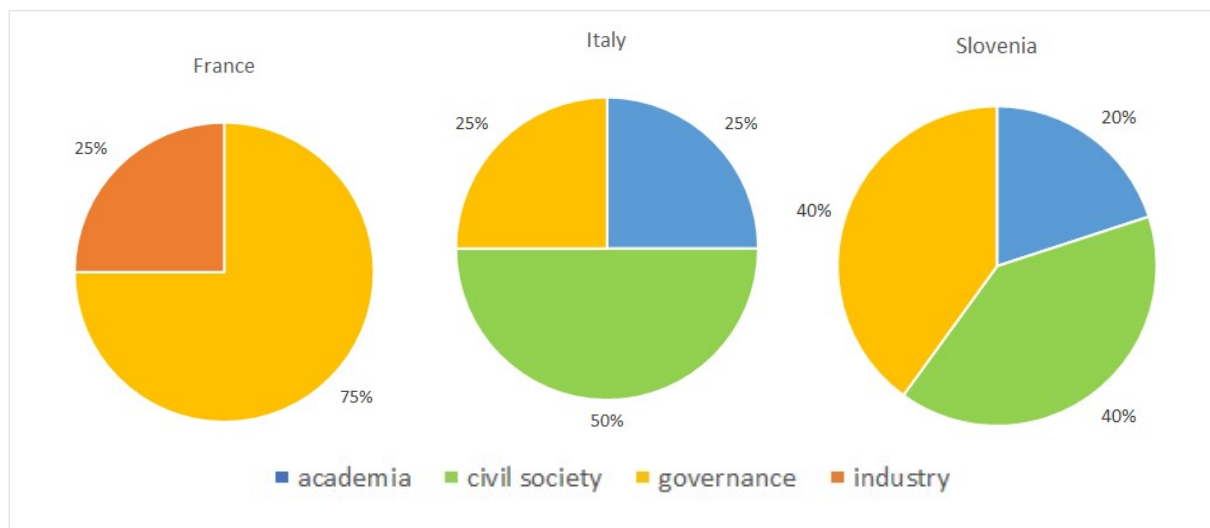


**Figure 43. Quadruple Helix actors involved in the operational process of policies, innovations and initiatives (N=64)**



Source: Own drawing based on AHA information survey.

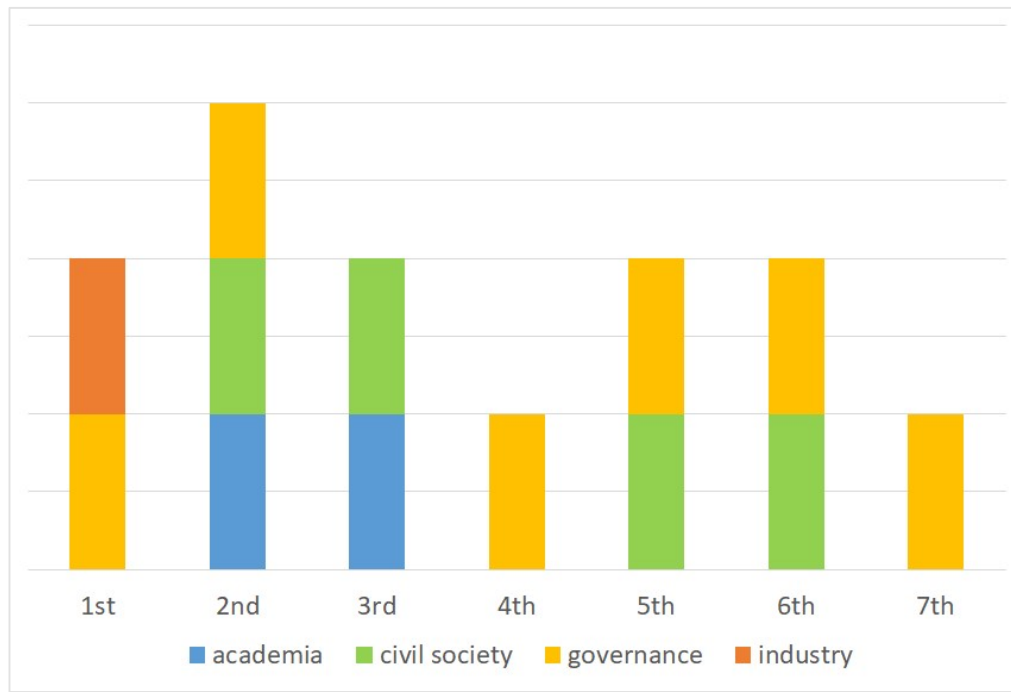
**Figure 44. Quadruple Helix actors involved in the operational process of AHA policies reported in different countries (N=7)**



Source: Own drawing based on AHA information survey.



**Figure 45. Quadruple Helix actors involved in the operational process of each reported AHA policy (N=7)**



Source: Own drawing based on AHA information survey.

#### 5.1.10 Good practices effectiveness and impact evaluation

In terms of evaluation, analysing all the 70 AHA good practices collected through the survey, it has been reported that, for 50 of them, at least intervention effectiveness has been evaluated, in 16 cases using a counterfactual approach. However, the results of this evaluation are only available for 26 good practices.

Regarding impact evaluation, it has only been reported for 28 AHA good practices and only in 13 cases its results are available (Figure 46).

With specific regard to policies, most of them are characterised by the presence of an effectiveness evaluation ( $n = 5$ ), which in 2 cases has been carried out using a counterfactual approach (Figures 47 and 48). Concerning the results of the effectiveness evaluation, in more than half of the policies ( $n = 4$ ) they are available (Figure 49). As with policies, most innovations

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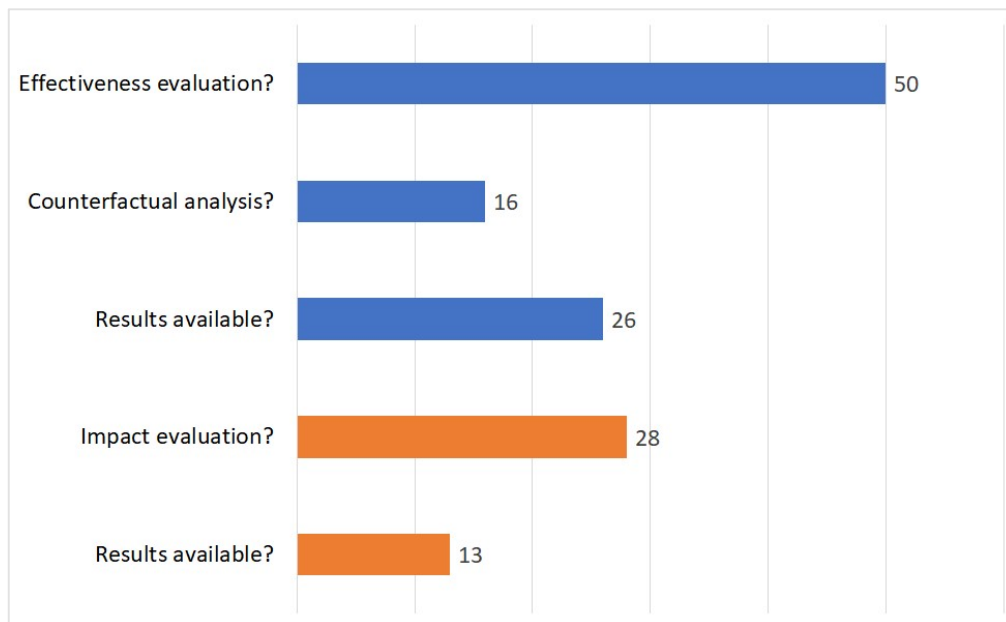
and initiatives boast the presence of an effectiveness evaluation ( $n = 21$  and  $n = 24$ , respectively), which in some cases has been conducted using a counterfactual approach ( $n = 6$  and  $n = 8$ , respectively) (Figures 47 and 48). Regarding these aspects, therefore, the picture offered by policies is broadly similar to innovations and initiatives one. In contrast, while the results of more than half of the policies are available ( $n = 4$ ), for innovations they are available only in a minority of cases ( $n = 8$ ) and for initiatives only in half of the cases ( $n = 14$ ) (Figure 49).

In summary, focusing on policies, 5 out of 7 are characterised by the presence of an effectiveness evaluation and in 4 out of these 5 cases the results of the evaluation are available. Regarding innovations and initiatives, on the other hand, there is a greater discrepancy between the number of AHA good practices characterised by an effectiveness evaluation and the number of them where the results of such an evaluation are available.

As for effectiveness evaluation, impact evaluation has also been reported for more than half of the policies ( $n = 4$ ) and the results of this evaluation are available in 3 out of the 4 cases. In terms of impact assessment, the picture provided by policies is similar to that provided by initiatives. Most of the latter, indeed, are characterised by an impact evaluation ( $n = 14$ ) and in 9 cases the results of this evaluation are available. In contrast, more than half of the innovations ( $n = 13$ ) are not characterised by the presence of an impact evaluation and the results of this evaluation are only available in one case ( $n = 1$ ) (Figures 50 and 51).

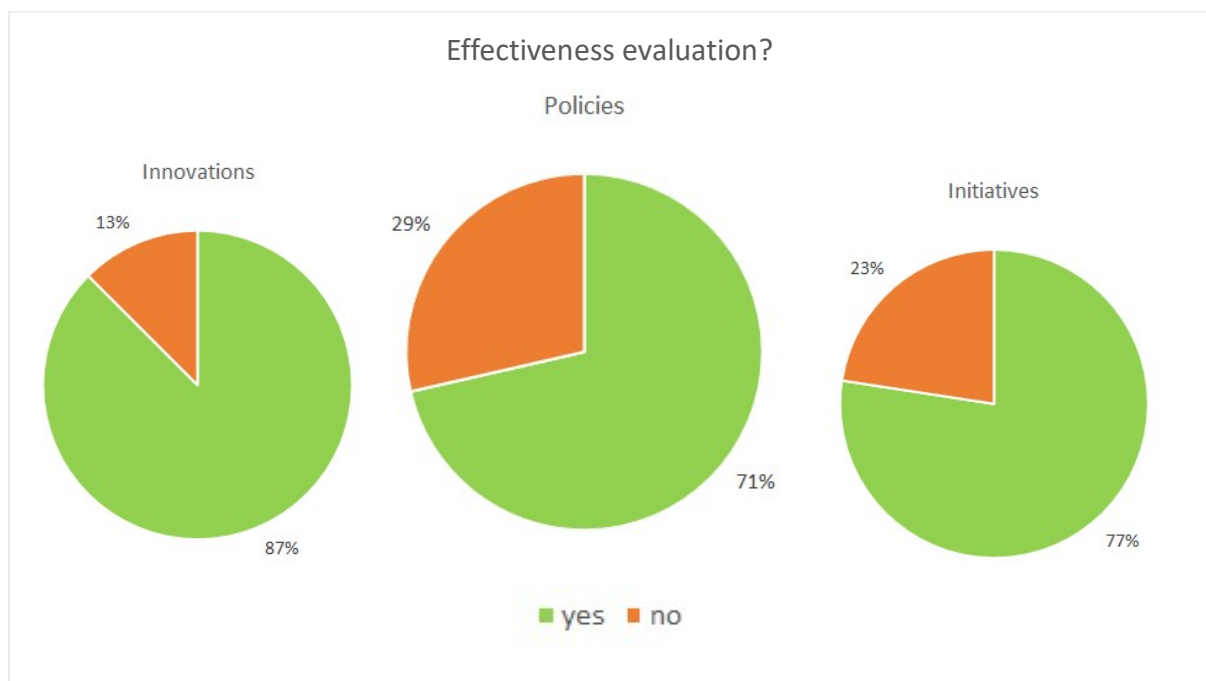
Overall, the area of evaluation of the collected AHA good practices, especially impact evaluation, shows considerable rooms for improvement, not only in terms of implementation of an evaluation intervention but especially in terms of availability of evaluation results. However, the implementation of effectiveness and impact evaluations and the sharing their results are very useful tools for planning and implementing increasingly appropriate and effective AHA policies, innovations and initiatives.

**Figure 46. Evaluation of reported AHA good practices**



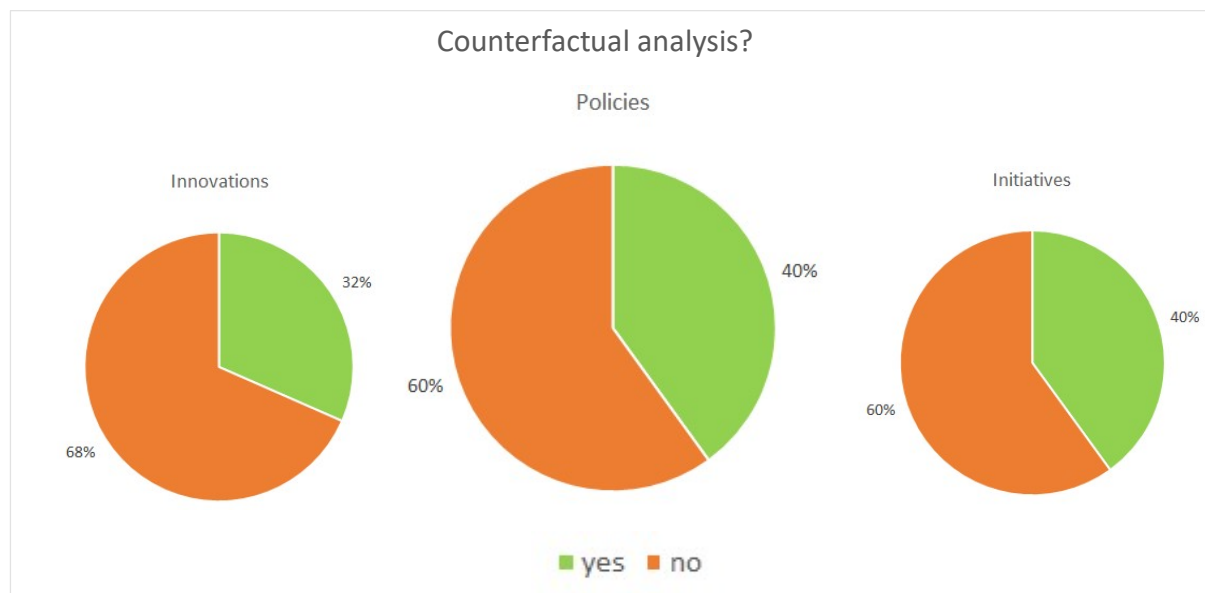
Source: Own drawing based on AHA information survey.

**Figure 47. Effectiveness evaluation of reported AHA policies, innovations and initiatives (N=62)**



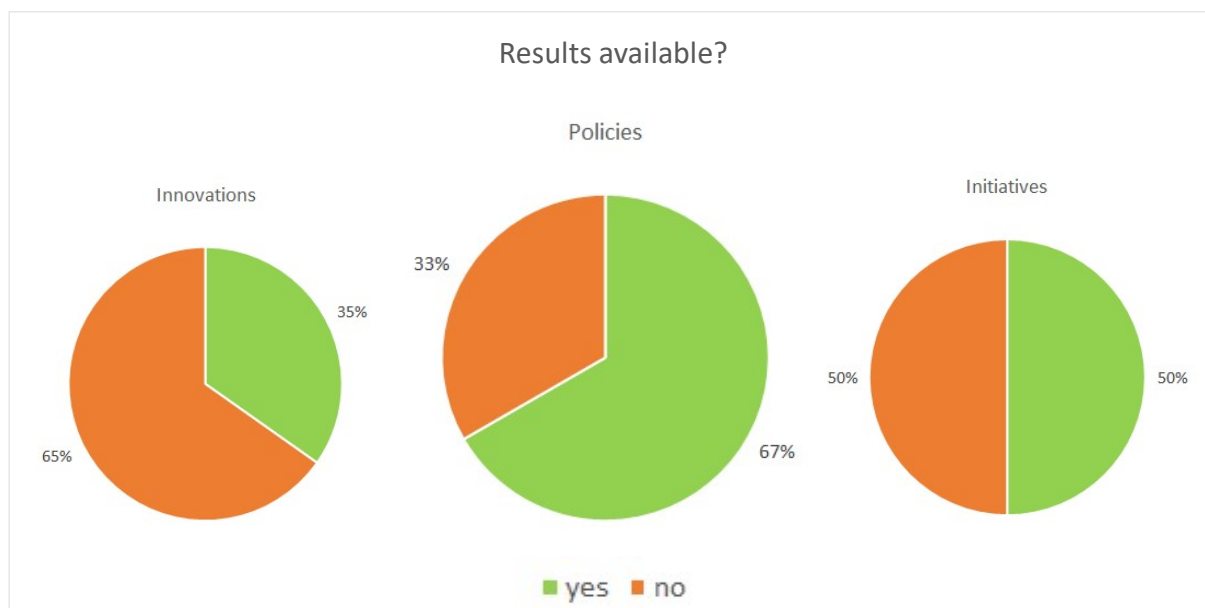
Source: Own drawing based on AHA information survey.

**Figure 48. Counterfactual analysis of reported AHA policies, innovations and initiatives (N=44)**



Source: Own drawing based on AHA information survey.

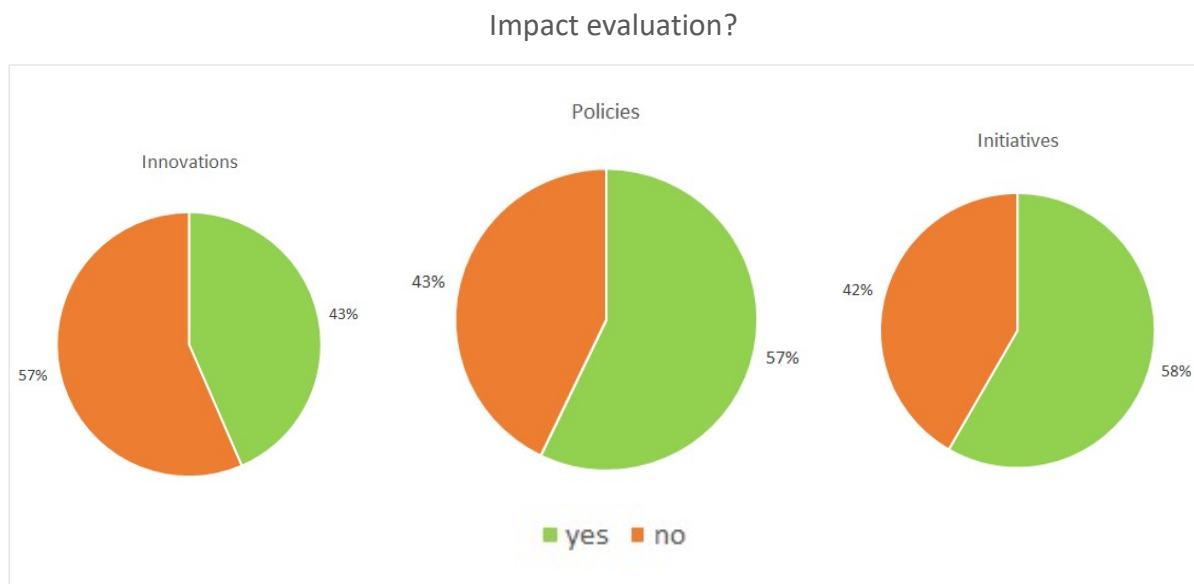
**Figure 49. Availability of the results of effectiveness evaluation of reported AHA policies, innovations and initiatives (N=57)**



Source: Own drawing based on AHA information survey.

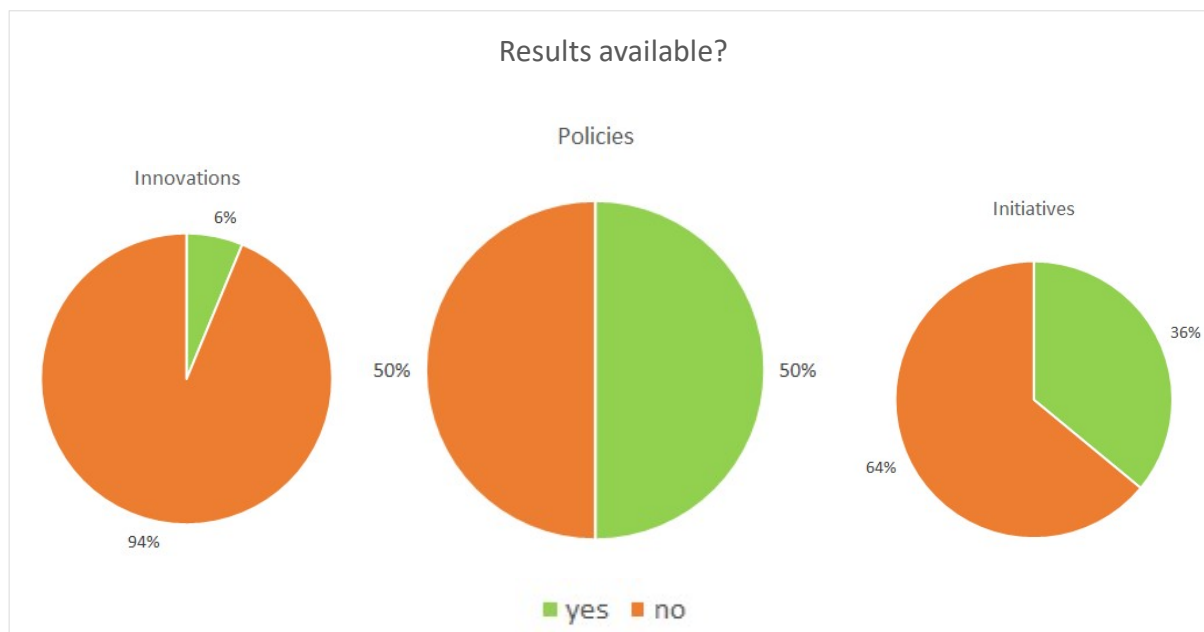
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**Figure 50. Impact evaluation of reported AHA policies, innovations and initiatives (N=54)**



Source: Own drawing based on AHA information survey.

**Figure 51. Availability of the results of impact evaluation of reported AHA policies, innovations and initiatives (N=47)**



Source: Own drawing based on AHA information survey.

Below is a summary of the key aspects of the AHA policies collected through the survey highlighted by the analysis.

AHA policies	
<b>NUTS-level</b>	NUTS1, NUTS2 and NUTS3
<b>Geographic context</b>	Mixed geographic contexts, including mountain, rural and urban areas
<b>Type of innovation</b>	Mostly service innovation and process innovation
<b>Maturity level</b>	Routine use (except for one case)
<b>Duration</b>	≥ 36 months (except for one case)
<b>Number of sectors</b>	At least 2 AHA sectors (except for one case) → multisectoral approach
<b>Primary sectors</b>	Health care and long-term care, followed by mobility & transport, social care and wellbeing
<b>Other sectors</b>	Culture & tourism, independent living and mobility & transport, followed by health care, long term care, social care and wellbeing
<b>Primary user groups</b>	Patients/citizens, followed by associations, professional caregivers, family caregivers and nurses or technicians
<b>Secondary user groups</b>	Associations, followed by family caregivers, patients/citizens, companies and professional caregivers
<b>Organisational form of the responsible stakeholder</b>	Public (except for one case where it is a mix of public and private)
<b>Quadruple Helix actors involved in the design process</b>	The dominant actor is governance (in all the policies), followed by civil society (in six policies), academia and industry
<b>Quadruple Helix actors involved in the decision-making process</b>	The dominant actor is governance (in all the policies), followed by civil society, industry and academia



<b>Quadruple Helix actors involved in the operational process</b>	The dominant actor is governance (in six policies), followed by civil society, academia and industry (in only one case)
<b>Effectiveness evaluation</b>	In five cases (more than half)
<b>Counterfactual analysis</b>	In two cases
<b>Availability of the results of effectiveness evaluation</b>	In four cases (more than half)
<b>Impact evaluation</b>	In four cases (more than half)
<b>Availability of the results of impact evaluation</b>	In three cases



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## 6 DISCUSSION AND CONCLUSIONS

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The results reported in this deliverable provide an overview of the policies for AHA currently implemented in the AS, highlighting some of their distinguishing features.

All the policies cover mixed geographical contexts (i.e., mountain, rural and urban areas), reaching thus territorial areas with very different characteristics and needs. While this point highlights the broad scope of the policies in terms of territorial coverage, it also shows the lack of policies exhibiting specific characteristics suitable for mountain areas and therefore tailored to mountain area-related peculiarities as well as deliberately aimed at responding to needs of this specific territory.

All policies, except one, are in routine use and have a duration of implementation above 36 months. Considering these two aspects, policies are characterised by a higher level of maturity than innovations and initiatives (examined in detail in DT3.2.1), resulting also as more long-lasting and consolidated good practices.

Moreover, all reported policies except one cover at least two different AHA sectors up to a maximum of seven different sectors, thus reflecting the multisectoral approach of the ASTAHG project. More in detail, the most affected primary sectors are health care and long-term care, highlighting the focus of AHA policies on the health of elderly with a long-term perspective. Furthermore, primary users of most policies are patients/citizens, which emphasises that policies act directly on these groups, involving them personally and actively.

Another salient aspect that emerged from the policy analysis is the dominant role of governance in the design, decision-making and operational processes of all the AHA policies analysed, which is in line with the results related to the organisational form of their responsible stakeholder. The latter is indeed public in all cases except for a policy whose responsible stakeholder is a mix of public and private.

The results of the policy analysis reported in this deliverable, together with the methodological framework provided by WP2 and the stakeholder consultation, will be used





for the development of the assessment model of governance for AHA extensively described in DT3.1.2 (Assessment of the governance models for AHA in the AS).

Overall, the policies collected and analysed represent an illustrative sample that indicate how governance for AHA is acting in the AS. These policies therefore represent a starting point that can be updated and enriched when the portfolio of the best practices of AHA governance application in the AS will be defined. The policies will then be assessed in order to identify their limits, institutional bottlenecks as well as strengths and rooms for improvement, so as to provide operational indications and suggestions to improve AHA in the AS to the governance actors and stakeholders.



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