



ASTAHG ALPINE SPACE TRANSNATIONAL
GOVERNANCE ON ACTIVE AND HEALTHY
AGEING

REPORT ON ASSESSMENT OF THE
GOVERNANCE MODELS
FOR AHA IN THE AS

D.T 3.1.2

Trieste, December 2020

WP3



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FRIULI VENEZIA GIULIA



PROVINCIA
AUTONOMA
DI TRENTO



REGIONE DEL VENETO



ULSS1
DOLOMITI



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Content

Executive summary	5
1 Introduction.....	6
1.1 Project Concept	6
1.1.1 Project objectives	6
1.1.2 Project outputs	7
1.1.3 Work package structure	8
1.1.4 Project target groups.....	9
1.2 Contribution of WP3.....	10
1.3 Deliverable description	11
2 A multidimensional perspective on active and healthy ageing	13
2.1 Global demographic change: challenges and opportunities.....	15
2.2 Active and healthy ageing as a political challenge	16
3 Governance models	18
3.1 Definitions of governance: a framework	18
3.2 Multiactor and multilevel aha governance models.....	19
3.3 From governance models to policy-making	21
4 The Assessment Model: method	25
4.1 Main dimensions for the evaluation of aha process	29
4.2 The selection of indicators	32
4.3 The selection of variables.....	36
4.4 Targets setting	37
5 Simulation of model application	38
6 Testing the assessment model.....	40
6.1 Assessment model testing: the method	40
6.1.1 Identification of indicators and variables	40



6.1.2 Content analysis 41

6.2 Assessment of governance models: graphical representation 47

7 Discussion and Conclusion 50

8 References 52



Executive summary

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 affected 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 development and application of the assessment model on governance for AHA in the Alpine Space area.



1 INTRODUCTION

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*).

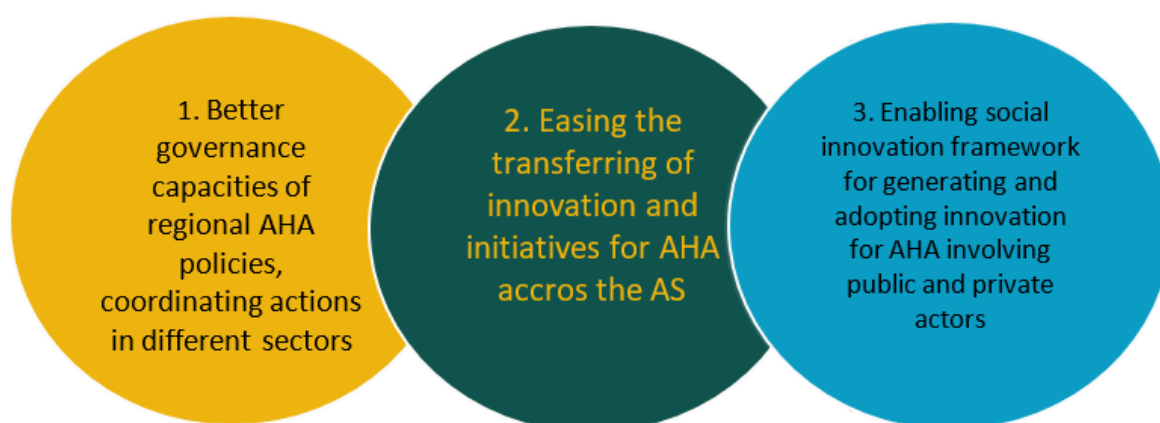
The specific objectives of the project, as reported on the ASTAHG application form, deal with :

- 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

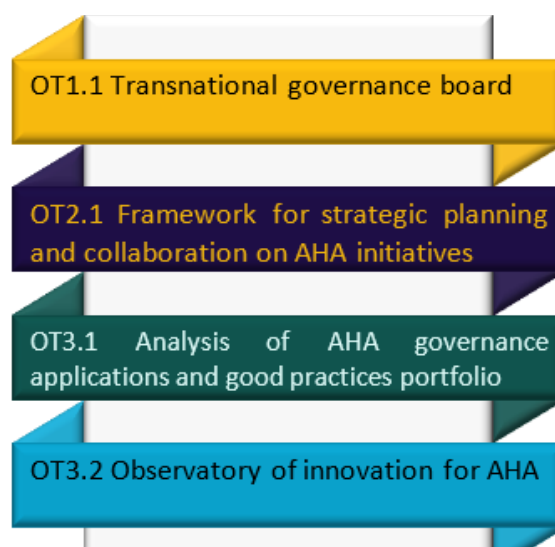


Source: Own drawing based on ASTAHG AF (2018).

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

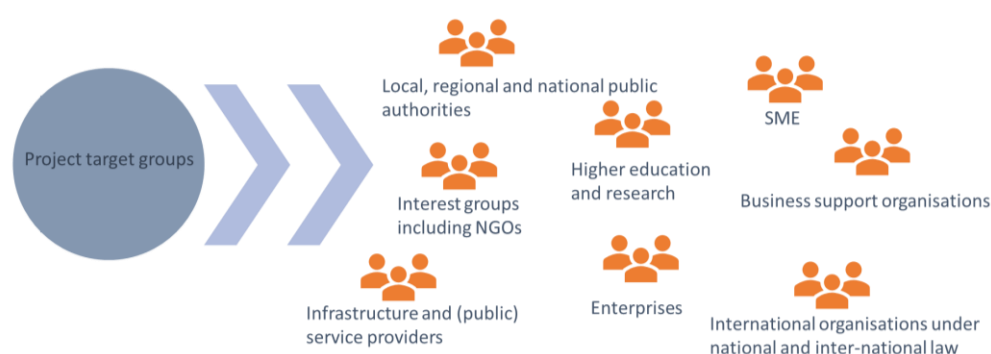


Source: Own drawing.

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 present deliverable describes the method used for the assessment of governance models and innovation. The main references and sources are the methodological framework provided by WP2, enriched by content analysis methodologies to better adapt the model to the AHA decision making.

The aim of the present deliverable is to identify and investigate the governance models emerging in the Alpine Space (AS) to address the AHA with a focus on the intersection between health and non-health sectors. Indeed, a crucial aspect of this exploration is considering not only how health affect other sectors but also how other sectors affect health, establishing effective exchanges and collaborations.

The investigation of governance models currently present in the AS will provide a policy framework useful for different actors and subjects, such as policymakers and planners, health care managers, nongovernmental organizations and charities or entities promoting and funding public health programmes, for designing and implementing further future policies



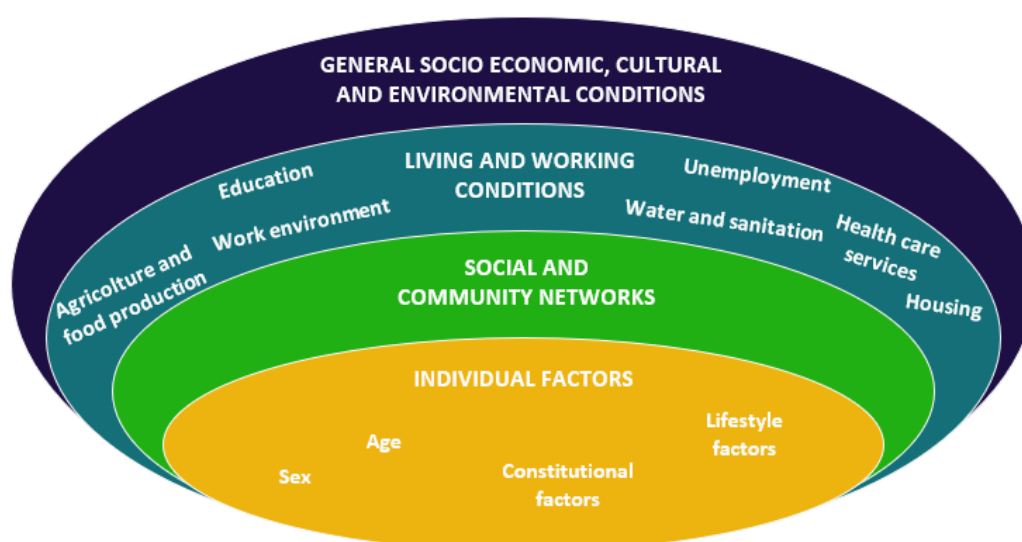
targeted at caring older people and improving AHA at different levels (national, regional and district/local). Moving in this direction, the final and long-term aim of the present deliverable is to provide a systemic and balanced approach to AHA through the definition of governance models involving multiple issues, sectors and actors. This framework may represent a useful tool for helping communities to strive for continual improvement in line with the current socio-demographic change.



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, programmes or interventions;
- developing new strategies, programmes 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, programmes 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.



3 GOVERNANCE MODELS

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.

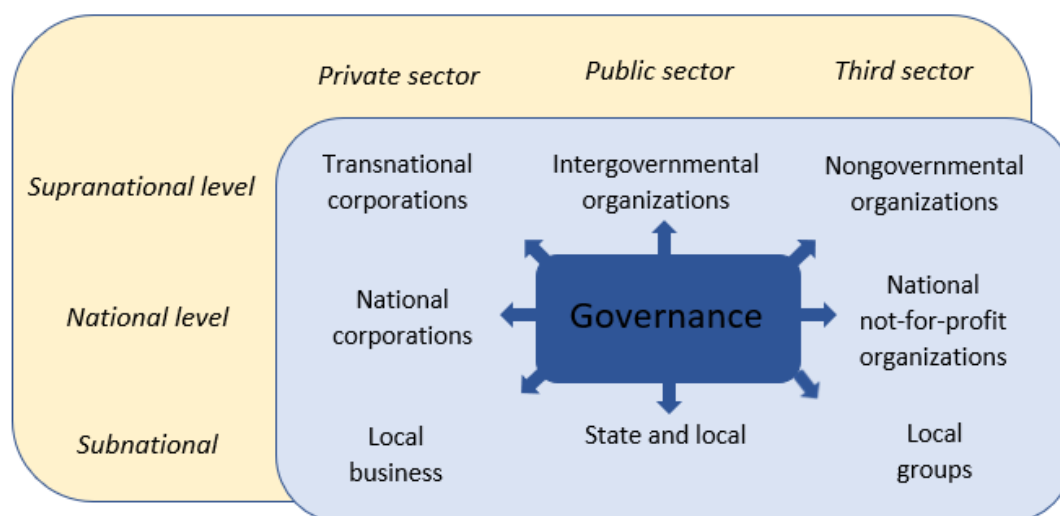


Governance for AHA promotes joint actions in many different sectors among public and private actors and citizens to pursue common objectives and interests. It requires a synergistic set of policies at all levels of governance, many of which act on multiple sectors and involve stakeholders outside government,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

As a consequence, 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
Governance	strong political commitment	PLANNING the policy lines	Regional health authorities
Policy Maker	governance application	SHARING and NEGOTIATING the policy with civil society for the implementation in the context	Municipalities, local health authorities...
3rd level	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	
Innovative	Questioning established methods and promoting new ideas
Joined-up	Horizontal and vertical integration
Informed by evidence	Based on evidence gathered using reliable and accredited sources
Adaptive	Learning from experience and being suitable to changing contexts
Inclusive	Taking account of the impact and both direct and indirect effects of the policy on all the actors involved
Accountable	Being transparent and responsive to the demands of citizens
Evaluative	Providing systematic evaluation methods and tools
Forward looking	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).



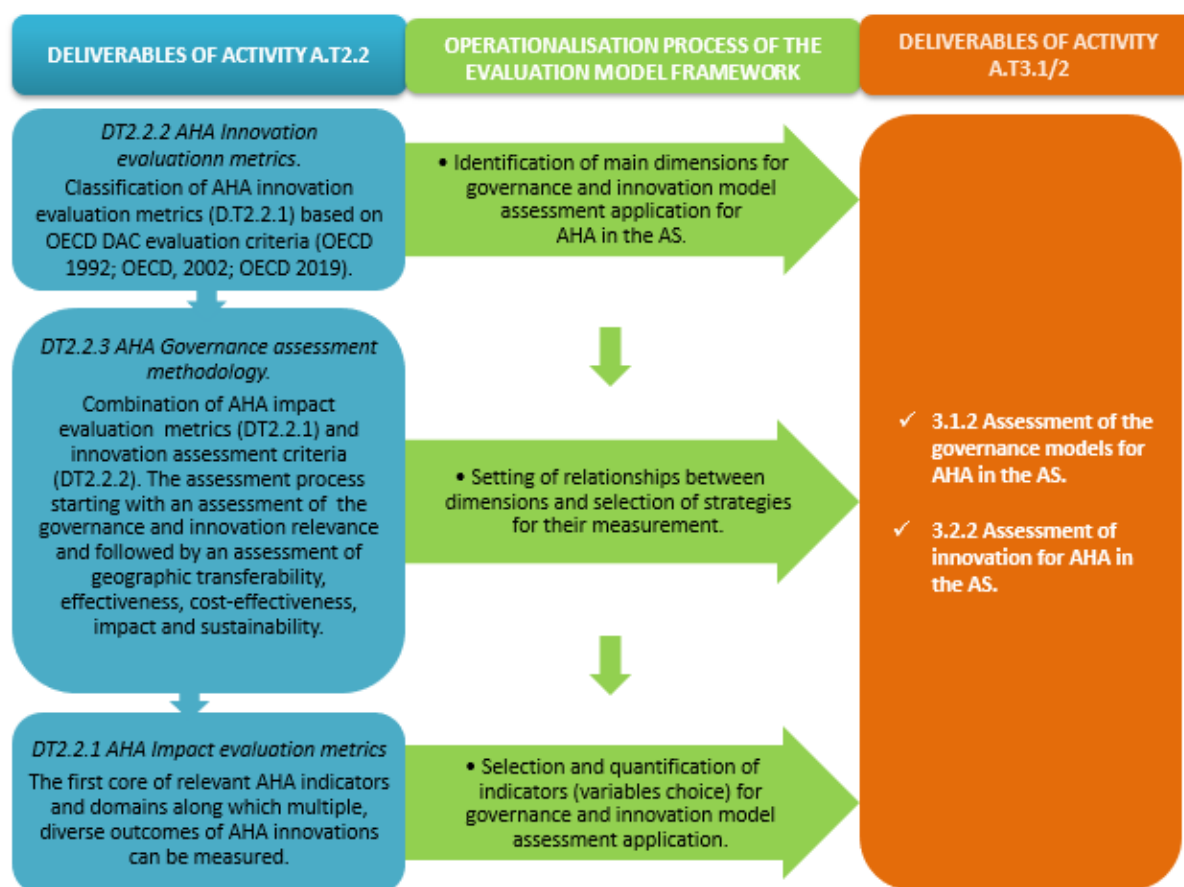
Since AHA policies in the AS, as all other types of policies in all territories, are influenced by the context and are embedded in specific national, economic, political, cultural as well as social structures (Parag, 2006), it is evident that there is a great diversity in how they are developed, adopted 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.



4 THE ASSESSMENT MODEL: METHOD

The assessment model of governance and innovation (the last is explored in DT3.2.2) for AHA in the AS is developed based on the methodological guidelines provided by WP2 through deliverables DT2.2.1 (AHA impact evaluation metrics), DT2.2.2 (AHA innovation evaluation metrics) and DT2.2.3 (AHA governance assessment methodology). The development of WP3 assessment model is a first attempt to operationalise the conceptual and theoretical framework developed in WP2, putting the governance assessment methodology reported in DT2.2.3 into practice. More precisely, Figure 9 shows the operationalisation processes linking A.T2.2 deliverables to DT3.1.2 and DT3.2.2. In such way, WP3 provides a transparent method and an operational tool for the assessment of AHA governance models, contributing thus to build up and enable capacities for evidence based and efficient AHA decision making in the AS area, at national, regional and local levels.

Figure 8. From A.T2.2 deliverables to DT3.1.2 and DT3.2.2: the operationalisation processes



Source: Own drawing.

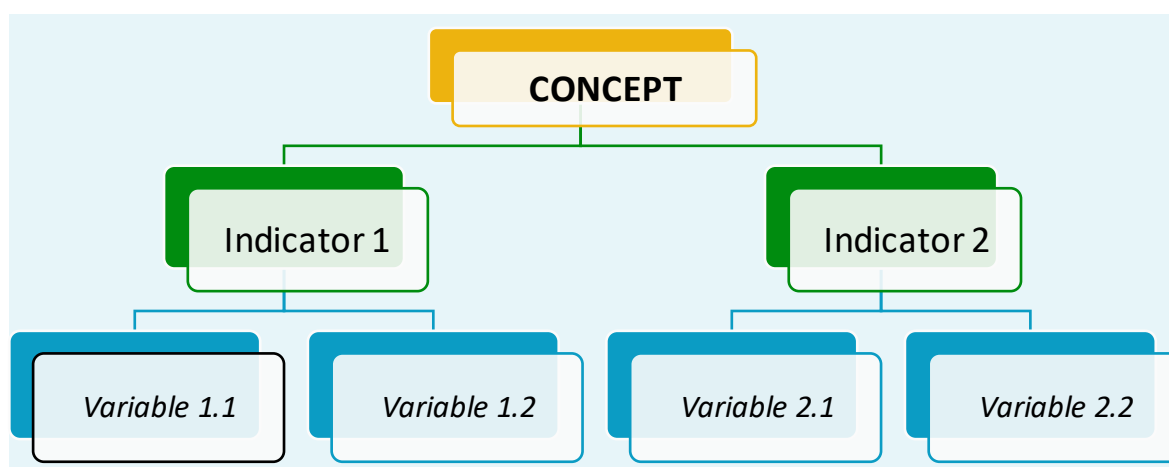
The reference methodological framework adopted by WP3 to operationalise the conceptual and theoretical framework developed in WP2 is Lazarsfeld's procedural model (Lazarsfeld, 1958, 1959; Lazarsfeld & Barton, 1951), based on which a logical-methodological procedure for the construction of complex variables (i.e., operationalisation) is applied (Lazarsfeld, 1958). The first stage of Lazarsfeld's model consists in defining a concept measurable to a variable extent.

This concept is then broken down into indicators, consisting in empirically detectable properties with a lower level of generality with respect to the concept to which they refer.



The indicators are in turn broken down and operationalised into variables, that are properties to which different values are assigned, to be able to empirically determine each time which value expresses each property in each single case. Indicators, therefore, have a synthetic function: to synthesise into a single piece of information a wider set of more analytical information (i.e., variables). Following this underlying logic, Lazarsfeld's model proceeds from the general concept to the more specific variables (Figure 9).

Figure 9. Relations among concept, indicator and variable



Source: Own drawing based on Lazarsfeld (1967).

The assessment model linked the framework provided by the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development, extensively described in DT2.2.2 (AHA innovation evaluation metrics) of WP2 as a stepwise process through which the space of potential AHA innovations funnels through, to the processes of selection of indicators, variables and related targets. More in detail, the assessment model developed in WP3 included the following four steps (Figure 10):

1. first step: identification of the main dimensions.

First, the main dimensions regarding the evaluation of AHA process, corresponding to OECD DAC Evaluation Criteria (i.e., relevance, coherence, efficiency and effectiveness, impact and



sustainability), has to be identified. These dimensions are conceptual macro-areas representing a widely adopted reference framework for the evaluation of public policies, projects and programmes, to allow the identification of the main aspects for governance models and innovation assessment.

2. second step: selection of indicators.

Through the second step of the model, the selection of indicators is carried out that means that, for each dimension, the indicators, that define the specific dimension, are selected (see Fig. 14 on ASTAHG indicators set in section 6.1).

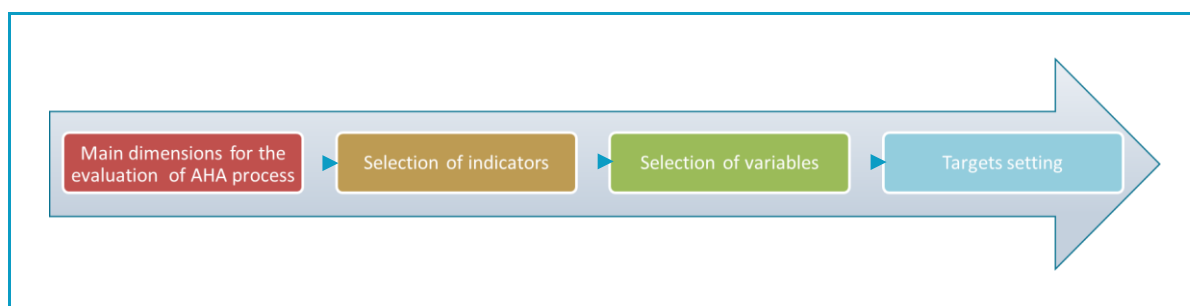
3. third step: selection of variables.

In the third step, for each indicator, the variables that allow its measurement and quantification are selected (see Fig. 15 on ASTAHG variables set in section 6.1).

4. fourth step: targets setting.

In the fourth and final step of the model, for each variable, the targets to be reached are set according to three main aspects associated with the specific evaluation to be carried out: the assessment objectives, the object of evaluation and the specific characteristics, needs and preferences of each territorial area/context.

Figure 10. The four steps of the “ASTAHG assessment model”



Source: Own drawing.



The development and application of the assessment model aims primarily at supporting local decision-makers in identifying the most effective and beneficial governance model for their respective geographic setting and context, allowing to make a step towards a more effective *multisectoral, transnational, and multilevel* AHA governance. More specifically, the objectives of the assessment of the governance models for AHA in the AS are:

- to provide policy makers with an example model adaptable to the profile of each specific territorial area/context;
- to provide a framework for the development of further practical tools through the involvement of specific expertise in the field of monitoring and evaluation;
- to identify rooms for improvement and challenges of AHA governance models in the AS to respond in an increasingly targeted manner to territorial needs.

4.1 Main dimensions for the evaluation of aha process

As mentioned in the previous paragraph, starting from the conceptual framework provided by WP2 in DT2.2.3 (AHA governance assessment methodology), we identified the OECD DAC Evaluation Criteria as main dimensions for the evaluation of AHA process (Figure 11), in an effort to guide AHA decision-making through a set of clearly defined and transparent assessment steps (OECD 2002; 2019). As explained in WP2, these criteria allow to investigate and assess some fundamental aspects of governance models to pursue an ever more evidence based and efficient AHA decision making.



Figure 11. The main dimensions for the evaluation of AHA process¹



Source: Own drawing.

More in detail:

- 1) **Relevance** relates to the extent to which the intervention addresses and responds to needs, priorities and preferences of a target population in a specific setting or context;
- 2) **Coherence** refers to two main aspects: the compatibility of the intervention with other interventions in the same context and, on the other hand, the maturity (i.e., “readiness” to receive) of the context to which the intervention should be transferred into;
- 3) **Effectiveness** is associated with outcomes, indicating the extent to which the intervention is achieving, or is expected to achieve, its objectives and results;

¹ See also D.T2.2.2 for more information about OECD Evaluation Criteria.



4) Efficiency covers both the economic and temporal dimensions, referring to the extent to which the intervention delivers results in an economic and timely way. It is, therefore, related to the use of resources;

5) Impact accounts for the extent to which the intervention has generated long-term effects (e.g., positive or negative, intended or unintended) touching different spheres (e.g., social, environmental, economic);

6) Sustainability is associated with the extent to which the benefits of the intervention continue or are likely to last over time.

Both impact and sustainability, therefore, refer to a broad time horizon, being projected into the medium and long term.

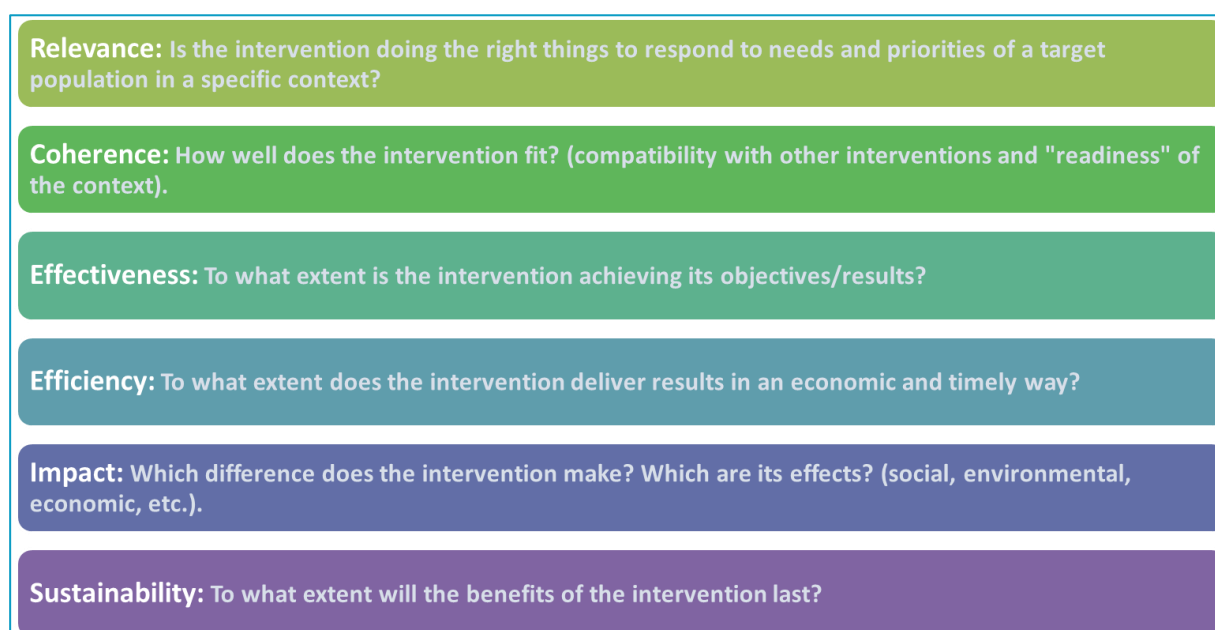
As clarified in DT2.2.2 (AHA innovation evaluation metrics), two main principles guide the use and the application of the six OECD DAC Evaluation Criteria (OECD, 2019):

1. the criteria need to be applied in the light of the evaluation questions and to be understood in depth through a process of **contextualisation**, that is in *“the context of each individual evaluation, the intervention being evaluated, and the stakeholders involved”* (DT2.2.2, p. 19). Such a use of criteria allows to support high-quality and useful evaluations.
2. the criteria need to consider the **aims and objectives of the evaluation** and to be applied accordingly to the context of the evaluation, that includes **stakeholder needs**. Issues such as data availability, timing, methodological aspects, drivers and opportunities as well as barrier and constraints may also influence the extent to which each criterion is met.

These two principles and the OECD indications reported in WP2 were the basis on which we clarified the main aspects to be investigated for each dimension (i.e., evaluation criterion) (Figure 12) in order to adapt the OECD DAC framework to the assessment of AHA decision making.



Figure 12. Which aspects for each dimension?



Source: Own drawing.

Overall, as highlighted in WP2, the use of these six OECD DAC Evaluation Criteria allows to progressively divide the governance models and innovation (i.e. the interventions to be assessed, which have been defined as '*spaces of innovations*' in WP2) in those that are relevant, coherent and effective in a specific context, efficient and with positive impact on their respective target populations as well as sustainable over time, from those governance models and innovation which do not sufficiently meet the OECD DAC criteria.

4.2 The selection of indicators

In the indicator selection process, the first step was the examination of the relationships among selected dimensions: were they connected or separated from each other?

According to D.T.2.2.3, the evaluation process *"is based on a combination of AHA impact evaluation metrics and innovation assessment criteria. It attempts to provide a structured*



methodology to prioritise AHA innovations in a transparent manner, starting with an assessment of their relevance in a particular setting, and followed by an assessment of geographic transferability, effectiveness, cost-effectiveness, impact and sustainability” (D.T. 2.2.3, p. 15). This means that, in the choice of indicators, the dimensions should be considered interlinked, in a pathway in which interventions are funnelled within an evaluation process that is aimed at selecting only the most valuable innovations, enabling thus decision-makers to act depending on the evidence collected and critically evaluated along the way.

At this point, two main issues emerge: How are the evaluation dimensions interlinked? And how does this link shape the choice of indicators? Initially, the choice of indicators is guided by the matching between the characteristics of the evaluated intervention and what is considered **relevant** to the context in which the intervention is being evaluated. More precisely *“for an innovation to be ‘relevant’ in a particular context, it must be able to serve the needs and preferences of the target population in that setting” (D.T2.2.3, p. 24).*

However, *“knowing that an AHA innovation may potentially be relevant for a particular setting does not mean that it may also yield the desired outcomes in that setting” (D.T2.2.3, p. 24).* Thus, through the **coherence** dimension, the characteristics of the intervention and the aspects, that have been considered as relevant, must be observed from at least two perspectives:

- the transferability on a larger scale of the evaluated governance model or innovation;
- the “readiness” and maturity of the context to accept the governance model or innovation.

In order to evaluate the dimension of **effectiveness**, it is necessary to take into account that *“one of the key problems of assessing AHA innovations’ effectiveness is their potential to yield multiple outcomes which may be relevant for various sectors of public policy making. As*



ASTAHG explicitly follows a multisectoral approach, this problem moves even further into the focus of AHA innovation effectiveness assessment” (D.T2.2.3, p. 31).

In the methodological framework (D.T2.2.3), this key problem is addressed with the Multi Criteria Decision Analysis (MCDA). The MCDA approach considers the criteria (or attributes) against which alternative innovations have been evaluated, as identified in the first dimension (i.e., relevance) of AHA process assessment (Thokala & Duenas, 2012, in D.T2.2.3, p. 32).

Regarding the **efficiency** dimension, beside the methods and techniques provided in the methodological framework in WP2 (D.T2.2.3), it seems important to underline that, in order to operationalise an assessment model of AHA governance and innovation, it is necessary to *“expand the multi-criteria decision analytic approach towards both the consequences and cost of AHA-innovations”* (D.T2.2.3, p. 38). In other words, what has been evaluated based on its effectiveness, in terms of results achieved, should also be evaluated based on its efficiency in delivering those results (e.g., products, services, etc.).

As long as the **impact** dimension is concerned, it is very important to highlight the distinction between outcomes (and also output) and impact of an intervention. The concept of impact concerns a broad time horizon and scope respect to the outputs and outcomes (OECD, 2002; 2019). *“First and foremost, as indicators for assessing innovations’ effectiveness must be identified and agreed upon, so must dimensions of impact”* (D.T2.2.3, p. 42). In order to measure the impact of an intervention, the first step is to identify the main dimensions (of impact) related to the selected indicators of effectiveness. A good example for the application of this procedure is the use of the Theory of change², that allows to investigate changes, realised or desired, from the perspective of each stakeholder.

² For more details on Theory of change see D.T2.2.2, section 3.



Lastly, according to the OECD Evaluation Criteria, the assessment of **sustainability** includes the “*examination of the financial, economic, social, environmental, and institutional capacities of the systems needed to sustain net benefits over time*” (OECD, 2002; 2019, in D.T2.2.3, p. 44). The methodological proposal to assess the sustainability of an intervention is to use the MCDA approach, thereby maintaining a clear link with the dimensions described above. According to the authors of the D.T2.2.3, “*in terms of financial sustainability, the framework allows, at least in theory, to work backwards from the overall MCDA score an innovation may achieve towards partial scores of (groups of) indicators within each AHA dimension listed above. This, in turn, also allows representing the partial value of an intersectoral innovation across relevant AHA dimensions, and this information could ultimately be used to support cross-sectoral resource allocation*” (D.T. 2.2.3, p. 46).

While this is a possible way forward with respect to economic and financial sustainability, other aspects of this dimension, such as social, environmental and political ones, seem to be neglected, although they should be taken into account according to the decisions made previously to measure outputs, outcomes and impacts.

Table 3 shows the main characteristics of the indicators according to the dimension they are associated with.

Table 3. The main characteristics of the indicators for each dimension

Dimension	Characteristics of the indicators
Relevance	<i>needs and preferences of the target population in relation to the object of the evaluation.</i>
Coherence	<i>2 sub-dimensions: 1) Adaptability of intervention in other contexts without changing effects and costs; 2) Maturity level of the context.</i>
Effectiveness	<i>Linked to relevance indicators, that are measured in terms of the results achieved (output).</i>



Efficiency	<i>Linked to effectiveness indicators, that are measured in terms of the delivering results (performance).</i>
Impact	<i>Referred to long-term horizon of effectiveness indicators. Quantification of effects through the application of Theory of change (outcome and impact).</i>
Sustainability	<i>Linked to effectiveness indicators. These indicators may concern economic, social, environmental, and political sustainability.</i>

4.3 The selection of variables

The selection of variables is the process of quantification of indicators. For each indicator within each dimension, the variables that allow its measurement and quantification are selected. For each variable, weights and measures are established to highlight the most relevant aspects of governance models and innovation.

The D.T2.2.1 provides a long list of indicators and variables for their quantification, while the D.T2.2.3 suggests some evaluation methodological frames and methods that can help in the choice of indicators and variables. Below are some of them³:

- B3 Maturity Model (for Coherence dimension)
- Multi Criteria Decision Analysis (MCDA) (for Effectiveness and Efficiency dimensions)
- Mafeip tool and Cost benefits analysis (for Efficiency dimension)
- Theory of change and Sroi model - Social Return on Investment - (for Impact dimension).

In particular, Sroi assesses the social impact of interventions and/or organizations. The application of Sroi helps to understand how ordinary and extraordinary activities can generate

³ For more details see also D.T2.2.3.



value; a value that is estimated in monetary terms and compared with the initial investment (see GECES, 2015; Maier et al., 2015; Human Foundation, 2012). The considered value does not only refer to outcomes that may be easier to measure, such as strictly economic ones, but also to social outcomes and, more generally, to the benefits that these activities can bring to the concerned stakeholders by the intervention/organization which is examined.

In addition to these methods and methodological frameworks, we consider essential to analyse the opinion of stakeholders in the application of the model. For this reason, as illustrated in section 4, in the choice of indicators and variables we also analysed the open-ended answers and the items of ASTAHG survey.

4.4 Targets setting

As previously explained, the main aim of the development and application of the model is to provide an assessment framework that may best support governance models and innovation assessment and AHA decision making in different contexts. In the step “targets setting”, for each variable the targets to be reached are set according to:

- assessment objectives;
- characteristics of the object to be evaluated;
- specific characteristics, needs and preferences of each territorial area/context;
- characteristics of target population.

The target setting aims at creating a flexible and adaptable model according to the specific context characteristics.

In the light of the operationalisation of the methodological framework carried out in the previous sections, the following sections provide a simulation of the model application, an example of its practical application.



5 SIMULATION OF MODEL APPLICATION

The simulation of the model application presented in chapter 4 was crucial to test the model internal consistency. We simulated the assessment of an **Initiative based on ICT solutions for heart disease prevention** (not collected in ASTAHG survey) by entering hypothetical data for all six dimensions.

Table 4 shows the data of this simulation, in which, for each dimension, we selected one indicator and for each indicator one variable. Then, we selected the target for each variable.

Table 4. Simulation of model application

Dimension	Indicator	Variable	Variable Target
Relevance	Current population according to age group	<i>Target population aged 60 and more</i> 1. Yes; 2. No	1.
Coherence	Innovation Management (EIP on AHA - B3 Maturity Model)	<i>Level of innovation management</i> <i>0. No innovation management in place</i> <i>1. Innovation is encouraged but there is no overall plan</i> <i>2. Innovation are captured and there are some mechanisms in place to encourage knowledge transfer</i> <i>3. Formalized innovation management process is planned and partially implemented</i> <i>4. Formalized innovation management process is in place and widely implemented</i> <i>5. Extensive open innovation combined with supporting procurement and the diffusion of good practice is in place</i>	3., 4. or 5.
Effectiveness	Current population according to age group	<i>Number of elderly involved</i>	100
Efficiency	Current population according to age group	<i>Average monthly cost (€) per elderly involved</i>	90



Impact	Health Services	<i>Monthly savings (€) for the healthcare system in the care of heart disease per elderly involved</i>	250
Sustainability	Multistakeholder approach	<i>Organizational form of the responsible stakeholder:</i> 1. public; 2. private; 3. a mix of both	3.



6 TESTING THE ASSESSMENT MODEL

The evaluation model was tested first on governance models in the AS area. We assessed the 7 policies (considered as an expression of governance model) collected by project partners through the ASTAHG survey.

Each partner gathered the data independently, by using as sources interviews, local events, public events and bibliographic sources. Only available information was entered.

However, considering the ASTAHG survey items and the type of information collected through the questionnaire, it was not possible to identify indicators and variables for all six dimensions. More specifically, it was not possible to collect enough data to explore the efficiency dimension.

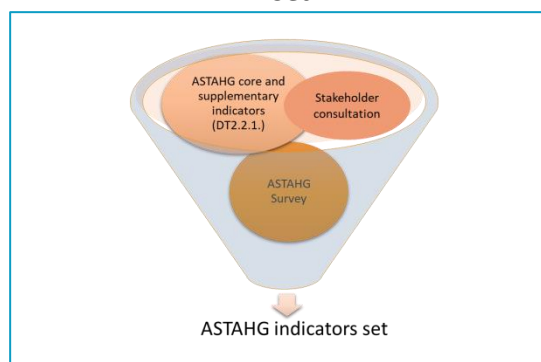
6.1 Assessment model testing: the method

6.1.1 Identification of indicators and variables

Starting from the six dimensions borrowed from OECD DAC Evaluation Criteria, we identified a first set of indicators and variables. The sources for the setting of indicators and the selection of variables (Figures 13 and 14) are:

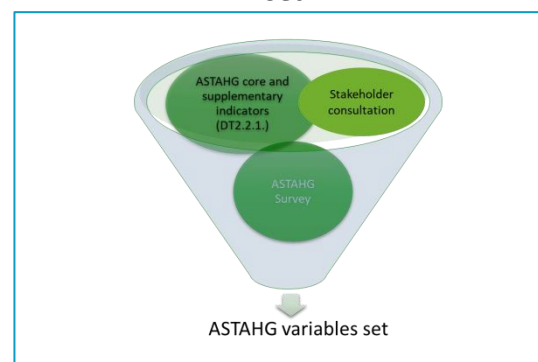
- ASTAHG Core Indicators set (reported in DT2.2.1 as a long list of potential measurable indicators);
- ASTAHG Supplementary Indicators set (reported in DT2.2.1 for qualitative data collection and further development);
- the ASTAHG survey items;
- stakeholder consultation: the textual analysis of the open-ended answers to the ASTAHG survey items.

Figure 13. Sources for ASTAHG indicators set



Source: Own drawing.

Figure 14. Sources for ASTAHG variables set



Source: Own drawing.

6.1.2 Content analysis

The textual analysis allowed us to consider the qualitative data collected through the ASTAHG survey items (i.e., stakeholder consultation) to identify the indicators and variables. Specifically, we carried out a content analysis, a method used to analyse the text.

Multiple, nuanced definitions of content analysis exist that reflect its historical development. We accept a broad-based definition by Krippendorff (2004), where the content analysis is described as *“a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use”* (Krippendorff, 2004, p. 18). The aim of textual analysis was twofold: 1) to select the most appropriate and suitable indicators for the application of the model among ASTAHG Core Indicators provided in D.T2.2.1; 2) to define new indicators (in addition to the ASTAHG Core Indicators provided in D.T2.2.1), more relevant and pertinent with respect to the AS area, based on recurrent aspects of the analysed interventions.

The categories considered to analyse the answers of the partners were all domains identified in D.T2.2.1 except for "Demographic & social structural data":

- Civic engagement & Social Participation
- Mobility & transport



- Communication, information & ICT
- Housing, outdoor spaces & enabling environment
- Health & care
- Security & safety

Table 5 shows some of the indicators that emerged from the textual analysis carried out and developed in an original way in WP3.

Table 5. Examples of indicators for the AS area

Domain	Indicator
Civic engagement & Social Participation	Community inclusion
	Accessibility of participation opportunities
	Multistakeholder approach
Communication, information & ICT	Digital literacy for the elderly
	Dissemination of information
Housing, outdoor spaces & enabling environment	Presence of AAL solutions
Health & care	Training to caregivers or care staff in institutions
	Supervision to caregivers or care staff in institutions
	Social and health services accessibility
	Social and health services usability
	Health promotion and prevention
	Integrated and transversal approach

Moreover, through the analysis of the ASTAHG survey items, we identified some indicators listed below which could not be associate with the domains analysed (i.e., identified in D.T2.2.1) but which, nevertheless, we used to test the model:

- quadruple Helix approach
- adaptability level of intervention
- effectiveness evaluation
- impact evaluation
- maturity level of intervention.



Overall, all indicators developed in WP3 may constitute a useful set to which stakeholders could refer in order to adapt the assessment model to the specific characteristics, needs and priorities of their contexts. Moreover, this set of indicators could represent for each stakeholder a starting point that could be expanded, enriched and modified according to the evaluation object and objectives, target population as well as needs of each territorial area.

Due to the lack of data gathered through the ASTAGH survey, during the model testing phase, it was not possible to collect information for all chosen indicators and variables.

Table 6 summarises the indicators (and their respective sources) and variables chosen based on the available information collected through the survey and, therefore, taken into account for the application of the model.

Table 6. The application model: indicators, related sources and variables

Dimension	Indicator	Source	Variable
Relevance	<i>Integrated and transversal approach</i>	Stakeholder consultation	Presence of different sectors involved (multiple choice) <ol style="list-style-type: none"> 1. Social care 2. Health care 3. Long term care 4. Independent living 5. wellbeing 6. Culture and tourism 7. Mobility & transport
	<i>Current population according to age group</i>	D.T2.2.1	Target population 60 years old and more <ol style="list-style-type: none"> 1. Yes; 2. No
	<i>Civic engagement</i>	D.T2.2.1	Engagement civil society as primary target <ol style="list-style-type: none"> 1. medical specialist - not 2. general practitioner - not 3. nurse or technician - not 4. family caregiver - yes 5. professional caregiver - not 6. patient/citizen - yes 7. associations - yes 8. companies - not



			Engagement civil society as secondary target 1. medical specialist - not 2. general practitioner - not 3. nurse or technician - not 4. family caregiver - yes 5. professional caregiver - not 6. patient/citizen - yes 7. associations - yes 8. companies – not
Coherence	Maturity level	ASTAHG survey items	Maturity level: 1. proof of concept 2. pilot stage 3. routine use
	Adaptability level	ASTAHG survey items	Geographic context: 1. Mountain areas 2. Rural areas 3. Urban areas 4. Mountain and rural areas 5. Mountain and urban areas 6. Rural and urban areas 7. Mountain, rural and urban areas
Effectiveness	Effectiveness evaluation	ASTAHG survey items	Presence of effectiveness evaluation 1. Yes; 2. Not
			Presence of counterfactual analysis for effectiveness evaluation 1. Yes; 2. Not
			Definition of effectiveness evaluation indicators 1. Yes; 2. Not
Efficiency	N.A.		N.A.
Impact	Impact evaluation	ASTAHG survey items	Presence of impact evaluation 1. Yes; 2. Not
			Definition of impact evaluation indicators 1. Yes; 2. Not
Sustainability	Multistakeholder approach	Stakeholder consultation	Organizational form of the responsible stakeholder 1. public; 2. private; 3. a mix of both
	Quadruple Helix approach	ASTAHG survey items	Actors involved in the design process 1. civil society; 2. governance; 3. industry; 4. academia
			Actors involved in the decision-making process 1. civil society; 2. governance; 3. industry; 4. academia
			Actors involved in the operational process 1. civil society; 2. governance; 3. industry; 4. academia



	Budget	D.T2.2.1	Sources of budget 1. public; 2. private; 3. a mix of both
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Finally, we set targets for each variable chosen (see Table 7).

Table 7. The application model: indicators, variables and variable targets

Dimension	Indicator	Variable	Variable target
Relevance	<i>Integrated and transversal approach</i>	Presence of different sectors involved (multiple choice) 1. Social care 2. Health care 3. Long term care 4. Independent living 5. wellbeing 6. Culture and tourism 7. Mobility & transport	2 or more sectors involved
	<i>Current population according to age group</i>	Target population 60 years old and more 1. Yes; 2. No	Yes
	<i>Civic engagement</i>	Engagement civil society as primary target 1. medical specialist - not 2. general practitioner - not 3. nurse or technician - not 4. family caregiver - yes 5. professional caregiver - not 6. patient/citizen - yes 7. associations - yes 8. companies - not	1 or more yes
		Engagement civil society as secondary target 1. medical specialist - not 2. general practitioner - not 3. nurse or technician - not 4. family caregiver - yes 5. professional caregiver - not 6. patient/citizen - yes 7. associations - yes 8. companies – not	1 or more yes



Coherence	<i>Maturity level</i>	Maturity level: 1. proof of concept 2. pilot stage 3. routine use	2 or 3
	<i>Adaptability level</i>	Geographic context stage: 1. Mountain areas 2. Rural areas 3. Urban areas 4. Mountain and rural areas 5. Mountain and urban areas 6. Rural and urban areas 7. Mountain, rural and urban areas	1, 4, 5 or 7
Effectiveness	<i>Effectiveness evaluation</i>	Presence of effectiveness evaluation 1. Yes; 2. Not	Yes
		Presence of counterfactual analysis for effectiveness evaluation 1. Yes; 2. Not	Yes
		Definition of effectiveness evaluation indicators 1. Yes; 2. Not	Yes
Efficiency	N.A.	N.A.	N.A.
Impact	<i>Impact evaluation</i>	Presence of impact evaluation 1. Yes; 2. Not	yes
		Definition of impact evaluation indicators 1. Yes; 2. Not	yes
Sustainability	<i>Multistakeholder approach</i>	Organizational form of the responsible stakeholder 1. public; 2. private; 3. a mix of both	3
	<i>Quadruple Helix approach</i>	Actors involved in the design process 1. civil society; 2. governance; 3. industry; 4. academia	2 or more actors
		Actors involved in the decision-making process 1. civil society; 2. governance; 3. industry; 4. academia	2 or more actors
		Actors involved in the operational process 1. civil society; 2. governance; 3. industry; 4. academia	2 or more actors
	<i>Budget</i>	Sources of budget 1. public; 2. private; 3. a mix of both	3



6.2 Assessment of governance models: graphical representation

We analysed the 7 policies (collected by project partners) using the variables and their respective targets. The analysis was carried out by reviewing the answers of the partners and checking, for each variable, the achievement of the assigned targets. To graphically represent the results, it was created a matrix (see Table 8) with the dimensions, indicators and variables in row and the policies analysed in column. The cells of this matrix were coloured green if the targets were attained, red if not, grey if the data were not available.

Table 8. The application model: graphic representation

Dimension	Indicator	Variable	POLICY						
			1	2	3	4	5	6	7
Relevance	Integrated and transversal approach	Presence of different sectors involved							
	Current population according to age	Target population 60 years old and more							
	Civic engagement	Engagement civil society as primary target							
		Engagement civil society as secondary target							
Coherence	Maturity level	Maturity level stage							
	Adaptability level	Adaptability level stage							
Effectiveness	Effectiveness evaluation implementation	Presence of effectiveness evaluation							
		Presence of counterfactual analysis for effectiveness evaluation							
		Presence of effectiveness evaluation set indicators							
Efficiency									
Impact	Impact evaluation implementation	Presence of impact evaluation							
		Presence of impact set indicators							
sustainability	Multistakeholder approach	Composition of responsible stakeholder							
	Quadruple Helix approach	Composition of design process							
		Composition of decision-making process							
		Composition of operational process							
	Budget	Composition of budget							

Source: Own drawing.

Key

Target attained	Target not attained	Data not available
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It is visually evident that such a model lends itself to a double reading:

- **horizontal reading** (among policies): it allows a comparative analysis of different policies by identifying their common elements and differences;
- **vertical reading** (within each policy): it allows the identification of strengths and rooms for improvement of each policy.

With reference to the above two points, it is important to highlight that the main objective of the model application was not to construct a ranking of the analysed policies, but to develop a tool for supporting governance in self-monitoring and self-evaluation processes through the following actions:

- identifying rooms for improvement and challenges for each governance model and innovation;
- providing policy makers with a transversal tool potentially applicable in a wide range of territorial, political and socio-cultural contexts;
- providing a framework for the development of further reflections, actions or practical tools through the direct and active involvement of expertise in the field of monitoring and evaluation.

The development and application of the assessment model described in the present deliverable was presented at the 3rd TGB meeting and 6^o PSG meeting last December and received the support of all ASTAHG project partners and TGB members. Both the methodology underlying the development of the model and its practical application have therefore been shared and recognised as valid.

Representatives of EUSALP and ITHACA project partners were involved, having been invited to the 6^o PSG meeting during which the assessment model of the governance and innovation for AHA in the AS, developed in WP3, was presented. Since the assessment model has now been defined and tested, representatives of EUSALP and ITHACA project partners will be involved in the next steps and will have the opportunity to contribute to the further expansion, diffusion and dissemination of the model, through actions such as its practical application or identification of other good practices. Knowledge exchange and synergy with TGB, EUSALP and ITHACA may be indeed an opportunity to identify further key strategic elements for AHA in the AS.

7 DISCUSSION AND CONCLUSION

For evidence based and efficient AHA decision making in the AS, governance models and innovation for AHA need to be subjected to a careful process of critical appraisal taking into account a multisectoral, transnational, and multilevel approach. Starting from this assumption, the present report represents a first attempt to operationalise and put into practice the theoretical and methodological framework developed in WP2, through the development and application of an assessment model of the governance and innovation for AHA.

We consider essential to emphasise that the main aim of the assessment was not to build a ranking of the governance models and innovation analysed, but rather to concretely support governance for AHA, providing policy makers with a structured method enabling governance to identify rooms for improvement, challenges and future directions to be pursued with a view to continuous improvement of policy making. The aim is not to identify who is doing better but to provide useful indications so that everyone can do better, particularly in a territorial context, such as the AS region, where cooperation is a key aspect, both at institutional and operational level.

More specifically, the model developed in WP3 is a tool for supporting governance in monitoring and evaluating the processes. It can be applied in both the pre- and post-evaluation phases, showing remarkable versatility. Depending on the stage, the model can be indeed calibrated to maximise its usefulness and effectiveness.

The model developed and applied by WP3 is indeed a very transversal and flexible tool, potentially applicable in a wide range of contexts and which can be adapted to the specific characteristics, priorities and needs that emerge in the different areas of the AS region. Depending on the assessment object and objectives as well as the characteristics of both specific context and target population, the choice of indicators, variables and targets may vary, in order to define a model that is as consistent as possible with the reality examined and corresponding to its needs.



However, to be applied following a structured and formally correct method, the assessment model we proposed, requires the involvement of a team of experts in the field of monitoring and evaluation. The use of specific expertise for the application of the model would allow not only to appropriately collect, analyse and interpret data, but also to exploit most of the potential of the tool and in a conscious way.

In the light of the work carried out in WP3, it would be desirable to develop a standardised procedure for the collection and analysis of data allowing the comparison of information from different areas of the AS. This comparison, which cannot be made at the level of indicators because of their strong link to the specificity of each context, could instead be made at the level of dimensions, if an index giving a measure could be defined for each dimension. This type of measurement (i.e., index), being at a much higher level of generality than a single indicator, would allow a comparison between very heterogeneous areas, contexts and territories, thus representing a valuable resource for policymakers.

Overall, the transparent method and the operational tool for the assessment of AHA governance models and innovation provided by WP3 could form the basis for the development of further reflections, actions and also standardised tools in support of AHA, with the ambitious goal of pursuing an increasingly evidence-based, transparent governance for AHA that meets the more genuine needs of older people in a targeted manner.



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