ASTAHG ALPINE SPACE TRANSNATIONAL GOVERNANCE ON ACTIVE AND HEALTHY AGEING

REPORT ON ASSESSMENT OF INNOVATION FOR AHA IN THE AS

WP3

D.T 3.2.2

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PARTNERS

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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 programs 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 "Identification and monitoring of the innovation in the AHA field" can be broken in 2 following categories: one related to collection of initiatives on AHA and the other with the assessment of their innovation. As part of this framework, the present deliverable concerns the development and application of the assessment model on innovation 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 program 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:

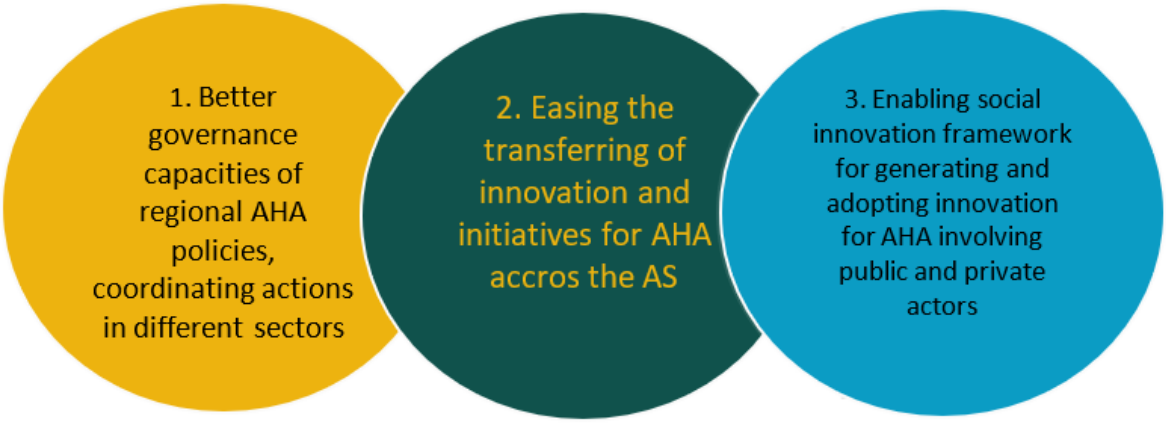
- by improving the public authorities' capacity to coordinate efforts from different sectors and at different levels;
- by responding with tailored initiatives to alpine territorial needs;
- by developing common strategies, a portfolio of good practices and an observatory of innovations to tackle the 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

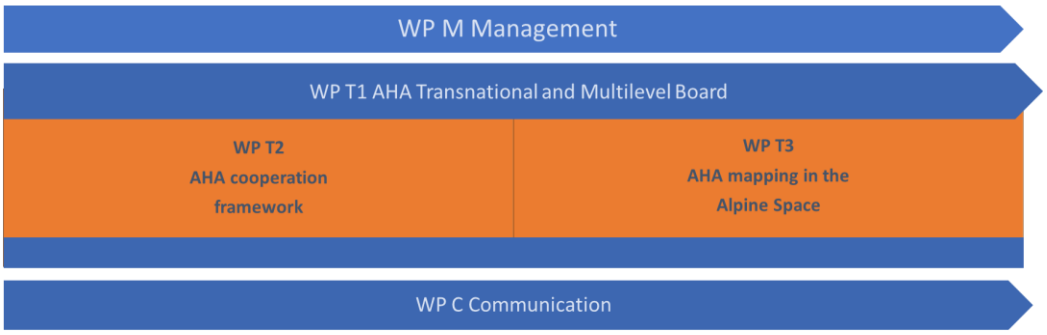
Source: Own drawing based on ASTAHG AF (2018).

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

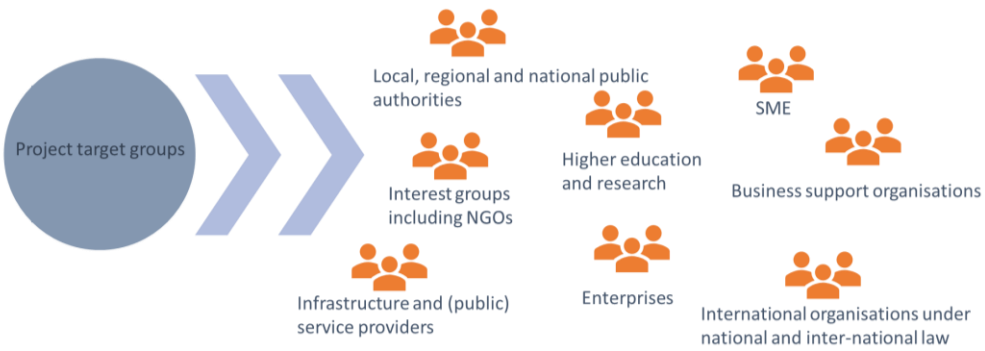


Source: Own drawing.

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 evaluate the innovation emerging in the Alpine Space (AS), addressing 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.

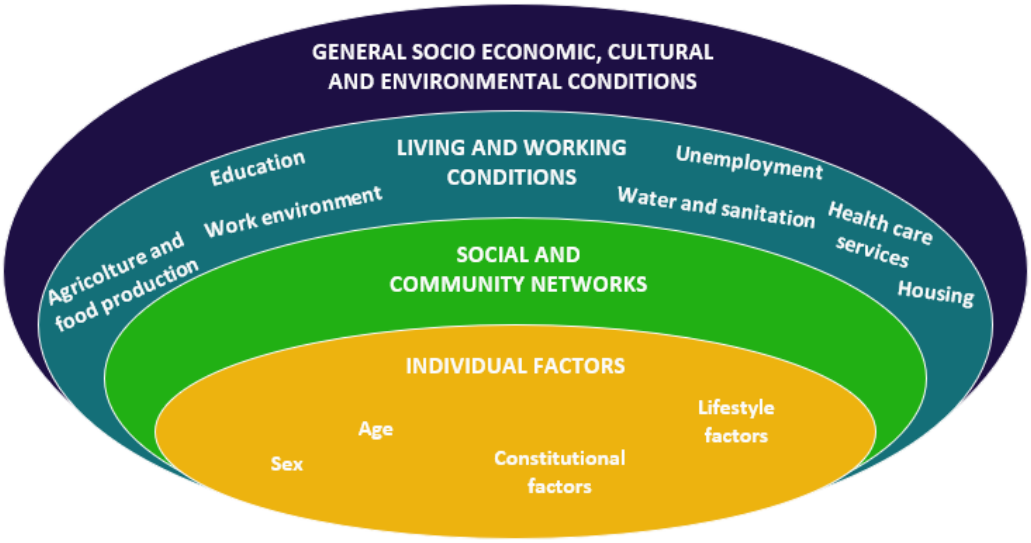
The assessment of innovation related to AHA good practices in the AS will provide a policy framework useful for different actors and subjects, such as policymakers and planners, health care managers, nongovernmental organizations and charities or entities promoting and funding public health programmes, for designing and implementing further good practices 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 good

practices 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, 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.

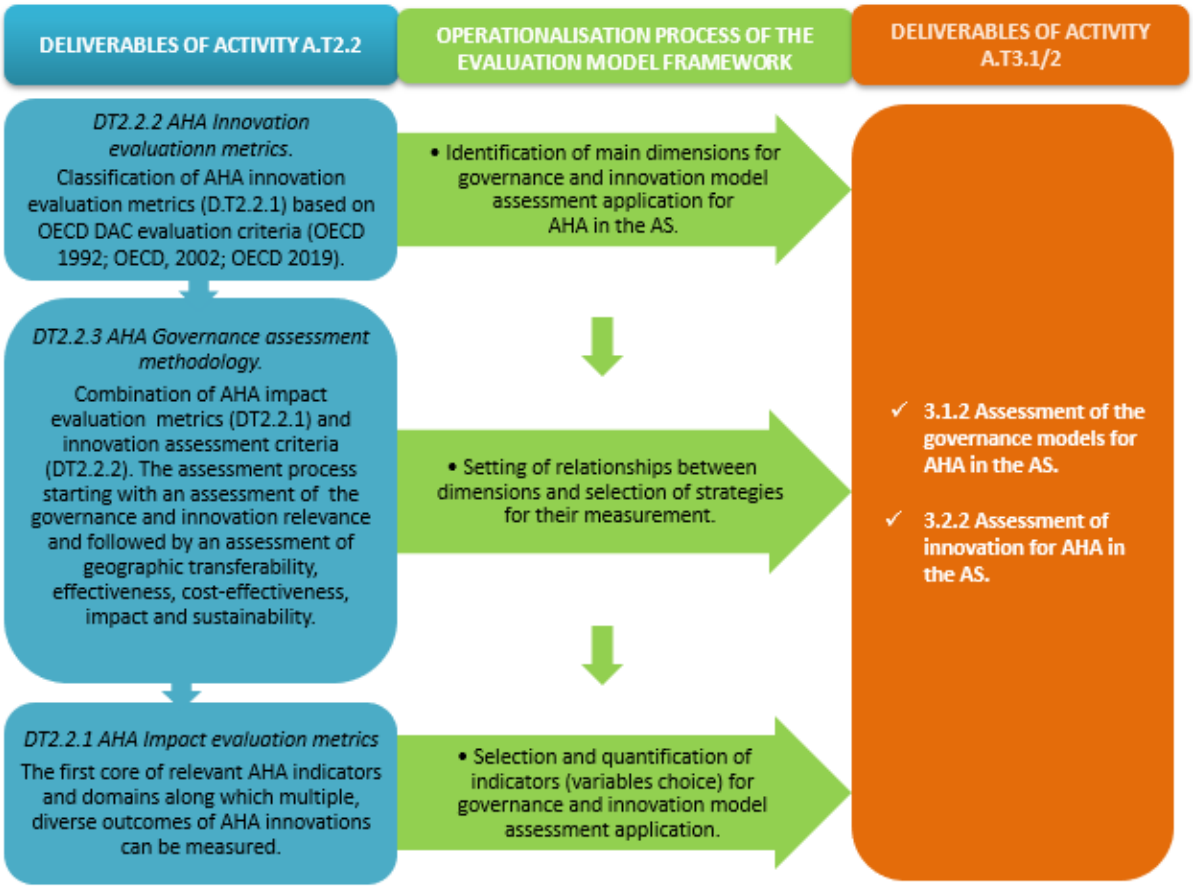
The above-mentioned aspects may be considered as a pre-condition for reaching the goal of an inclusive, smart, cohesive and sustainable growth in Europe, over the long term and with the new demographic context (for an in-depth examination see Boudiny, 2013; Foster & Walker, 2015).

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.

3 THE ASSESSMENT MODEL: METHOD

The assessment model of the governance and innovation (the first is explored in DT3.1.2) for AHA in the AS has been 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 6 shows the operationalisation processes linking A.T2.2 deliverables to DT3.1.2 and DT3.2.2. In doing so, WP3 provides a transparent method and an operational tool for the assessment of innovation for AHA, thus contributing to build up and enable capacities for evidence based and efficient AHA decision making in the AS area on national, regional, and local levels.

Figure 6. From A.T2.2 deliverables to DT3.1.2 and DT3.2.2: the operationalisation processes



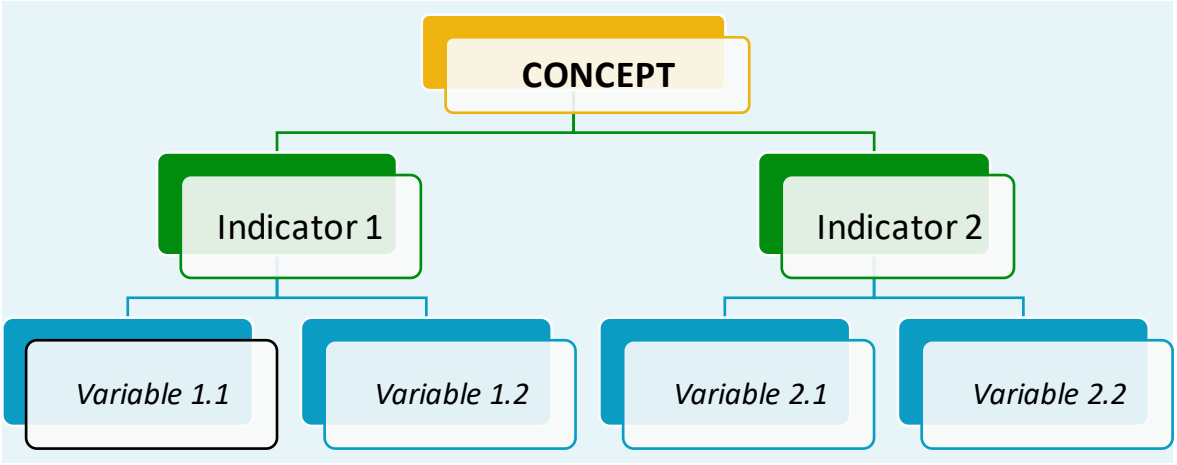
Source: Own drawing.

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), on the basis of 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 so that it can be empirically determined from time-to-time what value each property express in each single case. Indicators, therefore, have a synthetic function, that is 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 7).

Figure 7. 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 8):

1. **first step: identification of the main dimensions.**

First of all, 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 evaluating public policies, projects and programmes, allowing to identify 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. 11 on ASTAHG indicators set in section 4.1).

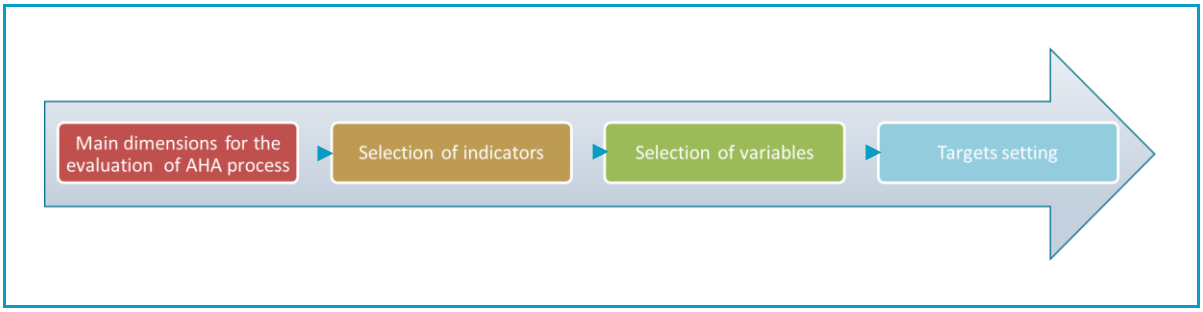
3. **third step: selection of variables**.

In the third step, for each indicator, the variables that allow its measurement and quantification are selected (see Fig. 12 on ASTAHG variables set in section 4.1).

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, that is the assessment objectives, the object of evaluation and the specific characteristics, needs and preferences of each territorial area/context.

Figure 8. The four steps of the "ASTAHG assessment model".



Source: Own drawing.

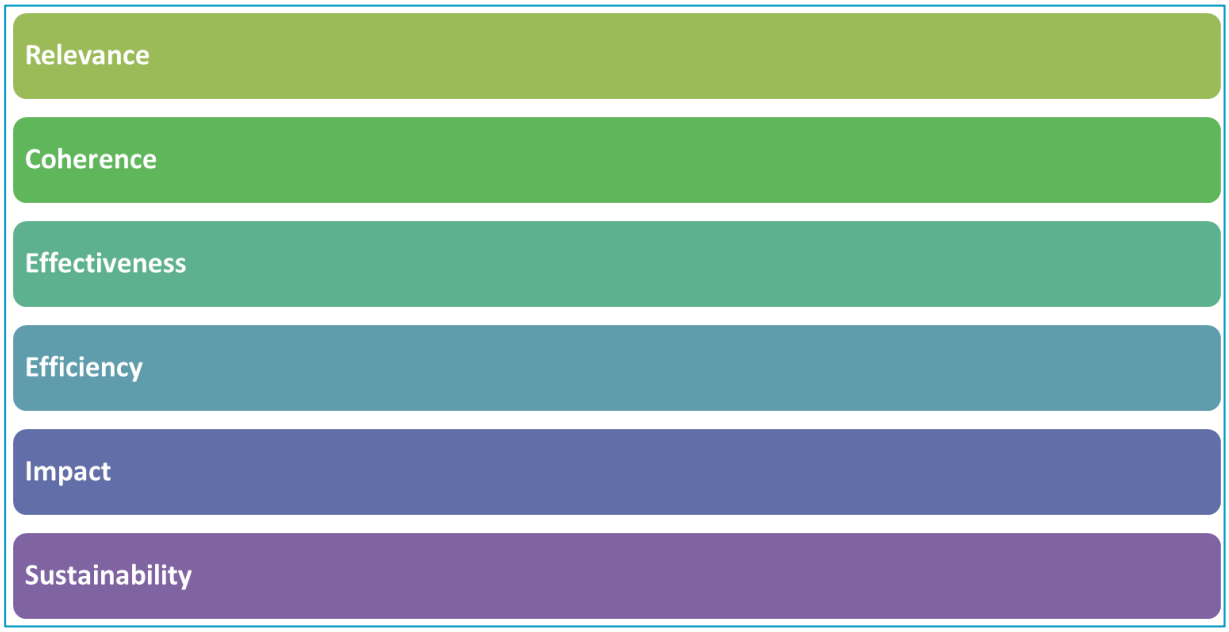
The development and application of the assessment model aims primarily at supporting local decision-makers in identifying the most effective and beneficial innovation for their respective geographic setting and context, allowing to make a step towards effective *multisectoral*, *transnational*, and *multilevel* AHA governance. More specifically, the objectives of the assessment of innovation 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 innovations for AHA in the AS to respond in an increasingly targeted manner to territorial needs.

3.1 Main dimensions for the evaluation of aha process

As mentioned in the previous paragraph, giving 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 9), 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 make possible to investigate and assess some fundamental aspects of innovation in order to pursue an ever more evidence based and efficient AHA decision making.

Figure 9. The main dimensions for the evaluation of AHA process[1]



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;

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;

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

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.

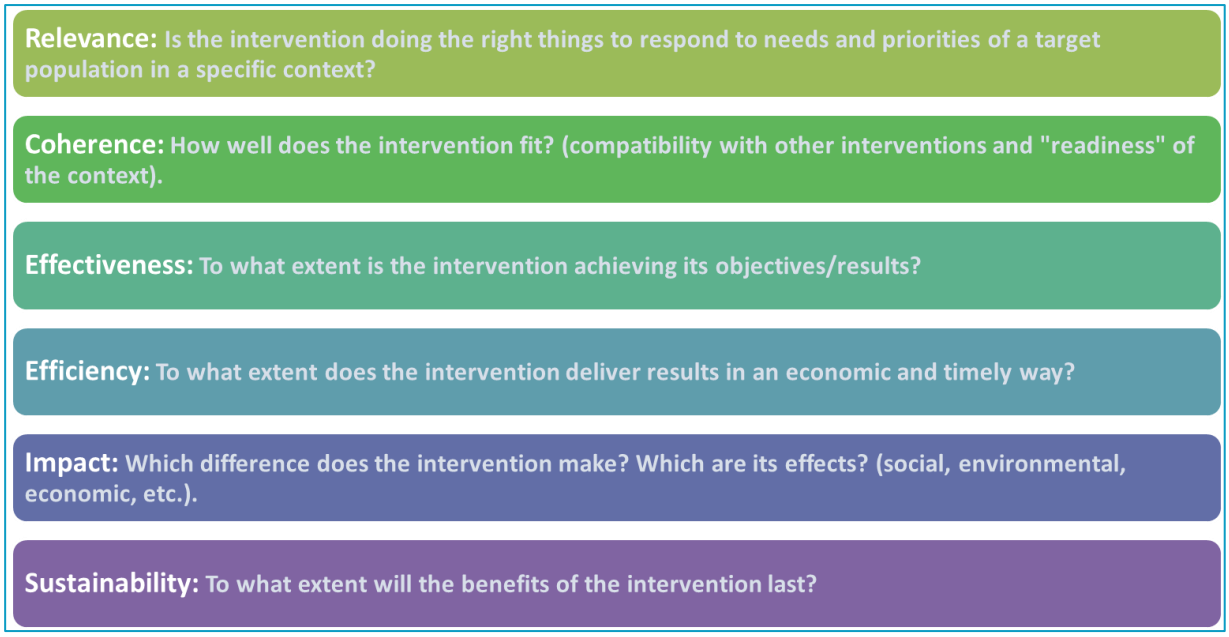
Both impact and sustainability, therefore, refer to a broad time horizon, being projected into the medium and long term.

As clarified in DT2.2.2 (AHA innovation evaluation metrics), two main principles guide the use and 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 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, including **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 10) in order to adapt the OECD DAC framework to the assessment of AHA decision making.

Figure 10. 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.

3.2 The selection of indicators

In the indicator selection process, the first step was the evaluation of the relationships among the 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 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). On this point, the MCDA approach takes into account the criteria (or attributes) against which alternative innovations have been evaluated, as identified

in the first dimension (i.e., relevance) for the assessment of AHA process (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 models 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 change[2], that allows to investigate changes, realised or desired, from the perspective of each stakeholder.

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*

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

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

Table 1. The main characteristics of the indicators for each dimension

Dimension	Characteristics of the indicators
Relevance	*needs and preferences of the target population in relation to the object of the evaluation.*
Coherence	*2 sub-dimensions: 1) Adaptability of intervention in other contexts without changing effects and costs; 2) Maturity level of the context.*
Effectiveness	*Linked to relevance indicators, that are measured in terms of the results achieved (output).*
Efficiency	*Linked to effectiveness indicators, that are measured in terms of the delivering results (performance).*
Impact	*Referred to long-term horizon of effectiveness indicators. Quantification of effects through the application of Theory of change (outcome and impact).*
Sustainability	*Linked to effectiveness indicators. These indicators may concern economic, social, environmental and political sustainability.*

3.3 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 them[3]:

- 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 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 it essential to analyse the opinion of stakeholder in the application of the model. For this reason, as

[3] For more details see also D.T2.2.3.

illustrated in section 4, in the choice of indicators and variables to be used to test the model we also analysed the open-ended answers and the items of ASTAHG survey.

3.4 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.

4 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 2 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 2. Simulation of model application

Dimension	Indicator	Variable	Variable Target
Relevance	Current population according to age group	*Target population aged 60 and more* 1. Yes; 2. No	1.
Coherence	Innovation Management (EIP on AHA - B3 Maturity Model)	*Level of innovation management* *0. No innovation management in place* *1. Innovation is encouraged but there is no overall plan* *2. Innovation are captured and there are some mechanisms in place to encourage knowledge transfer* *3. Formalized innovation management process is planned and partially implemented* *4. Formalized innovation management process is in place and widely implemented* *5. Extensive open innovation combined with supporting procurement and the diffusion of good practice is in place*	3., 4. or 5.
Effectiveness	Current population according to age group	*Number of elderly involved*	100
Efficiency	Current population according to age group	*Average monthly cost (€) per elderly involved*	90
Impact	Health Services	*Monthly savings (€) for the healthcare system in the care of heart disease per elderly involved*	250

Sustainability	Multistakeholder approach	*Organizational form of the responsible stakeholder:* *1. public; 2. private; 3. a mix of both*	3.

5 TESTING THE ASSESSMENT MODEL

The second test of the evaluation model, regarding the assessment of innovation for AHA in the AS, is conducted by assessing good practices defined, in the project, as:

- **initiative**: it may not have the same level of authority of a policy, or it may be implemented as part of an AHA policy in the respective region, and it may consist of several innovations to improve AHA for the respective citizens.
- **innovation**: technology, product, service or social innovation to improve AHA. "Innovation" may be targeted at different stakeholders (such as patients, citizens, practitioners etc.) and implemented as part of a wider initiative or policy.

We consider as "good practices" the initiatives and innovations, collected by the project partners in their territory, which have high potential for ASTAHG. These good practices have been pre-selected by the partners (therefore based on their own subjective judgement) and meet the requirements of:

- effectiveness (i.e., achieves its objectives)
- have impact (i.e., achieves changes in the respective target population)
- be cost-effective (i.e., is regarded to provide good value for money, compared to a suitable alternative)
- be deemed transferrable to other AS regions represented in the project (or at least there are no critical "knock-out-factors" that would hinder the transfer to another context).

Furthermore, the project partners were asked to prefer good practices that touch on more than one AHA sector, in line with the multisectoral approach of ASTAHG. The initiatives and innovations collected by the project partners will be defined hereafter as "good practices".

Overall, data and information were collected on 63 good practices*. However, the assessment model was tested on a subset of 14 good practices, which have been selected through a procedure that will be described in section 5.1.

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 (i.e., OECD DAC Evaluation Criteria). More specifically, as well as for governance models, it was not possible to collect enough data to explore the efficiency dimension.

5.1 Assessment model testing: the method

5.1.1 Selection of good practices

As mentioned in the previous section, the assessment model was tested on 14 over the 63 good practices collected by the project partners. More in detail, we decided to select 2 good practices for each project partners who contributed to the data collection through the ASTAHG survey (7 partners in total). The selection was carried out according to the following two criteria:

- **the prevalence of the priority sector of intervention**: for each partner, the prevalent priority sector of intervention has been identified (among Social care, Health care, Long term care, Independent living, Wellbeing, Culture & tourism, Mobility & transport);
- **the completeness of the information collected**: for each partner, among the good practices related to the identified prevalent priority sector of intervention, the two with fewer information missing in their description were selected.

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

Table 3 shows the list of identified prevalent priority sectors of intervention and selected good practices for each partner.

Table 3. Prevalent priority sectors and selected good practices for each partner

Partners	Prevalent priority sectors	Good practices selected
Autonomous Region Friuli Venezia Giulia	Social care	*1) Research Programme concerning the Integration Services for Autonomy Maintenance*
		2) Saluta il tuo vicino (Greet your neighbour)
Area Science Park	Health care	*1) NutriAct*
		2) SmartCare Project-Joining up ICT and service processes for quality integrated care in Europe
Autonomous Province of Trento	Social care	*1) Spazio d'argento*
		2) Progetto P.I.A. - Persone Insieme per gli Anziani
Pôle Services à la Personne, Provence-Alpes-Côte-d'Azur	Long term care	*1) ISERADOM first and 2nd part*
		2) Training to identify the frailty of people at risk of loss of autonomy for the personnel of home care and assistance services
National Institute of Public Health	Social care	*1) Socialnovarstveni program za starejše: "aktivna starost – sožitje generacij"*
		2) Spominčica - alzheimer Slovenia
Local Health Authority n.1 Dolomiti	Wellbeing	*1) Ginnastica del benessere*
		2) CrossCare - Approccio Integrato Transfrontaliera nella cura dell'Anziano initiative/innovation

University of Salzburg	Indipendent living	*1) Digital gesund Altern* *2) VergissDEINnicht*

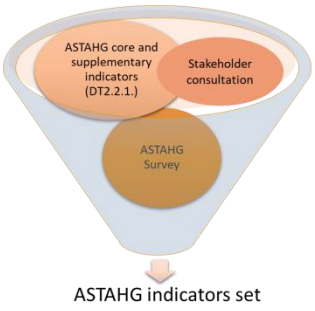
5.1.2 Definition of indicators and variables

Starting from the six dimensions borrowed from OECD DAC Evaluation Criteria, we identified a first set of indicators and variables.

We used the following sources for the setting of indicators and the selection of variables (figures 11 and 12):

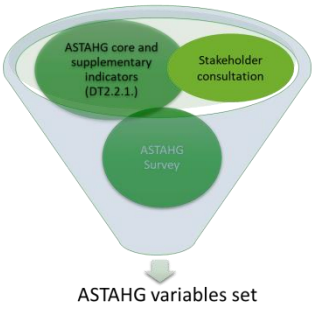
- ASTAHG Core Indicators set (reported in DT2.2.1 as a long list of potential measurable indicators);
- ASTAHG Supplementary Indicators set (reported in DT2.2.1 for qualitative data collection and further development);
- the ASTAHG survey items;
- stakeholder consultation: the textual analysis of the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

Figure 11. Sources for ASTAHG indicators set



Source: Own drawing.

Figure 12. Sources for ASTAHG variables set



Source: Own drawing.

5.1.3 Content analysis

The textual analysis allowed us to consider the qualitative data collected through the ASTAHG survey items (i.e., stakeholder consultation) in order to identify the indicators and variables. Specifically, we carried out a content analysis, as a type of textual analysis. 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) on the basis of recurrent aspects identified on analysed interventions, to define new indicators (in addition to the ASTAHG Core Indicators provided in D.T2.2.1) that are more relevant and pertinent with respect to the AS area.

Textual analysis was then carried out on the 14 good practices.

Regarding the first aim, the textual analysis was conducted in three steps:

1) all domains (except for "Demographic & social structural data") and core indicators identified in D.T2.2.1 were considered as categories;

2) for each good practice, the presence or absence of the core indicators was checked;

3) for each indicator, the total frequency in the 14 good practices was indicated (Table 4).

Table 4. Domains and indicators for the 14 good practices analysed

Domain	Indicator	Frequency
Civic engagement & Social Participation	Voluntary activities	*3*
	Social connectiveness	*7*
	Positive social attitude toward older people	*6*
Communication, Information & ICT	Availability of information	*7*
	Assistance available	*3*
	Use of ICT	*3*
Housing, outdoor spaces & enabling environment	Independent living	*2*
	Ability to age in place	*3*
Health & care	Quality of life	*13*
	Remaining life expectation	*4*
	healthy life expectancy	*7*
	Access to health and dental care	*2*
	Psychological wellbeing	*6*
	In need of care	*6*
	Disabilities	*4*
	Domestic care potential	*3*
	Medical supply	*2*
	Availability of home- or community-based services	*8*
	Emergency preparedness	*2*

The frequency analysis reported in Table 4 shows which core indicators provided by WP2 in DT 2.2.1 are most suitable for the evaluation of the 14 selected AS good practices.

Concerning the second aim of textual analysis, performed through the analysis of the open-ended answers of ASTAHG survey items, we identified specific new indicators related to some of the domains provided in D.T2.2.1. Table 5 shows these indicators developed *ex novo* in WP3, based on the good practices collected in the AS.

Table 5. An extract of ex novo indicators for the AS area

Domain	Indicator
Civic engagement & Social Participation	Prevention of social exclusion/isolation
	Raising awareness of existing forms of assistance
	Promoting citizen empowerment
	Cross-community approach
	…
	…
Communication, information & ICT	Providing certified health contents
	Providing information on care/assistance services
Health & care	Integrated approach to health
	Continuous professional education
	Providing assistance/support to relatives and caregivers
	Promoting health literacy
	…
	…
	…
	…

Moreover, through the analysis of the ASTAHG survey items, we identified other indicators, which cannot be associated with the domains considered in D.T2.2.1 but which refer to aspects that may be relevant for the assessment of an intervention. Newly identified indicators include (not exhaustive list):

- needs mapping and analysis
- customisation/personalization of the intervention
- monitoring and management of the intervention
- use of self-assessment tools
- interdisciplinary approach

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 accordingly to the evaluation object and objectives, target population as well as needs of each territorial area.

Although the indicators listed in Tables 4 and 5 can be considered relevant for the interventions reported in the set of 14 good practices analysed, the lack of data collected through the ASTAGH survey does not allow to collect information on these indicators or on variables that could measure them.

For this reason, in the present report, to assess good practices, we have used the same set of indicators and variables we used to assess governance models in DT3.1.2, on the basis of the available information collected through the ASTAHG survey (see Table 6).

Table 6. The application model: indicators, variables and variable targets

Dimension	Indicator	Variable	Variable target
Relevance	*Integrated and transversal approach*	**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
	Current population according to age group	**Target population 60 years old and more** 1. Yes; 2. No	Yes
	Civic engagement	**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	*Maturity level*	**Maturity level:** 1. proof of concept 2. pilot stage 3. routine use	2 or 3
	Adaptability level	**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	1, 4, 5 or 7
Effectiveness	*Effectiveness evaluation*	**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	*Impact evaluation*	**Presence of impact evaluation** 1. Yes; 2. Not	yes
		Definition of impact evaluation indicators 1. Yes; 2. Not	yes
Sustainability	*Multistakeholder approach*	**Organizational form of the responsible stakeholder** 1. public; 2. private; 3. a mix of both	3
	Quadruple Helix approach	**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

	Budget	**Sources of budget** 1. public; 2. private; 3. a mix of both	3

5.2 Assessment of innovation: graphical representation

We analysed the 14 good practices (collected by project partners) using the variables and their respective targets. The analysis was carried out by reviewing the information described by the project partners and checking, for each variable, the achievement of the assigned targets.

To graphically represent the results, we created a matrix (see Table 8) with the dimensions, indicators and variables in row and the analysed good practices in column. The cells of this matrix were coloured green if the targets were attained, red if not, grey if the data is not available. Table 7, in which the 14 good practices are anonymised and presented in random order, illustrates the results of the analysis.

Table 7. The application model: graphic representation

Dimension	Indicator	Variable	GOOD PRACTICES													
			1	2	3	4	5	6	7	8	9	10	11	12	13	14
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														
Effectivness	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

It is visually evident that such a model lends itself to a double reading:

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

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 good practices, 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° 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° 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.

6 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 considering 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 policymakers 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 policymaking. The aim is not to identify who is doing better but to provide useful indications so that everyone can improve, 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 will serve as 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 as consequence 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 context examined and better correspond 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 to appropriately collect, analyse and interpret data, and, on the other hand, to fully exploit the potentiality of the tool in a conscious way.

In view 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 standardised tools in supporting AHA, with the ambitious goal of pursuing an increasingly evidence based and transparent governance for AHA that meets the real needs of the elderly in a targeted manner.

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