

European Scaling-up Strategy in Active and Healthy Ageing

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1. Introduction

Health and care services in Europe are undergoing changes to adapt systems to a growing demand caused by ageing and the expansion of chronic diseases. This restructuring, which combines health and social care resources, involves the developing and testing of innovative solutions and eventually the large-scale implementation of the most successful practices.

The multitude of good examples developed throughout the EU has led to a realisation that a comprehensive scaling-up strategy is needed at European level. The European Innovation Partnership on Active and Healthy Ageing ("EIP AHA" or "Partnership") which brings together key stakeholders in this policy area, and supports the good practices and Reference Sites developed by its partners, can act as a catalyst to foster scaling-up across regions and countries.

This paper presents five steps for setting up an effective European scaling up strategy. The first three constitute a "what to scale up" element, while the remaining two "how to scale up" part:

| | | |
|---|--|--------------|
| Step 1 - Building a database of good practices | | WHAT? |
| Step 2 - Assessment of viability of good practices for scaling up | | |
| Step 3 - Classification of good practices for replication | | |
| Step 4 - Facilitating partnerships for scaling up | | HOW? |
| Step 5 - Implementation - Key success factors and lessons learnt | | |

Step 5 sets a framework for developing an individual scaling up strategy and provides the reader with a set of practical examples from the Partnership on how the different stages of implementation have been successfully accomplished:

1. Planning the innovative service and setting up a system for change
2. Organisational process and design choices
3. Monitoring, evaluation and dissemination

The EIP on AHA

The Partnership was established in 2012, and is now in its implementation stage with more than 3.000 partners involved (300 leading organisations are actively forming coalitions and consortia, covering stakeholders from all EU Member States, representing approximately 1.000 regions and municipalities).

The Strategic Implementation Plan of the EIP AHA focuses on promoting people-oriented, demand driven innovation for ageing well, which brings tangible and proven benefits to end-users, helps health and care systems to contain costs and unlocks business opportunities on European scale.

Partners are working in two main strands: (1) the Reference Sites, which are 32 regions, cities, or integrated hospitals/care organisations that implement a comprehensive, innovation-based

approach to active and healthy ageing and can give concrete evidence and illustrations of their impact on the ground; and (2) the 6 Action Groups, which over 3.000 partners have joined by submitting a Commitment (over 500 commitments received). The Action Groups focus on sharing information and solutions on how to overcome bottlenecks, pooling knowledge and resources and acting towards shared goals.

The Action Groups work towards the clear deployment targets in each of the six Specific Actions of the Partnership's Strategic Implementation Plan:

- A1: Prescription and adherence to medical plans. By 2014: To deliver tangible adherence approaches for various chronic disease areas in at least 30 EU regions.
- A2: Personalised health management and falls prevention. By 2015: To have in at least 10 European countries (15 regions) validated and operational programmes for early diagnosis and prevention of falls.
- A3: Prevention and early diagnosis of frailty and functional decline. By 2015: to have validated programmes for prevention of functional decline and frailty (with first action focused on malnutrition) among older people supported by tools, networks and information reaching at least 1.000 care providers across the EU.
- B3: Replicating and tutoring integrated care for chronic diseases, including remote monitoring at regional level. By 2015: Availability of programmes for chronic conditions/case management (including remote management/monitoring) serving older people in at least 50 regions, available to at least 10% of the target population (patients affected by chronic diseases in the regions involved).

By 2015-2020: Based on validated, evidence-based cases, scale-up and replication of integrated care programmes serving older people, supported by innovative tools and services, in at least 20 regions in 15 Member States.
- C2: Development of interoperable independent living solutions. By 2015: Availability of key global standards and validated implementations of interoperable platforms, solutions and applications for independent living, and also, availability of evidence on the return on investment of these solutions and applications, based on experience involving at least 10 major suppliers, 100 SMEs and 10.000 users.
- D4: Innovation for age-friendly buildings, cities & environments. By 2012: launching, based on the WHO age friendly cities initiative, a network of major cities/regions/municipalities committed to deploying innovative approaches to make their living environment more age friendly, including the use of ICT solutions.

The scaling up strategy constitutes another step in the development of the EIP AHA. The EIP AHA scaling up ambition can be defined as follows:

To mobilise sufficient resources and expertise, which combined with the collection of good practices and Reference Sites experiences, will ensure implementation of innovative solutions for active and healthy ageing on a European scale



Figure 1: EIP AHA model of the implementation stages.

Definition of scaling up

WHO Guide for scaling up¹ defines the term as

“(...) deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis.”

This definition stresses the importance of recognising the innovative solutions that are first successfully piloted and then become a mainstream policy.

But scaling up is not only about quality of the impact, scale and sustainability². The literature identifies four types of scaling up in terms of structures, programs, strategies or resource bases: quantitative, functional, political or organisational (for details see Annex 1)³.

Despite their differences all these dimension of scaling up are interrelated and often go together as scaling up rarely occurs in one single dimension. Quantitative or functional scaling up requires organisational adjustments and further expansion is triggered by political developments.

Scaling up is often considered as a continuous process of change and adaptation that can take different forms. It requires selection of good practices, the assessment of their viability for scaling up, the adjustment of good practices for replication locally followed by the lengthy implementation process⁴. Relevant work on scaling up has been carried by various organisations such as the ExpandNet and WHO⁵ and the Centre for Telemedicine and Telehealthcare in the Region of Central Denmark⁶.

The approach proposed in this paper focusses on two key elements – "what to scale up" and "how to scale up". The "what" includes identifying practices, projects and innovations to be scaled up, and the "how" focuses on the methods of going to scale. The latter part also discusses the organisational roles involved in scaling up (who and where) in the European context.

¹ *Practical guidance for scaling up health service innovations*, WHO 2009, http://whqlibdoc.who.int/publications/2009/9789241598521_eng.pdf

² *Scaling Up: A Framework and Lessons for Development Effectiveness from Literature and Practice*, A. Hartmann, J. F. Linn, Wolfensohn Center for Development at Brookings, Working Paper 5, 2008

³ *Fighting Hunger at the Grassroots: Paths to Scaling Up*, P. Uvin. World Development, 23(6): 927-939, 1995

⁴ *Scaling Up: A Framework and Lessons for Development Effectiveness from Literature and Practice*, A. Hartmann, J. F. Linn, Wolfensohn Center for Development at Brookings, Working Paper 5, 2008

⁵ *Nine steps for developing a scaling-up strategy*, <http://www.expandnet.net/tools.htm>, <http://www.expandnet.net/PDFs/ExpandNet-WHO%20Nine%20Step%20Guide%20published.pdf>

⁶ *Check! Telehealthcare at Scale*, <http://www.rm.dk/sundhed/faginfo/center+for+telemedicin/in+english/tools>, http://www.rm.dk/files/Sundhed/Center%20for%20Telemedicin/English/Check_final_UK.pdf

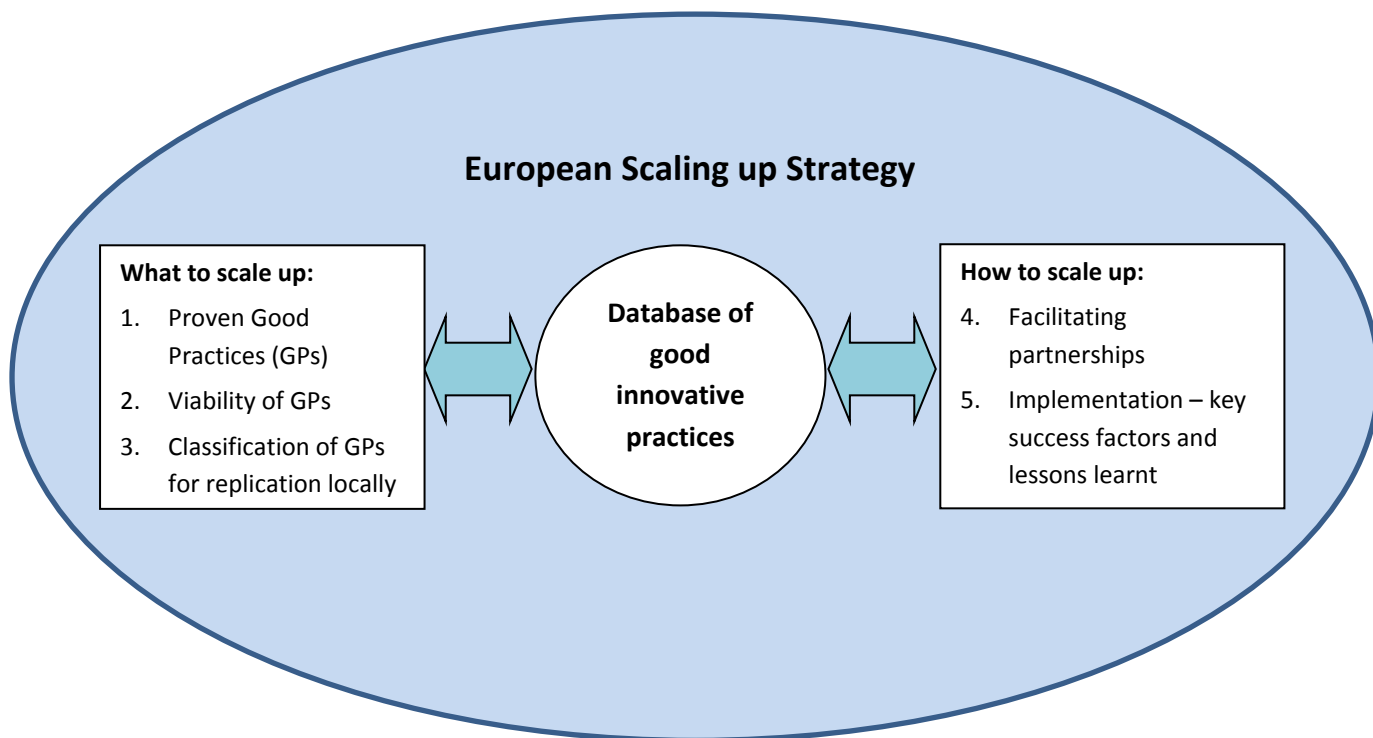


Figure 2: The 5-step model of scaling up.

2. What to scale-up

Step 1 - Building a database of good practices

Good practices are inspiring real-life examples of successfully applied innovations in active and healthy ageing. The Partnership, through the work of the Action Groups and Reference Sites, developed a collection of examples of what needs to be done for ageing people to stay active, independent and healthy for as long as possible. These also examined how to innovate in health and social care systems, and in age-friendly environments, in order to cater for real needs in a more effective and efficient way.

- Action Groups – the collections reveal a snapshot of innovative practices across the EU in 2013 in the areas covered by the Actions Groups⁷.
- Reference Sites – The *Excellent innovation for ageing “How to” guide*⁸ provides valuable information on how the Reference Sites have created their successes, what they learned along the way, and what elements of their approach could be transferred to or copied by others.

⁷ http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=documents

⁸ http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/how_to.pdf#view=fit&pagemode=none

The templates used by the Action Groups and Reference Sites for this collection used broadly the same key elements⁹:

- Description of the practice – methodology, process (how it was done), timing, target population, objectives, funding.
- Innovation – key innovative elements and ways of overcoming barriers to innovation.
- Impact / results – evidence on the coverage, health benefits, system's improved efficiency.
- Formal or informal evaluation / added value.
- Success criteria used to determine whether the initiative is working well.
- Transferability aspects for other organisations / regions.
- Lessons learnt and recommendations for others.

Through this work on the good practices from the Action Groups and the Reference Sites' "How to" guide, various lessons learnt and key success factors for effective scaling up are emerging. This knowledge and collection of good practices will eventually expand into an on-line database, which will serve as a toolkit for successful scaling up.

While extensive reference has been made so far to good practices coming from EIP AHA stakeholders, it is recognised that several other good practices exist in Europe, from stakeholders who are not yet engaged in the Partnership. These practices constitute equally valuable knowledge and enrich further the pool of expertise in applying innovations in the domain of active and healthy ageing. Such practices are also to be included in the developed database and become available for the steps of the strategy presented in this paper.

The European Commission in cooperation with the EIP AHA partners will:

- **develop an integrated on-line database of good practices, building on existing catalogues and repositories**
- **support stakeholders in showcasing successful and inspiring bottom-up innovation in active and healthy ageing**

Step 2 - Assessment of viability of good practices for scaling up

There is an important but difficult step to be taken when moving from the identification of promising initiatives, pilots and smaller projects to scaling up: assessing their viability for scaling up. Due to the complex and disruptive nature of the interventions in the health and care area it is often difficult to measure their effects in terms of efficacy and efficiency directly. It often takes a long while before the results of large scale changes can be assessed. The evidence to date points to the potential of innovative solutions for improving care, reducing waiting times, avoiding duplication of services, reducing elective admissions and outpatient attendances etc. At the same time, the results should be

⁹ The templates were built according to CORRECT features – seven key characteristics of innovation that have been found to facilitate its wider application: Credible, Observable, Relevant, Relative advantage, Easy and Compatible – for further reference see *Putting Knowledge to Use: Facilitating the Diffusion of Knowledge and the Implementation of Planned Change* by Edward M. Glaser, Harold H. Abelson, and Kathalee Garrison. (San Francisco: Jossey-Bass, 1983)

interpreted with caution as for certain studies the numbers are small, and the methodology debatable.

That is why this strategy proposes to assess the viability for scaling up by using comparability frameworks rather than "classic" evidence, such as that coming from randomised controlled trials. It is possible to compare systems on a larger scale and thus identify each system's characteristics and indicators of efficiency. This approach helps not only to relate practices to each other, but also to identify the characteristics of each practice and system.

This approach was also followed by the Member States in the Council Conclusions on a reflection process aiming to identify effective ways of investing in health, so as to pursue modern, responsive and sustainable health systems¹⁰, which invited the Member States to use health system performance assessment (HSPA) for policymaking, accountability and transparency¹¹. The Council's review was analysed by a multi-sectorial and independent Expert Panel, set up by the European Commission, which provides advice on effective ways of investing in health. In its opinion¹², the Expert panel proposed an assessment framework comprising an evaluation of: impact on common values, impact on outcomes, and a feasibility study, all analysed within a specific contextual frame (see Figure 3).

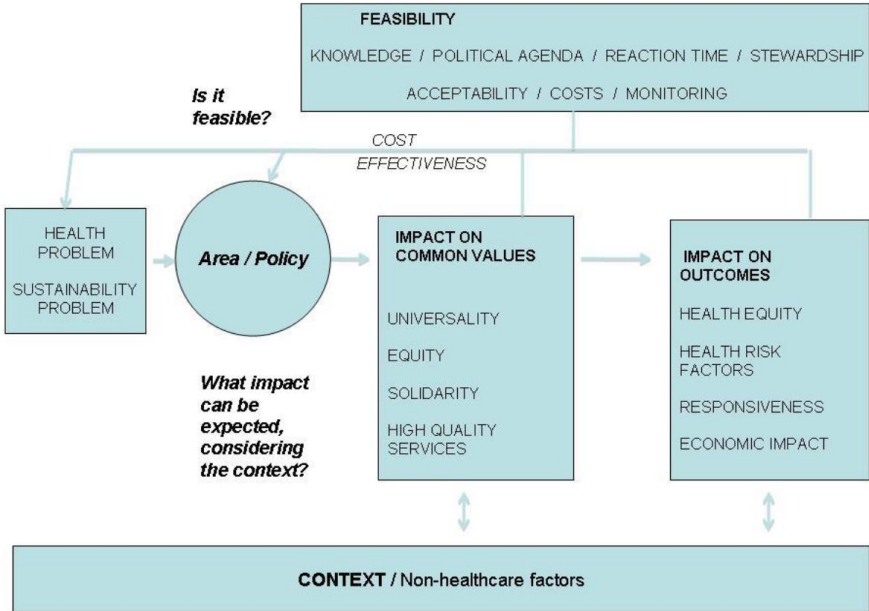


Figure 3: Elements for selection/prioritisation of policies/interventions.

¹⁰ Council conclusions on the "Reflection process on modern, responsive and sustainable health systems", EPSCO Council, 10 December 2013, http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/140004.pdf

¹¹ Working Party on Public Health at Senior Level, October 2013, Reflection process on modern, responsive and sustainable health systems – Report by sub-group 5: Measuring and monitoring the effectiveness of health investments: Annex 1 - Health Systems Performance Assessment: a review <http://register.consilium.europa.eu/doc/srv?!=EN&t=PDF&gc=true&sc=false&f=ST%2012981%202013%20ADD%204>

¹² Definition and Endorsement of Criteria to Identify Priority Areas When Assessing the Performance of Health Systems, Opinion of the Expert Panel on Effective Ways of Investing in Health, February 2014 http://ec.europa.eu/health/expert_panel/opinions/docs/002_criteriapperformancehealthsystems_en.pdf

There are also other examples of assessment frameworks that relate to specific types of innovation. For example, assessment tools have been developed by WHO-Europe together with the Healthy Cities Network in the area of age-friendly environments. Another example is MAST, the model for assessment of telemedicine¹³. It provides a structured framework for assessing the effectiveness and contribution to quality of care of telemedicine applications and covers three parts: preceding considerations before an assessment, a multidisciplinary assessment of the outcomes and an assessment of the transferability of results. The key multidisciplinary assessment includes seven domains of outcomes:

1. Health problem and characteristics of the application
2. Safety
3. Clinical effectiveness
4. Patient perspectives
5. Economic aspects
6. Organisational aspects
7. Socio-cultural, ethical and legal aspects

MAST is a widely used framework for assessment of the outcomes of telemedicine in Europe. A description of relevant outcome measures and methods for data collection within each domain has been produced¹⁴.

An impact analysis of common values and outcomes is a vital step in identifying good practices which are viable for replication. The Partnership has stressed the importance of evaluation and evidence to assess interventions. Given the national or regional competence of health systems management, the performance of these assessments is left nonetheless to those stakeholders involved in transfer and scaling up.

The European Commission in cooperation with the EIP AHA partners will:

- collect assessment tools and frameworks for innovations in active and healthy ageing
- provide a set of parameters and frameworks to enable stakeholders to carry out the viability assessment of good practices

The European Commission will also launch, if necessary, additional studies or projects in the field of assessment tools and frameworks for innovations in active and healthy ageing, addressing assessment in different European contexts

Step 3 - Classification of good practices for replication

To enhance the potential for scaling up across borders and regions, the identified good practices need to contain elements that can be sufficiently generic to allow their transferability and adaptation to varying local circumstances and conditions. There is no one size fits all. Therefore, good practices should be classified according to feasibility and contextual factors, as well as the characteristics of the system in which are they implemented. Feasibility, as proposed by the Expert Panel¹⁵, covers:

¹³ Kidholm et al. A MODEL FOR ASSESSMENT OF TELEMEDICINE APPLICATIONS: MAST. [International Journal of Technology Assessment in Health Care](#), Volume 28, Issue 01, January 2012, pp 44-51.

¹⁴ <http://www.renewinghealth.eu/en/assessment-method>, published in 2010

¹⁵ Opinion of the Expert Panel on Effective Ways of Investing in Health, February 2014, *idem*

- Knowledge – gaps between knowledge and practice (research, specific), existence of tested solutions (good examples, specific), large variations between countries (good examples, general).
- Reaction time – calendar (time needed for implementation), effects/visibility (time needed to assess impact).
- Stewardship – administrative and political capacity. Leadership, inside the health sector and in other sectors (Health in All Policies).
- Political agenda – electoral programme, social concerns, crisis, international institutions recommendations/ conditions, etc.
- Costs and affordability – it is important to consider the cost of the programme for selecting priority areas for investment. There could be decisions that need relevant investments (e.g. equipment, personnel, etc.) while others involve low direct economic cost (e.g. anti-tobacco strategies and legislation). The costs of a programme have to be considered in the context of the economic situation of the country (GDP/inhabitant; expansion/ recession/ stagnation; private and public debt; etc.).
- Acceptability – the support or the opposition that a certain policy is going to attract.
- Monitoring capability – the availability of the necessary information to monitor the starting point, the processes and the outcomes. It highlights also the importance of transparency.

Similarly, the contextual factors to be taken into account include demographic, social and economic conditions, cultural factors, and other non-healthcare determinants of health that impact on population health and wellbeing. The Expert Panel argues that determining the relative influence of health systems on health outcomes from the impact of the broader determinants of population health, especially living and working conditions, education etc., will be an important challenge. In addition, the time lags between policy changes and their impact on health outcomes, including possible unintended consequences, will also need to be taken into account.

The Reference Site guide¹⁶ included also examples of additional systemic elements to be considered for good practice adjustment to the local setting, notably type of health system (OECD clusters)¹⁷, level of systems' development (levels of expenditure and amenable mortality), level of systems' concentration (local, regional or national, primary, secondary or tertiary), eHealth readiness and expected overall impact of ageing on public finances¹⁸.

Furthermore, and considering the wider active and healthy ageing domain, beyond purely health and care issues, it is important to take into account the competences at local and regional level in fields such as transport, housing, urban design, etc.

The European Commission in cooperation with the EIP AHA partners will:

- provide tools for classifying good practices and identifying their transferable elements on the basis of systems' characteristics, feasibility and contextual factors

¹⁶ References Sites – Excellent innovation for ageing “How to” guide

¹⁷ Joumard, I., C. André and C. Nicq (2010), “Health Care Systems: Efficiency and Institutions”, OECD Economics Department Working Papers, No. 769, OECD Publishing. <http://dx.doi.org/10.1787/5kmfp51f5f9t-en>

¹⁸ The 2012 Ageing Report: Economic and budgetary projections for the 27 EU Member States (2010-2060), (European Economy. 2. May 2012. Brussels)

3. How to scale up

Once the database of good practices is established, and the proven examples have been validated by the interested stakeholders and classified by their contextual factors, the “raw material” is ready for scaling up.

But for scaling up to happen a true collaboration between the interested partners needs to be established, both for the scaling up within organisation as well as across organisations. The Partnership acts as a catalyst in this regard. Through its work in Action Groups and with Reference Sites it aims at increasing the capacity of organisations looking for innovative solutions and the willingness of the originating organisation to share their solution.

Step 4 - Facilitating partnerships for scaling up

Collaborators' roles

Usually there are at least two different organizational roles in scaling up: the originating organization that develops and pilots the model and the adopting organization that takes up the model¹⁹.

Tested good practices can provide invaluable help to the adopting organisation looking for an innovative solution to address its needs and gaps. It can prove resource-efficient to learn from other's successes and mistakes, avoiding duplications and saving time needed for the discovery, learning and implementation.

The originating organisation on the other hand benefits from collective learning, profits from the constant improvement of solutions, is able to compare/benchmark their accomplishments and sometimes gain from economies of scale.

Diffusion of good practices

There are several proven ways of diffusing good practices, facilitating exchange and scaling up. Many of them rely on personal contact and effective informal communication. They aim at enabling hands-on interaction with other stakeholders, helping to analyse and understand heterogeneities for efficient deployment and leading to creative problem solutions.

INTERREG IVC has developed a reference model for exchange of good practices on inter-regional level²⁰. According to their model these exchanges of experiences are in fact multidimensional and dynamic learning processes, geared towards achieving various forms of policy changes within the partner areas and beyond. Such a process should ideally start with learning at the project level, which then stimulates learning within the individual project partner organisations, and also learning between them and other organisations of the concerned regional/local policy subsystems in order to achieve policy change in the involved project partner areas as well as learning in an EU-wide perspective (see Figure 4)²¹

¹⁹ *Scaling-up Reproductive Health Service Innovations: A Conceptual Framework*, R. Simmons, J. Schiffman, . Paper prepared for the Bellagio Conference: From Pilot Projects to Policies and Programs, 2003

²⁰ INTERREG IVC provides funding for interregional cooperation across Europe and is implemented under the European Community's territorial co-operation objective and financed through the European Regional Development Fund (ERDF)

²¹ INTERREG IVC, Study on Exchange of Experience Processes, Final Report January 2013

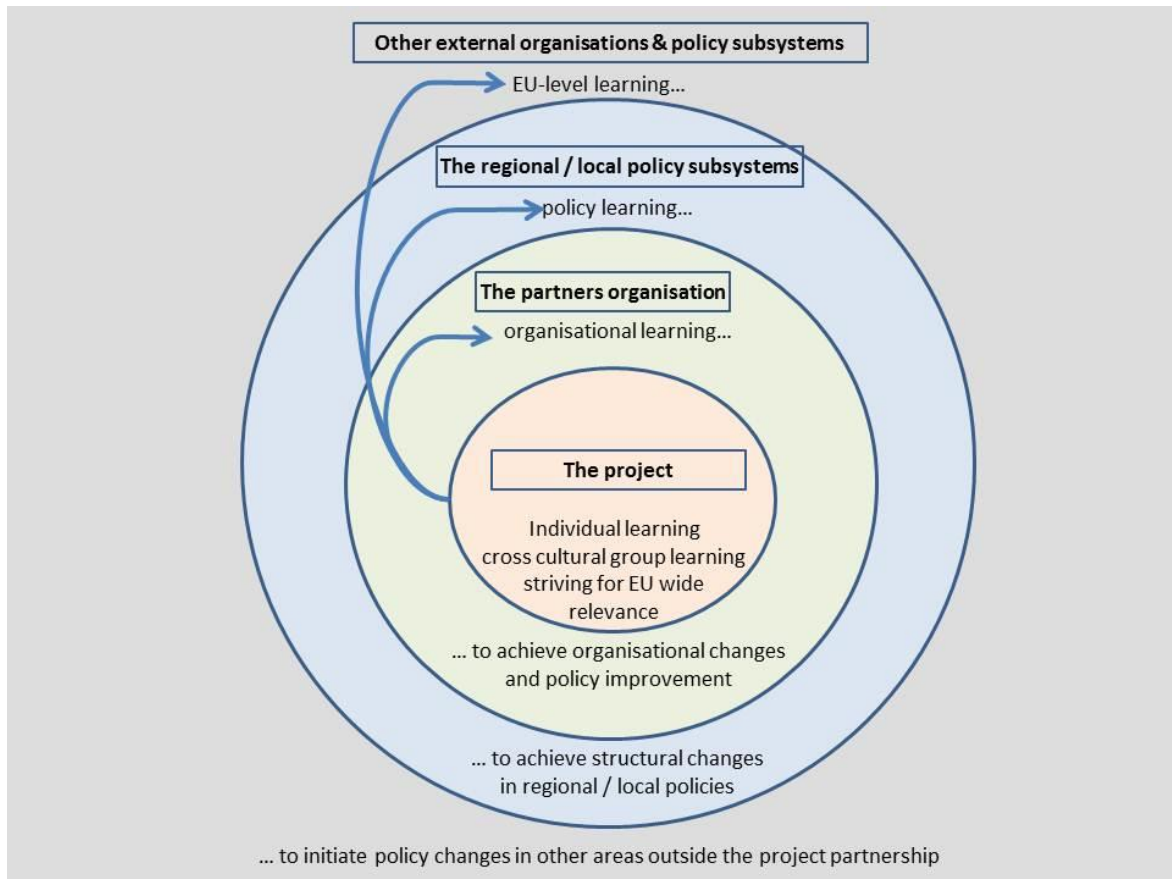


Figure 4: Interregional exchange of experience – a multidimensional process of learning & policy change
(Adapted from an original INTERREG IV C Programme table)

Typical tools for the exchange of experiences are networking activities such as thematic workshops, seminars, conferences, surveys, informal meetings and study visits. Possible project outcomes include, for example, case study collections, policy recommendations, strategic guidelines or action plans.

The Partnership has supported so far many forms of experience sharing; and several others are also being considered to be pursued too, e.g.:

- Action Groups and Reference Sites processes.
- Development of common guidelines and toolkits.
- Support to the learning networks, like in case of inter-regional collaboration is done via networks of regions such as EUREGHA, ERRIN, AER, ENSA and CORAL.
- Organisation of events or workshops and dedicated twinning sessions.
- Identification of leaders, pioneers or coordinators.
- (digital) Knowledge exchange platforms, like the EIP AHA Marketplace and Yammer.
- Common projects, activities, initiatives and publications.
- Dissemination and deployment of findings from EU funded projects.
- Coaching and tutoring which can consist of:
 - study visits and special training sessions allowing practical experience,

- staff exchanges or short-term secondments,
- tutorials and webinars, as well as
- scientific and non-scientific articles and other information material.

The European Commission in cooperation with the EIP AHA partners will:

- facilitate collaboration through dedicated match-making / twinning sessions
- facilitate coaching and policy partnerships between regions from different European Countries, aimed at sharing knowledge, objectives and programmes for the deployment of innovations in the domain

Step 5 - Implementation - Key success factors and lessons learnt

Once the co-operation is established with roles clarified, the actual scaling-up process can start. The framework proposed in this paper builds on the work done by WHO / ExpandNet, which identifies that strategic choices have to be made in the following five areas²²:

- type of scaling up,
- dissemination and advocacy,
- ways to organize the process,
- assessing costs and mobilizing resources,
- monitoring and evaluation.

Based on WHO / ExpandNet work and the Partnership's work on the good practices catalogue and Reference Sites' 'How to guide', the following framework for implementation of scaling up is proposed:

1. Planning the innovative service and setting up a system for change
2. Organisational process and design choices
3. Monitoring, evaluation and dissemination

Each of the following section focuses on a single step of this framework strategy. It aims at being general, allowing interpretation adjusted to the specific needs. To illustrate the steps, lessons learnt and key success factors for effective scaling up have been described; examples from the Reference Sites are given in [brackets]. The list will eventually expand into a jointly developed toolkit for successful scaling up.

1. Planning the innovative service and setting up a system for change

Preliminary assessment

Despite the often intuitive advantages of scaling up, research findings show it is necessary for the interested organisations to do first a preliminary assessment of the context where scaling up will occur. This helps to ensure that the strategy takes into account opportunities and threats in the new environment and adjusts to social conditions present in the new context where scaling up is

Key elements:

- Good understanding of the context
- Needs' evaluation
- Political endorsement
- Engagement of relevant stakeholders
- Strategy and roadmap
- Cost assessment
- Financial viability and business model

²² *Practical guidance for scaling up health service innovations*, WHO 2009, http://www.expandnet.net/PDFs/WHO_ExpandNet_Practical_Guide_published.pdf

anticipated. It also helps to estimate the cost, both financial and non-financial, of implementing changes in the system, which also include the initial inefficiencies. Hence, successful transfer of innovations is facilitated when certain attributes are present²³:

- a. The members of a user system perceive a need for the innovation, and consider it beneficial and congruent with the system's central ideas and concepts.
- b. The user system has the appropriate implementation capacity, values, and openness.
- c. The timing and circumstances are right.
- d. The user system possesses effective leadership and internal advocacy.
- e. The source and user systems (from the originating and adopting organisations respectively) are similar in characteristics and are in close physical proximity. The compatibility of a good practice with the new values, norms, organisation and systems of potential users or adopting organisations defines how much adaptation and capacity building will be needed, and what resources will be required.

In the context of public authorities, there are two elements which affect the adopting organisation's commitment to scaling up that require more in-depth analysis: securing political and stakeholders support.

Needs, strategy and roadmap

The starting point is to lay solid foundations, by identifying the real needs the innovations will serve and building a strategy on that basis. This can be achieved through an extensive consultation with a wide-ranging group of stakeholders concerned [Collage Ireland]. Following that, a strategic plan for deployment is required, with a well-defined roadmap, costs assessment analysis and budget [Northern Netherlands]. This can also entail putting in place an action plan between the national, regional and municipal authorities involved.

Appropriate financial planning is needed, right from the outset. This can be based on historical data, such as cost analysis of relevant good practices, and take into account the envisaged level of service coverage across the population and risk adjustment models, considering both direct and indirect costs.

Securing political support

Strong, committed leadership from both the central and local authorities is a vital element for the scaling up of a good practice from elsewhere. It can be expressed in various forms. At the top level, national and regional parliaments can do this by passing bills on active and healthy ageing to encourage and empower the government to boost relevant actions. National and regional governments can launch initiatives to introduce innovative care services and commit to making their large scale deployment a national/regional priority [Scotland, Region of Southern Denmark].

Such deployment is facilitated by national and regional political decisions and by agreements between regional authorities and the associated municipalities (city councils). For example, the creation of a ministerial portfolio with specific responsibility for e.g. older people or active and healthy ageing was seen as an important driver [Wales]. Another example is the envisaged Covenant on Demographic Change, along the lines of the Covenant of Mayors on Sustainable Energy, bringing political commitment at EU level with a peer process. In practical terms, in several successful cases,

²³ *Facilitating Large-scale Transitions to Quality of Care: An Idea Whose Time Has Come*, Ruth Simmons, Joseph Brown, and Margarita Díaz, (Studies in family planning, 2002; 33[1]: 61–75)

governments have provided programme management support, while the support of local politicians has been secured through good evidence, engagement events and training sessions held by the local partnerships.

Establish multi-stakeholder collaboration

According to the magnitude of the practice to be scaled up different type of stakeholders must be engaged. The plan should identify key stakeholders relevant for each step of the implementation process. In most complex examples, an effective working partnership is needed at all levels (national, regional and local). This requires the formation of a multi-sectorial stakeholder alliance, under the leadership of a committed national or regional manager who sustains the top-level will to innovate [Collage Ireland, Region of Southern Denmark].

Such an alliance, or ecosystem, needs to encompass collaborators from national and regional authorities, municipalities, social services, health centres, care organisations, insurers, housing and transport sectors, third sector, industry, universities and research institutes (perhaps coming from a local innovation cluster), and, importantly, representatives of patients and older people. In practical terms, it involves an intimate collaboration of these stakeholders in multidisciplinary teams, using state-of-the-art infrastructures and highly trained staff [Ageing@Coimbra].

The active co-operation of the health and social care providers and end users in these ecosystems is essential. If the innovative service is demand-driven, e.g. from healthcare providers or patient interest organisations, then buy-in from the remaining stakeholders is eased. Clinical engagement should therefore commence as early on as possible in the process of service design and continue throughout the service implementation.

In the context of these alliances, new relationships are essential. For instance, between public administrations, private companies and research centres to foster innovation and competitiveness. Or similarly, agreements among public administrations, voluntary associations, community participation agents and home care and telecare service providers [Basque Country].

Maximum engagement can be obtained through the involvement of these stakeholders, including political representatives and older people's representative bodies, across a range of participatory meetings and events. Such events bring these stakeholders together to commit jointly to the development of a shared strategy and a common, shared action plan. The shared ownership and shared vision on goals and outcomes can help sustain common efforts [Collage Ireland].

It is important to use the expertise of each partner in the ecosystem to analyse the local needs. Functional groups where doctors, nurses, patients and any stakeholder involved in any care process can express their specific requirements to be covered by the service are a means to achieve this. Subsequently, the developers of the service need to ensure that the needs and wishes of end users (patients or older people, including their carers) and care professionals are reflected in the service design. Having a service founded on intensive participation of a wide range of stakeholders in its conception and realisation phases, allows a high degree of readiness to be reached for the use of the service [Region of Southern Denmark]. Bottom up initiatives are a key source of innovation and should be encouraged and nurtured [Basque Country].

Experiences from successful implementations highlight the importance of the participation of civil society. For example, the set-up of a representative forum of older people (or older people's champions) to guarantee that the voices of older people, as well as their families and carers, are heard [Wales], or a Council of Elderly People [Andalusia] encompassing regional authorities, associations of older people and the third sector, to facilitate social participation of older people into political life of the region. Being guided by the voices and participation of older people underpins the legitimacy and helps prioritise needs. There are several ways to engage patients in the planning and implementation phase of an innovative service. For example, the opinions of patients (and carers)

can be sought during the process of procuring a service, in terms of detailing specifications and assessing equipment which is offered by various bidders [Northern Ireland].

To ensure that everyone involved is positive to the changes required, it is essential to anchor the changes to all the actors in the care chain and to demonstrate the benefits to all of them before the innovative service is introduced. And prior to this, a “narrative” beyond “cost containment” is required as a start, to provide an attractive vision and common understanding on where the main problems are, what the key issues to tackle are and how to do this [Basque Country].

In cases where a programme or service is imported from elsewhere, there is a need to make changes to adapt it to the local setting. It is important that the local staff take true ownership of this process of adaptation [Collage Ireland, Northern Netherlands].

All parties should be involved, not only in the design phase as mentioned above, but also in the development, financing, implementation, evaluation and dissemination of the service. For instance, it is beneficial to establish standards and treatment pathways agreed by all partners. Formalised agreements between parties can consolidate their common undertaking. A Joint Governing Board, or oversight group, comprising all the key stakeholders, is a practical mechanism to maintain the engagement, support the necessary policy framework and ensure that the innovative service delivers the expected outcomes [South Holland, Collage Ireland].

Once implementation has begun, care professionals, citizens and patients should be empowered to use the service, e.g. to access their health data through their personal health records [Andalusia, Region of Southern Denmark].

Sometimes, financial incentives, as well as provision of technical and organisational support, may help motivate stakeholders such as care professionals to participate in the collaborative networks and eventually use the service. Some examples encountered in practice are [Emilia Romagna]:

- funding of IT equipment and data connections;
- fee given to general practitioners (GPs);
- payment of the care professionals involved in the pilot projects

Pilots can bring to participating stakeholders the experience of real-life deployment of services. This can give birth to a set of champions in the pilot locations, which in turn can facilitate a snowball effect for the larger deployment of services in these locations [Catalonia].

Securing financial support

Little can be achieved without a plan for securing financial support. Experiences from the ground recommend providing ring-fenced financing for scale up [Scotland], and having all the partners involved in the cooperation contributing to the financial plan.

Dedicated public funding is seen as a catalyst. In many cases, it has been primarily the public authorities, including government departments, financing from their annual budgets (e.g. by dedicating a small percentage annually [Basque Country]) the development and introduction of innovative services and change, as well as their maintenance. Public authorities are seen also to fund directly the programme management, events and learning and coordination networks. Performance-based funding can be configured at national and regional level to underpin the continuation and expansion of services [Skåne]. In addition, public authorities can promote standardisation of procurement, in support of interoperability (see relevant section below).

Setting up a fund-raising organisation can be a success factor.

A combination and grouping of funding from various sources has been applied, and has been essential, in many cases (national, regional, local, private, from hospitals, non-profit organisations etc.) [Regions of Ile-de-France, Pays de la Loire and Northern Netherlands].

Various European funding programmes can be considered for the above purposes. Activities under the INTERREG, Horizon 2020 and the Public Health Programme can support interregional co-operation for pilot actions and transfer of knowledge and good practices. The European Structural and Investment Funds (ESIF) can provide regions with significant support for the deployment of operational services at large scale.

Configuring the business and reimbursement model

The lack of a business model or of arrangements for the reimbursement of the service is often quoted as a significant barrier to large scale deployment. Nevertheless, several practices on the ground can provide useful examples of how this major issue can be addressed.

It is noted that the development of a business model based on rental of the technology system rather than individual acquisition, can facilitate the scaling up [Region Ile-de-France].

The establishment of a shared risk model with a shared savings agreement (Public-Private-Partnership in investment) between the key participating stakeholders is seen as a promising option, e.g. between the healthcare provider and the IT provider, or between the municipality and the health insurer [Catalonia].

Performance-based funding and rewards is another approach that has been applied in a few cases; those doing well can be given extra funding [Skåne, Scotland].

Such agreed "risk and reward share" approaches, combined with appropriately defined tariffs in a Payment by Results system, can remove the reluctance of stakeholders who would otherwise feel deterred from deploying innovative services if that deployment meant an income reduction for their organisations [Yorkshire and the Humber].

Self-financing can be an option for some elements of the service: e.g., training courses can be paid by the users themselves [Liguria].

It is seen that in some cases, remote care services have been financed in the same manner as traditional care by national health care insurance and private insurance companies. Health insurers have also issued special modules for e.g. "integrated care" to finance the care provided through this model [Nijmegen, South Holland and Northern Netherlands]. Insurance companies and municipalities have also developed joint business cases to stimulate integrated and structural financing of integrated care models for older people living in the community [Northern Netherlands]. Bundled payment schemes can also be considered in NHS type systems, linking a predefined part of the budget to shared objectives of different healthcare organisations such as primary care, hospitals and nursing homes [Basque Country].

Finally, the implementation of the preventive measures is in some practices paid by the national healthcare systems, to ensure that screening, early diagnostic and prevention of infections are sustainably done [Northern Netherlands].

2. Organisational process and design choices

Training and re-skilling the workforce

Education for care professionals and citizens (patients) in the use of new tools and services is an essential element for success. To this

Key elements:

- Investing in human capital
- Integrating ICT solutions
- Organisational changes

end, a national/regional/local training strategy must be developed and implemented, starting from the identification of the training needs [Northern Ireland].

The new services may require a redesign of a care professional's role or even new roles, e.g. the role of case manager as the lead for the different patient management programmes. This calls for training of staff in relevant skills and promotion of professional qualifications. The latter is ultimately to be addressed via formal educational routes; for example, remote monitoring of patients with chronic diseases becoming part of the curriculum of schools for staff of care organisations [Noord-Brabant], and training programmes being organised on the changing roles and tasks of all professionals from all disciplines involved in the provision of integrated care [Northern Netherlands].

New job roles, shaping the profile of present and future care workers, introducing tele-assistance, community medicine tools, integrated and personalised care, new models of prevention-centred care, etc. should be designed with post-graduate faculties and in strict co-operation with civil society and regional stakeholders such as associations, city councils and informal carers [Piemonte]. The role of universities and research centres is relevant in this respect, whilst the engagement of carers and patients is important to the success of this process.

The development of a range of guidelines and Standard Operating Procedures (SOPs) for care professionals, end users and any staff who could be in the service of older users (even from outside the care sector, e.g. in public transport) helps embed the technical solution into daily practice. This needs to be accompanied by an up-skilling and training programme to ensure that all stakeholders are able to competently undertake their new roles and responsibilities in the context of the service.

Various other channels can be considered to help with the training and re-skilling of patients and of the care workforce. These may employ methods of e-learning and of internet, television and radio channels to make remote teaching resources available for educational courses to citizens and professionals, formal and informal carers [Galicia].

Making technological and design choices to ensure interoperability and scalability

ICT solutions are best developed through active user involvement in the development phase. It is fruitful to have both the ICT provider and the care provider contributing human resources in developing the service platform [Catalonia].

Good infrastructure, e.g. internet and broadband are essential. The technical implementation is strengthened by developing ICT as tools to support the work process that relates to the agreements and instructions.

Simple and robust technological solutions are preferable for ensuring interoperability, and extensive adoption. An open ICT platform supporting organisational interoperability and collaborative work is an important enabler of implementation [Catalonia]. Adopting (open) standard formats and processes/procedures promotes the interoperability and scalability of the achieved solutions, while a scalable design of the ICT systems is a pre-requisite, for large scale implementation, either at regional or national level.

Implementing the technical solution and integrating in daily practice

The successful implementation of a technical solution requires significant attention. Dedicated resources are required to develop and incorporate the technical solutions as part of the daily practice, as well as organise and manage the new service. The design phase is crucial and adequate time should be devoted to it. A motivated programme management team needs to be in place, both at top and local level [Liverpool, Scotland]. This team should be tasked with following the entire process, ready to support the implementation of the new organisational structures, but also to assist in the roll-out of the new technical tools. In areas where there is joint collaboration between several

players, it is beneficial to establish working groups with representatives of the different sectors to further the decision making process and to develop the new organisation of services [Region of Southern Denmark].

When the innovative service is being set-up, e.g. for the very first time or through the transfer of a good practice, an initial version of the solution is to be made available as a first prototype, to be improved and refined from learning by early adopters [Valencia, Scotland]. During the implementation phase, workshops should be organised with care professionals and end users (patients and citizens) to get their input, first in the design of the solution (usability) and, subsequently, for its continuous refinement on an iterative basis through comments, evaluations and proposals. Engagement of care professionals and end users in such a way ensures that any ongoing issues and desired improvements are being attended to [Andalusia]. The implementation is, at the same time, an ongoing process of testing and evaluating the co-operation between all partners [Saxony, Region of Southern Denmark].

Flexibility should be built within the service to support innovative use by care professionals as well as to personalise care in order to suit the needs of the different profiles of patients with long term conditions who may be at different stages of their disease (i.e. at different clinical state and social status). The End-to-End Managed Service model (where a provider assumes the responsibility for building-operating-managing the service package) is a useful proposition for developing services which require innovation and flexibility [Northern Ireland]. Customer Relations Management tools (CRM) allow for information flows and care coordination between and within patients and health professionals [Basque Country].

To ease the integration of new software modules in the solution, a modular design should be adopted, keeping interoperability needs in mind. A strong interaction between the provider of the technical solution and the management of the care centre (e.g. hospital) and its ICT services is at the core of this process, to ensure maximum impact [Campania].

Providing, technical support and troubleshooting

User training and a strong helpdesk for user support ease the introduction of a new service.

Throughout the operational period of any service, it is essential to have a team available for continuous development of services and for upgrading the services when new technological possibilities arise.

Support officers or support centres can be put in place, with key duties of ensuring that the system and associated processes are integrated into daily practice by providing frontline support, local training, working alongside staff as and when needed, and helping with stakeholder engagement activities [Northern Ireland, Andalusia].

Applying service re-design and organisational changes (change management)

Organisational processes, both clinical and administrative, have to be clearly defined and shared among stakeholders. A common intervention plan and agreement for the new services, shared among all the care professionals involved (either from the health care or social care side) is at the foundation.

The organisational implementation works best when clear agreements and instructions on the tasks of all individual stakeholders and on the use of any ICT solutions are formulated. Cross-sector organisational implementation is most successful when the procedures and instructions are a result of cooperation across all sectors and new practices are taught in a cross-sector set-up, where staffs from the various sectors are trained together [Region of Southern Denmark].

Organisational and cultural aspects of the change need to be prioritised. Recognising tensions and taking them into account in the service design phase is crucial. A modular approach is wise to adopt,

with small scale testing and refinement of a change in a locality, before moving to implementation; the spread to larger scale is then more successful [Collage Ireland, Scotland]. This modularity can be also applied differently, with gradual roll-out of complementing functionalities. For example, start with one simple service but implement it universally and once it has matured and is used proactively and widely by the target group, move on to implementing another service, profiting from the existing infrastructure as much as possible.

Several success factors and recommended approaches for achieving change management can be derived from experiences to date [Northern Ireland, Languedoc Roussillon, Catalonia, Region of Southern Denmark]. Change management can be addressed by:

- adopting a recognised project management approach;
- agreeing strategic and operational objectives along with responsibilities;
- investing time to build relationships between the clinical triage team and the patient care team;
- developing and implementing an agreed operational plan;
- accepting that things take time and that the plan for the change must be dynamic;
- establishing new structures, e.g. new clinics or care units that apply the new service and organisational structure right from the beginning of their operations;
- developing and executing a communications strategy and a regional training strategy;
- incentivising change by consolidating an appropriate business model.

Scientific societies of stakeholders involved in the care chain, such as health care professionals and pharmacists, can contribute to change management through their support and advocacy.

Strong political leadership is fundamental to service transformation. System-wide transformative change happens when many policy levers are aligned and activated in the same direction. Organisational strategies should be equally aligned [Basque Country, Catalonia, Andalusia]. The driving role of public administrations is extremely important for change management; it can maximise the change of all sectors and stakeholders through continuous and consistent support to joint actions and co-participation. For instance, transition can be facilitated by making the transformation of the healthcare model a priority health policy, with a clear vision and defined objectives. Culture change can be delivered through distributed leadership, with such leadership reaching the local level too [Basque Country]. It is important to have dedicated local implementation officers to support the central implementation teams, perhaps in the form of a cross-agency office, anchored in the local authority, to provide support to the local stakeholders. Such a set up entails "local leaders" or "local coordinators" being in place to support all tasks, measures and activities to bring about the implementation of new strategies, structures, systems, processes or behaviours [Liguria, Scotland].

3. Monitoring, evaluation and dissemination

Evaluating outcomes

Robust performance monitoring and evaluation of the service should be embedded from the start, to ensure the collection of high quality evidence of the benefits, which often is compulsory anyway in order to ensure regional government support.

Economic evaluation is needed to examine cost effectiveness, in order to guarantee the sustainability of the services and unlock the support

Key elements:

- Assessment indicators
- Mutual learning
- Dissemination activities
- Scaling up of the new GP

for corporate strategies and adaptation to change.

The evaluation should however, not only focus on the economic aspects but also aspects covering the patient and care giver perspectives, clinical effectiveness, health outcomes, impact on daily activities etc.

Use of surveys, routinely collected data and dedicated studies to monitor and evaluate outcomes can be employed for these purposes (e.g. the EHR-IMPACT study²⁴).

Knowledge exchange and learning

In order to make sure that any problems encountered in one area are not replicated across other areas, collaboration between areas is to be encouraged via Learning Networks, for learning and sharing best practices. Such networks also provide a means to learn about what works and what does not work, and the best methods to adopt.

Special training meetings for networks of stakeholders, e.g. on the care of patients suffering from a specific condition [Saxony] or the School of Patients, a network of patients, carers and associations [Andalusia], turned out to be very successful in several practices. Similarly, knowledge transfer and sharing of learning and experiences in the development of care pathways have been facilitated by learning events and courses [Piemonte], as well as via regular contact with the "local leaders" or "local coordinators" and with patients, their families and informal carers (see above). In cross border and other international settings, there are benefits to be gained from offering language training [Northern Netherlands].

Next to such learning networks, it can be useful to establish mechanisms to encourage clinicians to champion their success stories and disseminate good practice.

Communicating to raise awareness and acceptance

The implementation process must be accompanied by a strategy for communication and dissemination. Such a strategy may consist of high-level political statements, speeches, official launches, dissemination at Parliamentary fora, conferences, workshops and training courses, with wide coverage in the national and local media. It may also include a marketing plan with a powerful branding to raise awareness of the offer, its wider goals and added value. A network of community champions (or "local leaders" - mentioned above) is another proven mechanism to raise awareness and demand [Wales, Liverpool].

Roadshows for the wider public and meetings with key groups across a region can take place to explain the new process and illustrate its benefits. For instance, combining health promotion and screenings with local sport events is an effective way to enhance the awareness of active lifestyle for good health [Campania].

Making a range of multimedia learning resources, good practice examples and stories (personal experiences) from end users available for wide dissemination can facilitate adoption. The value of the latter should not be underestimated; patients listen and rely on the experiences of their fellow citizens.

Scaling up at different levels

Besides the lessons learnt and success factors mentioned above, there are further elements to consider when embarking on large-scale deployment at regional, national or cross-border level. Many of these elements apply to all these three levels. For reasons of brevity, they are mentioned only under the section dealing with scaling up at regional level.

²⁴ <http://www.ehr-impact.eu/index.htm>.

- *Within the region*

A plan for service growth and implementation at scale needs to be defined at the outset. The scaling-up plan needs to build on the strengths of the local ecosystem, with the all necessary support from national, regional or local authorities. Usually, an initial feasibility study or pilot is carried out, which may provide evidence of benefits and result in recommendations to apply the service at scale. This recommendation needs to be underpinned by a committed political decision, at national, regional or local level [Northern Ireland, Andalusia].

In addition to this, assigning dedicated personnel for this purpose is a key factor in taking forward implementation at scale [Campania, Region of Southern Denmark].

A further point is the development and use of appropriate tools for continuous assessment of the deployment experience. This is critical to the scaling up process, because it provides the results and lessons learned during the implementation process, which can be used to drive adoption further in the most effective way. A flexible pace of adoption is a sensible strategy to overcome contextual factors beyond immediate control [Catalonia].

A well-defined ICT policy can ease implementation (e.g. all hospitals in the region deploying the same Hospital Information System, with these systems bound to a unique identifier for patients). Existence of pre-deployed Electronic Health Care Record and Integrated Information Systems is a major facilitator for the wide implementation of new services and ways of working [Andalusia, Galicia].

Large home care organisations can be the first buyers of innovative applications, for example eHealth ones. This can result in critical mass for further development and expansion.

Other measures can be considered with regards to specific types of stakeholders. One way to support the wide use of innovative services in GP practices is through the inclusion of such services in GP contracts [Scotland].

- *Within the country*

Large scale deployment within the country can be based on combination of project-based approaches and policy-driven decisions.

Nationwide take up is facilitated if the composition of the local/regional multi-stakeholder ecosystems can be replicated organisationally in adjacent regions or localities [Collage Ireland].

Using national networks, e.g. the Mutualité Française network in France, for exchange of knowledge and good practices can shorten the learning curve for the local authorities which are about to embark on implementation. Short-term secondment of personnel provides practical and meaningful support to the transfer of a good practice to another locality.

- *Across EU regions*

Replicability across EU regions can rely on inter-regional collaboration; this can be a key element to analyse and understand heterogeneities for efficient deployment. Such collaboration can be sought via networks of regions such as EUREGHA, ERRIN, ENSA, CORAL, Regions for Health Network from OMS-Europe and AER.

Cross border collaboration can lead to creative problem solutions, boosting also the productivity of SMEs. It is therefore important to have a continuous interaction with other international stakeholders in the field to learn from others' experiences. Initiatives such as the EIP AHA, the AAL Joint Programme and the INTERREG programme offer opportunities to this end.

The European Commission will encourage national and regional authorities in:

- scaling up viable good practices
- enhancing the viability of practices that need further improvement

The European Commission will examine the feasibility of the PPI instrument (Public Procurement for Innovative solutions) in Horizon 2020 to support scaling up

Member States and Regions can consider the use of instruments such as Structural Funds, national innovation funds and innovative procurement schemes in order to finance the deployment of innovative services on large scale

4. Actions and Timetable

The five steps of the presented European scaling up strategy need to be supported by specific actions, as listed in the table below. Some actions need to conclude and deliver in the short-term, in the period 2014-2016, while others have a more continuous nature, carrying on in the long run.

| | Action | Responsible Actors | Timing |
|---|---|---|--|
| 1 | Develop an integrated on-line database of good practices, building on existing catalogues and repositories | European Commission, Reference Sites, Action Groups and the EIP AHA Support Action funded by Horizon 2020 | First Version: June 2015 Updated Versions: December 2015 and December 2016 |
| 2 | a) Collect assessment tools and frameworks for innovations in active and healthy ageing b) Provide a set of parameters to enable viability assessment of good practices | European Commission, Reference Sites, Action Groups | a) By February 2015 b) By April 2015 and updated on a regular basis (every 6-12 months) |
| 3 | Launch, if necessary, additional studies or projects in the field of assessment tools and frameworks for innovations in active and healthy ageing, addressing assessment in different European contexts | European Commission | During 2016 |
| 4 | Provide tools for classifying good practices and identifying their transferable elements on the | European Commission, Reference Sites, | By June 2015 |

| | | | |
|---|---|---|--|
| | basis of systems' characteristics, feasibility and contextual factors | Action Groups | |
| 5 | Support stakeholders in showcasing successful and inspiring bottom-up innovation in active and healthy ageing | European Commission | Continuously |
| 6 | Facilitate collaboration through dedicated match-making/twinning sessions | European Commission, Reference Sites, Action Groups | Continuously |
| 7 | Encourage and facilitate national and regional authorities in: - scaling up viable good practices - enhancing the viability of practices that need further improvement | European Commission | Continuously |
| 8 | Member States and Regions engaging in collaboration partnerships for sharing knowledge and programmes, transfer of elements of good practices and for deployment of innovations in the domain | Reference Sites in the lead, working with National and Regional authorities | Continuously, with the following milestones: - By March 2015: Reference Sites, National and other Regional authorities to identify each 1-3 other regions to twin with and at least one other region to coach. - By July 2015: agreements and plans for twinning on specific topics are in place and coaching has commenced - Within 2015: Regions would have the possibility to apply for any funding available via INTERREG - By June 2016: coaching is up and running and adopting regions have <u>started implementation</u> of elements of transferred practices. |
| 9 | Member States and Regions finance the deployment on large scale | Reference Sites in the lead, working with National and Regional authorities | By end of 2015: - Regions would have the possibility to apply for Structural Funds via calls issued by the Managing Authorities - Committing national innovation funds |

| | | | |
|----|---|---------------------|--|
| | | | - Making use of innovative procurement schemes |
| 10 | Examine the feasibility of the PPI instrument (Public Procurement for Innovative solutions) in Horizon 2020 to support scaling up | European Commission | In calls of 2015 and 2016 |

Annex 1 – Types of scaling up

Following the classification proposed by Uvin²⁵, there are several types of scaling up:

- **Quantitative scaling up** is the geographical spread to more people and communities within the same sector or functional area. This form is often referred to as horizontal scaling up or scaling out.
- **Functional scaling up** is expansion by increasing the scope of activity, when an organization expands the number and the type of its activities. This scaling up is largely vertical and involves institutionalisation of more services.
- **Political scaling up** refers to expansion through efforts to influence the political process and work with other stakeholder groups. Through political scaling up, individual organizations can move beyond their scope of activities toward empowerment and change in the larger organisational structures, thus achieve greater influence and affect political and institutional change that sustains scaled up interventions.
- **Organizational (or institutional) scaling up** means the expansion of the organization implementing the intervention, mainly by increasing their organizational strength so as to improve the effectiveness, efficiency and sustainability of their activities. This can involve both horizontal and vertical organizational expansion, the former involving similar institutions while the latter means going up the ladder from community to local to regional to national (and in some cases even supra-national) institutions.

²⁵ *Fighting Hunger at the Grassroots: Paths to Scaling Up*, P. Uvin. World Development, 23(6): 927-939, 1995