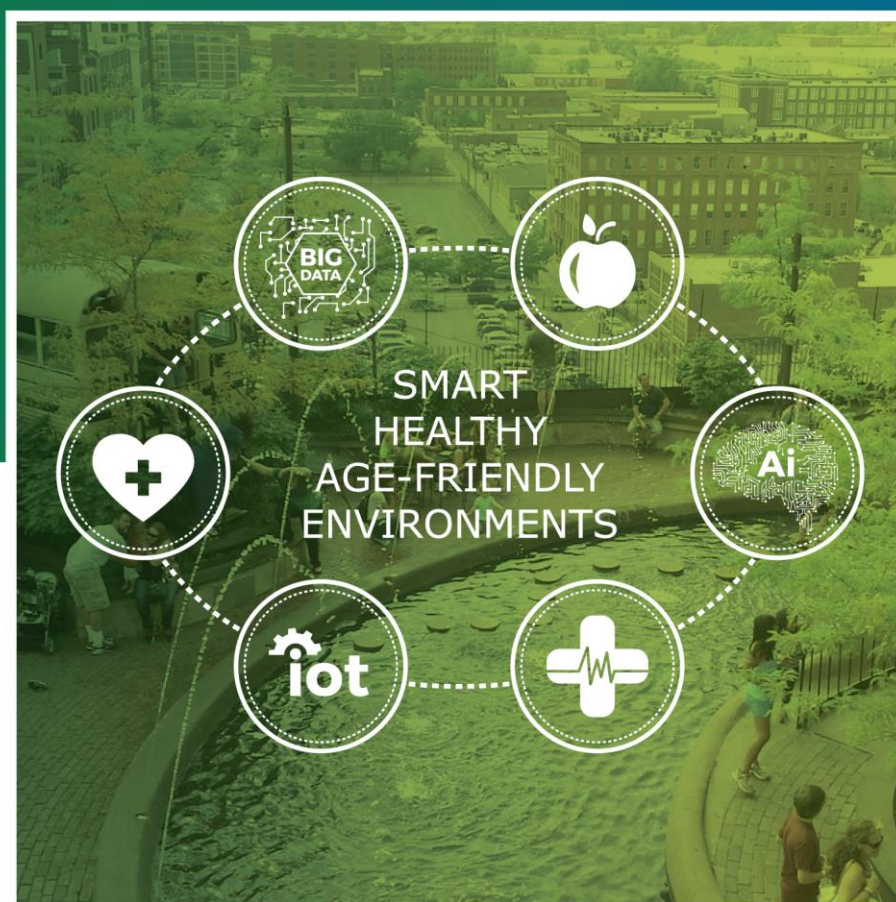


THEMATIC NETWORK 2018

SMART HEALTHY AGE-FRIENDLY ENVIRONMENTS



Caritas Diocesana
de **COIMBRA**

With the support of:



FRAMING PAPER - Table of Contents

1. Introduction.....	3
2. Background and challenges.....	4
3. Scope	6
4. Objectives.....	7
5. Questions.....	8
6. Partners	9
7. Definitions and indicators.....	11
7.1. Definitions	11
7.2. Indicators.....	15
8. Methods	17
9. Outcomes	18
10. Answering the questions	18
11. Conclusions	18
12. Recommendations → Towards the Joint Statement	18
ANNEX 1	19

1. Introduction

Caritas Coimbra and AFEdemy Ltd, are coordinating one of the three Thematic Networks for 2018, under the theme [Smart Healthy Age-Friendly Environments](#) (SHAFE), in close cooperation with main partners, such as the European Innovation Partnership on Active and Healthy Ageing (EIP-AHA), European Innovation Partnership on Smart Cities and Communities (EIP-SCC), Reference Sites Collaborative Network, European Covenant on Demographic Change, Eurocities, Utrecht University (as former partner of the European Framework for Age-Friendly Housing), European Centre Social Welfare Policy, European Health Telematics Association (EHTEL) and ECHAlliance.

The European Commission (DG SANTE) launched a call for proposals in November 2017 on strategic initiatives for a Joint Statement in 2018. Ten proposals were voted until December 7th in the [European Union Health Policy Platform](#); SHAFE was the most voted and was confirmed by the European Commission in March 2018.

The Network kick-off meeting was held on April 10th, at the European Commission premises in Brussels, and was attended by EC representatives and the coordinators of the three selected networks - besides SHAFE, also Societal Impact of Pain and Consumption of Fresh Fruits and Vegetables.

In 2018, Thematic Network SHAFE will deliver a Framing Paper and a Joint Statement on Smart Healthy Age-Friendly Environments that will be presented to the European Commission in November.

SHAFE will aim to discuss and facilitate the creation of healthy and friendly environments for all ages through the use of new technologies as a priority for 2018, towards the production of a comprehensive and participatory joint statement. In more concrete terms, it is intended to highlight the importance of People and Places in the creation of digital solutions for eHealth and mHealth, with quality but still accessible to all. Main aim is to value the Person as a central element of the whole process of digitization.

This Thematic Network aims to create a high-level political alignment of different networks and initiatives for age-related themes. It is aligned with the [EU's Health Priorities](#) in creating synergies that will increase quality, innovation and sustainability for the implementation of better health and care systems, economic growth and sustainable health, in line also with the Blueprint on Digital Transformation of Health and Care.

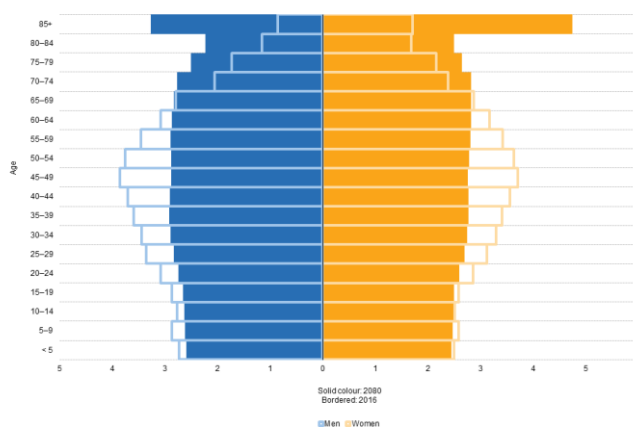
2. Background and challenges

The impact of demographic ageing within the European Union (EU) is likely to be of major significance in the coming decades. Consistently low birth rates and higher life expectancy are transforming the shape of the EU-28's age pyramid; probably the most important change will be the marked transition towards a much older population structure, a development which is already apparent in several EU Member States.

The population of the EU-28 on 1 January 2016 was estimated at 510.3 million. Young people (0 to 14 years old) made up 15.6 % of the EU-28's population (see Table 1), while persons considered to be of working age (15 to 64 years old) accounted for 65.3 % of the population. Older persons (aged 65 or over) had a 19.2 % share (an increase of 0.3 % compared with the previous year and an increase of 2.4 % compared with 10 years earlier).

According to projections from Eurostat, the overall size of the population is projected to be slightly larger by 2070 than in 2016. The EU population is projected to increase by about 3.5% between 2016 (511 million) and 2040 (at 528 million) when it will peak, to then remain stable until 2050 and to thereafter decline to 520 million in 2070 (see Table 1). While the total EU population will increase by 1.8% over 2016-70, there are wide differences in population trends across Member States, with the population increasing in half of the EU countries and falling in the other half.

POPULATION PYRAMID EU-28, 2016 and 2080
(% of the total population)



Note: 2016: estimate, provisional 2080: projections (EUROPOP2015).
Source: Eurostat (online data codes: demo_sjangroup and proj_15spms)

1

The demographic old-age dependency ratio (people aged 65 or above relative to those aged 15-64) is projected to increase significantly in the EU as a whole in the coming decades. Being about 25% in 2010, it has risen to 29.6% in 2016 and is projected to rise further, in particular up to 2050, and eventually reach 51.2% in 2070. This implies that the EU would move from four working-age people for every person aged over 65 years in 2010 to around two working-age persons over the projection horizon.

¹ http://ec.europa.eu/eurostat/statistics-explained/images/f/f5/Population_pyramids%2C_EU-28%2C_2016_and_2080_%28%25_of_the_total_population%29.png

As a result, the proportion of people of working age in the EU-28 is shrinking while the relative number of those retired is expanding. The share of older persons in the total population will increase significantly in the coming decades, as a greater proportion of the post-war baby-boom generation reaches retirement. This will, in turn, lead to an increased burden on those of working age to provide for the health and social expenditure required by the ageing population for a range of related services.

Health care services represent a high and increasing share of government spending and of total age-related expenditure. Furthermore, the ageing of the EU population may entail additional government expenditure. This makes public spending on health care an integral part of the debates on long-term sustainability of public finances.

The projection for those aged 80 years is almost triple in 2060. This trend will cause an increase of social expenses in forms of pensions, healthcare and institutional or private care. Under this scenario public spending on the elderly will be a major problem in upcoming years.

This demographic change will have considerable consequences for the EU public finances. Based on current policies, it is estimated that **public expenditure 'exclusively' age-related (pensions, health and long-term care) will increase by 4.1 percentage points of GDP between 2010 and 2060, from 25% to 29%**. Only expenditure on pensions are expected to increase from 11.3% to nearly 13% of GDP by 2060. However, there are large differences between countries, depending largely on the progress made by each country in the reform of the pension system, which confirms the need for a policy action to meet the challenges of ageing population.²

² The 2018 Ageing Report: Underlying Assumptions and Projection Methodologies
https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-underlying-assumptions-and-projection-methodologies_en

Eurostat - Population structure and ageing
http://ec.europa.eu/eurostat/statistics-explained/index.php/Population_structure_and_ageing

3. Scope

Moving age-related topics to the big umbrella themes of Health and Digital Single Market is a vital process to pursue the societal scope of a Europe prepared to provide quality of life and well-being through the whole life cycle. The revitalization of Active and Healthy Ageing initiatives (preparing post2020) will imply high-level crossover discussion between different groups, networks, DGs, EIPs and even international organisations, understanding the symbiotic interdependence of these subjects towards a Healthy and Competitive Europe. This TN intends to create a high-level policy alignment of all these networks and initiatives towards Health in Ageing subjects.

The specific aim of SHAFE will be to enhance the 2 main aspects of Age-Friendly Environments - Places and People - in the creation of eHealth and mHealth solutions - especially focused on quality and costs.

On eHealth a special emphasis will be given to its current state of the art in Europe e-support of smart homes to patients who suffer from chronic diseases and impairments - e-support like robotics, smart living environments and smart communication with formal and informal care. These smart environments need to align technological development with the building industry in terms of policy and funding, in order to make smart homes available, affordable and large-scaled in Europe. This broad adoption may be the keystone to a more efficient health care system that adds better quality for less investment.

With mHealth the focus will be on understanding and bridging the main gaps between technological development and user real needs and expectations, proposing policy measures that favour and enhance a real market entrance of new products, hoping to decrease inequalities in the access to Health services.

Alignment with European health priorities

It aligns with EU Health priorities in creating synergies that will increase quality, innovation and sustainability towards the implementation of better health and care, economic growth and sustainable health systems.

It is also proposed inline with the Blueprint on Digital Transformation of Health and Care - more specifically, with the following objectives:

1. Deployment of Innovation
2. Investment in digital innovation for health and care
3. Reach people in Europe benefitting from digital innovation on active and healthy ageing

In terms of the Digital Single Market, this proposal crosses with the following objectives:

1. Cybersecurity (especially privacy issues)
2. Boosting e-commerce
3. European data economy
4. Adapting ePrivacy rules to the new digital environment
5. Helping to develop the necessary digital skills for everyone

4. Objectives

SHAFE's main objective are the following:

- Produce a Joint Statement 2018 that summarizes a common position on Smart Healthy Age-Friendly Environments, priorities for policy making and recommendations beyond 2020, aiming at a White Paper in 2019;
- Provide a forum to exchange policy priorities and technical expertise on AFE and eHealth/mHealth;
- Inform the Commission and Member States on knowledge/expertise available in stakeholder community about challenges, solutions and best practices;
- Bring better local practices already implemented by Local and Regional Authorities that have been identified in the EIP-AHA for twinning or scaling-up and collect lessons learned towards policy drawing;
- Promote common principles as person-centred interventions, protection of personal data, standardisation, interoperability, data-enabled research, personalised medicine, quadruple helix.

5. Questions

As a departing point to the research activities, 4 questions were defined. The answers to these questions will define SHAFE's outcomes:

1. How to enhance Places and People in the use and installation of eHealth and mHealth provisions, with special focus on quality and costs?
2. What is the current state of the art in Europe of e-support at home to people with chronic disease and/or impairments?
3. How to align technological development with the building industry for smart environments with in terms of policy and funding, enhancing a more efficient health care system that may add better quality for less investment?
4. How to bridge the main gaps between technological development and user's real needs and expectations?

6. Partners

The partnership of the Thematic Network is developed in a quadruple layer-scheme, with the intention to implement a Europe-wide network of stakeholders that actually provide inputs to the Joint Statement framing paper and call to action:

1. Coordinators

Cáritas Coimbra and AFEdemy develop the overall strategy of the Thematic Network, coordinate the partnership contributions, tasks and roles, provide the dissemination materials and external communications and represent SHAFE in events and by the European Commission. They also develop the main guidelines of the framing paper and call to action and will make the final edition of the document to be presented as Joint Statement.

2. Main partners

The main partners are the European organisations and networks that supported the Thematic Network official proposal:

- European Innovation Partnership on Active and Healthy Ageing (EIP-AHA)
- European Innovation Partnership on Smart Cities and Communities (EIP-SCC)
- Reference Sites Collaborative Network
- European Covenant on Demographic Change
- Eurocities
- Utrecht University (as former partner of the European Framework for Age-Friendly Housing)
- European Centre Social Welfare Policy
- European Health Telematics Association (EHTEL)
- ECHAlliance

3. Associated partners

The associated partners are all organisations and networks that cooperate with the coordinators by delivering work, suggestions and comments on the draft Framing Paper and draft Joint Statement. The already registered partners are:

- AGE Platform Europe
- UA paal, University of Alicante, Dep. Of Computing Technology
- Friedrich-Alexander Universität Erlangen-Nürnberg
- Lega Italiana per la lotta contro i Tumori (LILT)
- BMGI Consulting
- Warsaw School of Economics, Poland
- Hamburg Ministry of Health and Consumer Protection
- TNO
- DKIT Netwell Casala
- Dublin Institute Technology - DIT
- UPM - Universidad Politécnica de Madrid, LifeSupporting Research Group
- Center for Assisted Living Technology

- CORAL Network
- Istituto Rittmeyer
- LANUA International Healthcare Consultancy
- INNJOY
- SLOVECO
- Kosice - Saca DSS, Slovakia
- Gradient
- The Bartlett Real Estate Institute UCL
- Society for Psychosocial Research and Intervention SPRIQ
- University of Deusto
- De Montfort University
- Ideable Solutions
- Quiron Salud
- Campania Reference Site
- Dublin City University
- European Health Futures Forum
- Porto4Ageing
- Smart Homes
- Lithuanian University of Health Sciences
- Universitat Rovira i Virgili - Smart Health Research Group

4. Endorsing partners

The endorsing partners are all networks or organisations that subscribe the final version of the Joint Statement that is presented to the European Commission in November 2018.

7. Definitions and indicators

7.1. Definitions

- **eHealth or Electronic-Health:** it is the health service provision supported by Information and Communication Technology-based systems, services and resources as an enabler of managing health (Lau & Kuziemsky, 2017).
- **mHealth or Mobile-Health:** it is the medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants or guidance systems, and other wireless devices, including mobile applications (lifestyle and wellbeing) that may connect to medical devices or sensors that facilitate health information or medication usage by SMS or telemedicine (eHealth Network, 2016).
- **E-support or Electronic-support:** it is the support of people with the use of electronic devices, with a special focus on robotics, smart living environment including sensors and smart communication for the purpose of formal and informal care. Smart, meaning wireless connected and accessible, that is connected to a telecommunications network like the Internet. It consists of electronic data exchange with the purpose of information, communication and subsequently supportive services or activities (Deloitte, 2015).

- **Safety:**

- Personal data safety

Security of individual health data when using health technologies, with the purpose of either storing or transmitting the data requires protection. Loss or theft of sensitive information is of great importance. Therefore, the technology should comply with data protection regulations (European Commission, 2014).

International organisation for standardisation (ISO) provides international standards, in collaboration with the WHO, about the design, deployment and maintenance of a national eHealth infrastructure. Standardisation is necessary for the safe exchange of data. See ISO/TR 14639-1, and ISO/TR 14639-2: health informatics - eHealth enterprise architecture for emerging and developing countries. (ISO, 2009)

- General Data Protection Regulation

It has been made effective in Member States since 25.05.2018, concerning data privacy and protection of personal data.

Key points:

- Applies to all organisations processing personal data of individuals in the EU, regardless of their location. Including the offering of goods and services to EU citizens and the monitor of behaviour that takes place in the EU.

- ❑ Conditions for consent have been extended, the request for consent must be given in an intelligible and easily accessible form using clear and plain language. It is no longer accepted the use of illegible terms of conditions, with legal jargon. It must also be as easy to withdraw consent as it is to give it.
- ❑ Right to access - the right for data subjects to obtain from the data controller confirmation as to whether or not personal data concerning them is being processed, where and for what purpose. Further, the controller shall provide a copy of the personal data, free of charge, in an electronic format. This change is a dramatic shift to data transparency and empowerment of data subjects.
- ❑ Right to be forgotten - it entitles the data subject to have the data controller erase his/her personal data, cease further dissemination of the data, and potentially have third parties halt processing of the data.
- ❑ Privacy by design - calls for the inclusion of data protection from the onset of the designing of systems, rather than an addition. In other words, *the controller shall implement appropriate technical and organisational measures in an effective way, in order to meet the requirements of this Regulation and protect the rights of data subjects*'. (EU GDPR Portal, 2018)

- Patient safety

It is the prevention of errors and adverse effects to patients associated with health care. (World Health Organization, 2018), either through the actions of health professionals, medicine or technological applications. To govern the patient safety and the performance of medical devices over time, regulations are in place. An instrument that is intended to be used for diagnostics and / or therapeutic purposes, could be classified as a medical device. Also, in vitro diagnostics (bodily sample tests) intended to provide medical information need a classification. These classifications come together with regulations that protect patients from any malfunctioning devices that could lead to dangerous situations (Medtech Europe, 2018).

- **Places and People:** referring to both the physical and social environment that contribute to an age-friendly environment, in any way possible. In relation of the individual interaction with the social, physical & technological environments (eHealth Network, 2016).
- **Satisfactory:** There are different point of views about what's satisfactory: "High satisfaction ratings do not necessarily mean that patients have had good experiences in relation to the service; rather, expressions of satisfaction may more often reflect attitudes such as "they are doing the best that they can", or "well, it's not really their job to do..." (Williams, Coyle & Healy, 1998). According to the study from Borg et al. some of the most important factors for life satisfaction among older people with reduced self-care capacity are: overall health, enough money in relation to needs, ability to perform activities of daily living, and being involved in social life (avoiding loneliness and feeling worried. (Borg C., Hallberg I. R., Blomqvist K., 2006). The outcome of the health intervention should meet the needs and expectations of an individual.

- **Home-based independent living:** Is the daily demonstration of a self-regulatory capacity, through the combination of various environmental and individual factors that allow (disabled) people to have control over their own lives. Including the opportunity to make real choices and decisions regarding where to live, with whom and how to live. It requires accessible built environment, transport, and information. Also, the availability of technical aids, access to personal assistance, and / or community-based services regardless of gender, age or level of support that is needed (European Network of Independent Living, 2018).
- **Age-Friendly Environments:** environments that foster health, well-being and participation of people as they age. They promote health and prevent or delay the onset of disease and functional decline. It is a people-centred service, by making people's surrounding more accessible, equitable, inclusive, safe, secure, and supportive. They are divided in eight domains. (World Health Organisation, 2017)
- **Chronic diseases:** refers to the long duration, generally more than three months, and generally slow progression of a disease, with four main types: cardiovascular disease (heart and blood pressure problems), cancer, chronic respiratory disease (like asthma and COPD) and diabetes, neurodegenerative disease, like dementia and Parkinson (adapted, World Health Organisation, 2016).
- **Chronic condition:** including both mental and physical conditions.

Costs:

These direct costs refer to the physical health resources required to utilise a specific eHealth or mHealth service. The direct costs can be subdivided in different categories like purchase, implementation, maintenance, fees, and environmental adaptations.

- Health / Social care perspective

Upfront are the purchase costs. This could be a one-time investment or a monthly or yearly leasing cost. Implementation costs can include training costs of staff or adjusting IT systems. Maintenance could be provided via a monthly subscription which can also include future updates and improved versions. It could also be included in the warranty, for a limited amount of time. Finally, maintenance could include internal or external IT staff costs.

- User perspective

Purchase costs could be directed to the patient or (partly) directed to the health insurance company. Which can include a one-time investment or a monthly or yearly leasing cost, with or without ownership. Implementation costs can include user training costs, and adaptation time for the service to be fully effective with or without the help of the health professional. Maintenance, depending on ownership, could be provided via subscription service, warranty or IT staff costs.

In both situations (health care and user perspective), other fees may include the assistance of relatives or social services, extra equipment or specialised staff. Environmental adaptation could be required, like the expansion of the electricity or telecommunication network or the adaptation of the building itself (Bergmo, 2015).

- **Benefits:** Social, economic and environmental benefits from using eHealth and mHealth.
- **Quality:**
 - Life quality: the effect on the life expectancy, quality of life or both. It can be determined using ‘quality adjusted life years’, which reflects the amount of life years gained in combination with quality of life (Dutch National Health Care Institute, 2016).
 - Technical quality: meaning that the solution does not have any technicalities or malfunctions, and that it is properly tested in pilot studies. It implies there is a high level of accuracy and technical reliability. In the case of medical devices, it also implies that it conforms with EU regulation and ISO standardisation.
 - Quality of service delivery: concerns the personal user experience (PUX). A PUX-enabled system relates to the accommodation, involvement and empowerment of the user with the technology. (EIP AHA C2 WG, 2016).
- **Quality of life:** is the individual perception of their position in life in the context of the culture and value systems in which they live in, and in relation to their goals (McNally, 2009).
- **End-users:**
 - Primary end-user is the person who actually is using the product or service, a single individual, “the well-being person”. This group directly benefits by increased quality of life;
 - Secondary end-users are persons or organisations directly being in contact with a primary end-user, such as formal and informal care persons, family members, friends, neighbours, care organisations and their representatives. This group benefits directly when using the products and services (at a primary end user’s home or remote) and indirectly when the care needs of primary end-users are reduced;
 - Tertiary end-users are such institutions and private or public organisations that are not directly in contact with the technical products and services, but who somehow contribute in organising, paying or enabling them. This group includes the public-sector service organisers, social security systems, insurance companies. Common to these is that their benefit comes from increased efficiency and effectiveness which result in saving expenses or by not having to increase expenses in the mid and long term. (AAL 2018).

7.2. Indicators

With the definitions collection, it is possible to collect and highlight a number of possible indicators that may respond to the main goals of eHealth or mHealth technology: enhancing Age-Friendly environments or independent living for people with chronic diseases or impairments.

Below some are listed:

- **Quality**
 - Shows high technical quality: complies to EU regulations and ISO standardisation, shown by an up to date certification.
 - Measures the effect on life quality in terms of life expectancy, quality of life or activities of daily living.
 - Accommodates high quality service delivery via:
 - System adoption and modularity to answer personal wishes, needs and preferences in a specific context of use as much as possible.
 - User-driven design, high involvement of users in the designing, developing, testing, and redesign phases.
 - Significant contribution to users' empowerment, by supporting and training the individual user to better understand and express their own current and future wishes, needs and preferences.

- **Costs**
 - Societal / system perspective:
 - Amount of public / private funding provided by insurance companies, national health services, municipalities, local or regional authorities.
 - Effects on healthcare premium
 - Effect on taxes
 - Social benefits

 - Healthcare perspective:
 - Purchase costs and options
 - Implementation costs, procedures or protocols
 - Maintenance or renting options and costs
 - Possible other fees
 - Environmental requirements

- User perspective:
 - Purchase costs and healthcare options, either by public funding or insurance/health system reimbursement
 - Implementation costs, user knowledge requirements, adoption time
 - Depending on ownership, maintenance costs via subscription or staff costs
 - Other fees, extra professional costs or equipment costs
 - Environmental requirements
- Extra
 - eHealth or mHealth solutions compared to regular health services or treatments for people with chronic diseases or impairments.
 - Description of development process and the contribution of technology push and demand pull to that development.
 - Solutions tested in an empirical study or clinical trial for chronic diseases or impairments, preferably randomized, either as single study or collectively in a systematic review with or without meta-analyses.

8. Methods

The research activities concerning the previous sections are now being executed, and the first results will be available on mid-June and presented during the webinar of June 19th.

Research is being executed by performing:

- Desk research using dedicated search terms in databases such as: Google Scholar, PubMed, Cochrane, Scopus, Worldcat, PiCarta, Web of Science, ACM Digital Library, NARCIS, OATD, DOAJ, BASE, CORE, Paperity, AAL-database, CORDIS and Innoradar.eu.
Including search in grey literature in EU countries, using search terms in own languages by associated partners.
- Interviews with several opinion leaders on the topics related to eHealth, mHealth, active ageing, Age-Friendly Environments, chronic diseases and impairments or living independently, with the help from associated partners (documents related to the interview available in annex 1)
- Survey on Smart Healthy Age-Friendly Environments, published online in EU Survey website and broadly disseminated through the networks of the Coordinators and Main partners.
SHAFE designed the survey with a common framework but adapted the questions to 11 specific target groups:
 - [Person \(or partner, family, informal care\) with limiting chronic disease\(s\) and/or physical and/or sensory impairment\(s\)](#)
 - [ICT - development, provision, installation](#)
 - [Construction and building](#)
 - [Healthcare/social care](#)
 - [Citizens representation/advocacy](#)
 - [Public authority \(local, regional, national, European administration\)](#)
 - [Financing/investment](#)
 - [Insurance](#)
 - [Regulation \(standards, norms, codes of practice\)](#)
 - [Research \(universities, applied science university, research centers\)](#)
 - [Architecture, urban planning](#)

The end of the research period is expected to be by June 30th, although some extensions, namely on the interview results integration will be expected in mid-July.

Besides research, activities of discussions, comment and support on the draft Joint Statement and research results are expected through events and dissemination activities, namely:

- EIP-AHA Action Group meeting in Manchester (2-3 July 2018), during which SHAFE will have a 30 minutes slot to be presented and interact with EIP and Eurocities members.
- AAL Forum Silver Week Bilbao 2018 (24-26 September) - SHAFE had a workshop approved and will present and discuss results
- Online consultation through SHAFE's webpage - <https://www.caritascoimbra.pt/en/shafe/>
- Webinar in September - to be confirmed

9. Outcomes

The Thematic Network main conclusions shall concern the role of Places and People in the use and uptake of eHealth and mHealth solutions, with special focus on quality and costs.

Although still under discussion, especially because it shall be addressed during the webinar of June 19th, the main outcomes of SHAFE will most probably be grouped in 4 main areas:

1. Well-being and Quality of Life
 - Social contacts (digital, physical)
 - Adaptation and accommodation (accessibility, aids, lifestyle)
 - Safety
 - ...
2. Health
 - Prevention (lifestyle, falls, physical activity, mobility)
 - Cure and therapy (telehealth, telemonitoring, physical activity therapy, training)
 - ...
3. Independent living
 - Physical and social environments
 - Community support and provisions
 - ...
4. Efficiency and efficacy
 - ...

Sections 10 to 12 shall be addressed in the next phase of the works.

10. Answering the questions

11. Conclusions

12. Recommendations → Towards the Joint Statement

ANNEX 1

INTERVIEW DOCUMENTS

Thank you for your interest and willingness to actively collaborate in this interview as an opinion leader, towards the creation of a Joint Statement by November 2018, through the Thematic Network Smart Healthy Age Friendly Environments (TN SHAFE).

The specific aim of SHAFE is to enhance two main aspects of Age-Friendly Environments – Places and People – in the creation of eHealth and mHealth solutions - especially focused on quality and costs. These smart environments need to align technological development with the building industry in terms of policy and funding, in order to make smart homes available, affordable and large-scaled in Europe. This broad adoption may be the keystone to a more efficient health care system that adds better quality for less investment. You may consult all the details at: <https://www.caritascoimbra.pt/en/shafe/what-is-shafe/>

[Cáritas Coimbra](#) and [AFEdemy](#) are leading this TN and expect to collect a high-policy vision on this theme, so we will propose you to relate Digitalisation, Health and Age-Friendly Environments with relevant strategic documents of the European Commission and World Health Organization.

Your views and insight will be essential to frame the final content of the Joint Statement.

1 – European Commission Health priorities give emphasis on creating synergies that will increase quality, innovation and sustainability towards the implementation of better health and care, economic growth and sustainable health systems. But how to accomplish it in Europe and how do we achieve better quality for less investment?

The European Commission's role is to support the efforts of EU countries to protect and improve the health of their citizens and to ensure the accessibility, effectiveness and resilience of their health systems. This is done through various means, including by:

- Proposing legislation
- Providing financial support
- Coordinating and facilitating the exchange of best practices between EU countries and health experts
- Health promotion activities.

In your opinion, how shall the European Commission support EU countries on public health aiming at better quality for less investment? Could you select what you consider to be the 3 strategic actions that could lead to these outcomes?

2 - The Blueprint Digital Transformation of Health and Care for the Ageing Society states that: "Given the diversity of initiatives at EU, regional, national and local level and by industry, that relate to the digital transformation of professional and informal health and social care, the Blueprint will "connect the dots" between policy, health governance and R&I, between demand and supply, across health, social care and wellbeing, across technology, solutions and services platform (e.g. data). It will support the development of a broader and more compelling political vision on digital innovation for ageing well and the silver economy that will strengthen the societal dimension of the Digital Single Market and the digital society portfolio of the European Commission."

In your opinion, has this objective already been achieved with policy and concrete measures?

If yes, can you give us 1-3 examples on eHealth or mHealth?

If not, what are the main issues or initiatives you believe should be put into action to have a true implementation of a broader political vision for ageing well?

3 – The World Health Organization defines Age-friendly environments as those that foster health and well-being and the participation of people as they age. They are accessible, equitable, inclusive, safe and secure, and supportive. They promote health and prevent or delay the onset of disease and functional decline. They provide people-centered services and support to enable recovery or to compensate for the loss of function so that people can continue to do the things that are important to them.

Do you know a true AFE? Where and why?

What are the main features you believe a Smart Healthy Age-Friendly Environment should include regarding People (as in people-centered) and Places (as in building environments) so it could integrate digitalisation in the best way possible?

4 - Sustainable Development Goal number 3 aims to “Ensure healthy lives and promote well-being for all at all ages”.

How can we progress in terms of policy, both from EU and as from Member States, to implement Smart Healthy Age-Friendly Environments?

GUIDELINES TO THE INTERVIEWER

- Start by contacting your participant by email and be sure to have the consent form signed before making the interview.
- Inform the participant that he may ask all questions necessary and place him/her in contact with SHAFE coordinators if necessary.
- Inform on the estimate time of the interview – between 30 to 45 minutes.
- Ask permission to record the interview and keep the audio recording in your possession until the end of the TN (November 2018).
- Make a summary (**not more than 1 page**) of the interview (in English or native language, as previously agreed with the participant) in the period of 1 week maximum after the interview.
- Send the summary to the participant for acceptance or revision, for maximum a period of 10 days.
- Send the consent form and the summary of the interview to carinadantas@caritascoimbra.pt and willeke@afedemy.eu in the maximum period of 30 days after engagement as interviewer.

A Successful Interviewer is:

1. *Knowledgeable*: is thoroughly familiar with the focus of the interview.
2. *Structuring*: gives purpose for interview; rounds it off.
3. *Clear*: asks simple, easy, short questions; no jargon.
4. *Gentle*: lets people finish; gives them time to think; tolerates pauses.
5. *Sensitive*: listens attentively to what is said and how it is said; is empathetic.
6. *Open*: responds to what is important to interviewee and is flexible.
7. *Steering*: knows what he/she wants to find out.
8. *Critical*: is prepared to challenge what is said, for example, dealing with inconsistencies.
9. *Remembering*: relates what is said to what has previously been said.
10. *Interpreting*: clarifies and extends meanings of interviewees' statements, if needed.
11. *Balanced*: does not talk too much or too little.
12. *Ethically sensitive*: ensure the interviewee appreciates its purposes and legal compliance.

The Interview as an Interpersonal Encounter – use ORCS:

- Use **O**pen questions, as opposed to closed questions which you can answer with 'yes' or 'no'.
- **R**eflect, to what you see or hear, 'It seems you find this important, is that true?', 'It seems you put emphasis on ..., may I ask why?'
- **C**onfirm, 'so I can state that your opinion on this is...', which can be used to clarify.
- **S**ummarize, can be used during the interview or at the end, not only to make an overview for yourself but also for the person being interviewed. To check if you have everything. Then you can always end with 'Is there anything else you would like to add, or did I miss anything?'

Also:

- ☑ Use social skills of empathy, warmth, attentiveness, and humour.
- ☑ Do not use judgmental attitudes, neither of shock or discomfort.
- ☑ Never answer a question for the respondent.
- ☑ Be completely engaged with the respondent, keeping track of the questions one needs to ask.
- ☑ Use every active listening technique at your disposal:
 - o Repeating back or saying, "That is really interesting."
- ☑ Don't be afraid of silence; you can use it to prod the respondent to reflect and amplify an answer
- ☑ Don't follow the interview guide—follow the respondent. Follow up new information that he or she brings up - BUT without losing sense of where you are in the interview.

Thanks for your work!

CONSENT FORM

Smart Healthy Age Friendly Environments (TN SHAFE) is a Thematic Network approved by the European Commission, towards the creation of a Joint Statement by November 2018.

The specific aim of SHAFE is to enhance two main aspects of Age-Friendly Environments – Places and People – in the creation of eHealth and mHealth solutions - especially focused on quality and costs. These smart environments need to align technological development with the building industry in terms of policy and funding, in order to make smart homes available, affordable and large-scaled in Europe. This broad adoption may be the keystone to a more efficient health care system that adds better quality for less investment. You may consult all the details at: <https://www.caritascoimbra.pt/en/shafe/what-is-shafe/>

[Cáritas Coimbra](#) (Carina Dantas) and [AFEdemy](#) (Willeke van Staalduinen) are leading this Thematic Network and, along with the network partners, will collect different stakeholders opinions and visions on the theme, in order to produce the Joint Statement. These opinions will be collected by personal interviews and an online survey. The answers collected will help our investigators understand main trends, difficulties and best practices around Europe, although SHAFE cannot assure that all the opinions collected will be represented in the final document. You may contact carinadantas@caritascoimbra.pt or willeke@afedemy.eu for any information.

ID		NAME		SURNAME	
ADDRESS					
EMAIL		PHONE			

Please tick all the boxes you fill appropriate:

<input type="checkbox"/>	I hereby declare voluntarily that I'm willing to take part in SHAFE's interview
<input type="checkbox"/>	I declare that I have been properly informed about the Thematic Network SHAFE and I understand the explanation that was given to me, either written and verbally.
<input type="checkbox"/>	I was given proper time to reflect on the participation proposal; I had the opportunity to make the necessary questions and I received satisfactory answers.
<input type="checkbox"/>	I authorize audio/video recordings which will only be used for analyzing the data from the interview and further technical development.
<input type="checkbox"/>	I know that the data from the interview will be analyzed and summarized by my interviewer; I will have the right to review this summary before it is shared with the research team for integration in the Joint Statement document.
<input type="checkbox"/>	I was informed that the data will only be stored until the end of the Thematic Network (2018), after which it will be deleted and that I can access or change/delete it at any time.
<input type="checkbox"/>	I understand I won't be quoted and my name will only be displayed with my express consent.
<input type="checkbox"/>	I understand I can withdraw my participation at any time, without having to give a reason and will have no penalties because of it.

Please, select ONLY ONE option:

<input type="checkbox"/>	I would like my name to be used as a participant in SHAFE's interviews and I understand it can be used in different reports and publications within the scope of this project.
<input type="checkbox"/>	I do not allow my name to be used

PARTICIPANT

Name:

Date:

Signature:

RESEARCHER

Name:

Date:

Signature:

TO KEEP YOU WELL INFORMED ON CURRENT LEGISLATION

How Informed Consent is described in the General Data Protection Regulation

http://ec.europa.eu/justice/data-protection/reform/files/regulation_oj_en.pdf

Article 4. Definitions

(11) 'consent' of the data subject means any freely given, specific, informed and unambiguous indication of the data subject's wishes by which he or she, by a statement or by a clear affirmative action, signifies agreement to the processing of personal data relating to him or her;

Article 6. Lawfulness of processing

1. Processing shall be lawful only if and to the extent that at least one of the following applies:

(a) the data subject has given consent to the processing of his or her personal data for one or more specific purposes;

Article 7. Conditions for consent

1. Where processing is based on consent, the controller shall be able to demonstrate that the data subject has consented to processing of his or her personal data.

2. If the data subject's consent is given in the context of a written declaration which also concerns other matters, the request for consent shall be presented in a manner which is clearly distinguishable from the other matters, in an intelligible and easily accessible form, using clear and plain language. Any part of such a declaration which constitutes an infringement of this Regulation shall not be binding.

3. The data subject shall have the right to withdraw his or her consent at any time. The withdrawal of consent shall not affect the lawfulness of processing based on consent before its withdrawal. Prior to giving consent, the data subject shall be informed thereof. It shall be as easy to withdraw as to give consent.

4. When assessing whether consent is freely given, utmost account shall be taken of whether, inter alia, the performance of a contract, including the provision of a service, is conditional on consent to the processing of personal data that is not necessary for the performance of that contract.