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Europe's health economies exchange

HCN Report 2

How the health sector can contribute to regional development:

the role of affordable capital investment

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North East South West INTERREG IIIC

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The European Health Property Network (www.euhpn.org) is a non-profit organisation that brings together professionals from governmental departments and research centres, with a common interest in health property: capital planners, strategic asset planning specialists, architects, and urban planners.

The opinions and recommendations contained in this report represent the collective view of Health ClusterNET partners and the European Health Property Network. They should not be taken to represent the views of individual partner organisations, ONE North East (the lead partner) or the Interreg IIIC Programme.

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Executive summary

Introduction

The purpose of this report is to present the knowledge and experiences shared by partners that explored how the health sector can contribute to regional development through its capital investment activities.

Who should read this report

- For **health service decision makers** this agenda supports the development of the corporate social responsibility role of their organisations and also shows their commitment to the health inequalities and health improvement agenda.

- For local health organisations such as **acute hospitals and primary care organisations,** this agenda helps show commitment to joint working with local government and other partnerships to develop fully engaged communities at both individual and organisational levels.

- For **SMEs**, the adoption of this agenda in a region or community, offers a clear basis for lobbying for simpler, more transparent procurement processes with less bureaucracy and the development of an enterprise aware culture in health service organisations.

- For relevant **directorates within the European Commission** (DG Enterprise, DG Research, DG Regional Policy, DG Health & Consumer Protection), this agenda offers a platform for an approach that cuts across individual DG competencies in order to achieve European added value.

Key messages

Within partner regions, spending by health services on staff, goods & services, buildings, IT and equipment ranges from 6 to 9% of regional GDP. This is a significant level of economic activity. But it is not optimised to positively contribute to regional development agendas. Nor is it used to maximise the population health benefit of health care expenditure.

If capital investment in health care is to contribute to regional development then our workshop, case studies and policy forum identify a number of key messages:

- Where regions have been given responsibility for decisions in any of the basic elements of health care - public health, primary care, rehabilitation services, acute hospitals, mental health – it is vital that they also have the autonomy to plan, finance, and implement solutions to health care needs.
- Governments are increasingly looking to sources of finance other than central treasury funds earmarked for health care, whether this involves the private sector, not-for-profit organisations, or a re-appraisal of how other public funds can be put to use. Regions have to be aware of the shifting ground, and prepared, through staff with relevant competencies, to propose solutions that will benefit their local economies.
- Regional health organisations should be familiar with, and able to speak, the language of the Treasury/Finance Ministry, to show that the benefits of rational planning of health infrastructure extend far beyond the immediate needs of treating patients. There may be a case here for education and training of senior policy makers and planners. The experience of PFI and LIFT in the UK has shown that best value for communities is obtained when local personnel have the significant knowledge and experience of new capital models.
- Although it is tempting to solve only today's problems (and sometimes only yesterday's), there is widespread recognition that this does not amount to an effective application of capital investment. Health care buildings should be built, renovated, or reconfigured to meet future needs – as far as this is possible. In the interests of sustainability, is it possible to consider joint capital investment projects with other sectors in order to reduce the overall capital burden?
- Regions with low population density, or with widely dispersed communities, may find ICT solutions more cost effective that the traditional hub and spoke hospital model.

- By focusing too closely on capital, and in how it interacts with economic development, we run a risk of losing sight of the social, human values bound up in health care buildings. This echoes one of the themes of the Lisbon Agenda: health care is about people. Regional authorities should bear in mind that the services they are responsible for, or at least have influence over, need to reflect the aspirations and needs of local populations. This is especially true in the case of health care facilities that have become part of the fabric of a locality, such as Brandenburg's Municipal Hospital.
- Master planning is increasingly emerging as an element of regional development that promotes an integrated approach to urban regeneration, stimulation of local economies, private care and the positioning of hospitals. It provides a clear vision of what people are collectively aiming for. The question, however, is whether health is ready to become part of the regional development agenda, especially in the new EU member states and the pre-accession countries.

Case study examples

Etela Suomi – Coxa Hospital.

Capital funding for southern Finland's health service comes in the main from central government, with regional and municipal bodies taking responsibility for organising health and social services. Current thinking on capital investment focuses on the issues of an ageing population, the merits of building new health premises, reducing efficiency differences in primary care units, and outsourcing some services.

The Coxa Hospital is a striking example of a Design-Build-Finance-Operate PPP project. Initiated by physicians at Tampere University Hospital who wanted to improve the outcomes of patients undergoing implant joint replacement surgery, the Coxa provides Pirkanmaa hospital district with endoprosthetic surgery, and the whole country with treatment of some of the most difficult cases. It is owned by a mixture of public and private shareholders, and is an notable instance of a PPP in practice. To date, the Coxa Hospital has succeeded in providing better clinical outcomes for patients and greater productivity. The model used by the Coxa is part of a growth strategy which will see a further 3-5 joint replacement hospitals being built. The project has emphasised at least two features of PPP: the need to create a shared vision between public bodies and private companies, and the emerging possibility that specialised units can take some of the burden off both the primary and acute sectors.

Electonic Patient Record – Pais Vasco

The Basque Country has fiscal autonomy over capital investment decisions in health care. Accessibility, patient choice, and decentralised services are among the region's current priorities, along with a need to promote evidence-based capital investment decisions. A key element in achieving these aims has been the creation of an IT infrastructure based on the electronic patient record (EPR). Citizens are equipped with health smart cards, and hospitals and clinics are supplied with the necessary hardware and software to make data collection and analysis a reality.

The EPR has been designed to meet current and future Europe-wide requirements, but with the proviso that it should be possible for local, regional suppliers to offer innovative, linked products. Developed at regional level, the EPR is seen as an essential tool in advancing the cause of public health measures and in ensuring that capital is wisely invested to the benefit of all citizens.

St. Helens, Knowsley, Halton and Warrington LIFT

The UK's Local Initiative Finance Trust (LIFT) is an arrangement by which public and private bodies share in a strategic partnership to improve the provision of primary care premises. This has to do with more that just the quality of buildings (although this is an important consideration), but also with addressing health inequalities, a shift from secondary to primary care, and regeneration of urban environments.

The St. Helens, Knowsley, Halton and Warrington LIFT programme is one of the most complex examples to date, worth around €180m over 20 years. It will see the construction of 20 new primary care facilities, integration with social, community and leisure services, and emphasis on the regeneration of

the most deprived communities. Hundreds of jobs are forecast to be as a result of this partnership, and new space will be provided not just for health care, but also for local businesses and other organisations.

Health sector capital investment in Pomurje Region, Slovenia

Slovenia's health system operates through a mix of public and private providers, and is funded via compulsory and voluntary insurance funds. Political and administrative decisions are taken on both national and municipal levels. Pomurje Region recently carried out an analysis of health care construction and equipment commissions placed during 2004, which revealed that, while 90% of construction commissions went to local firms, only 52% of equipment purchases were awarded to local suppliers. The reasons for this discrepancy are varied, but it has been suggested that local construction companies are better able to market their expertise and to join forces to compete with international organisations.

The key lesson here – apart from what it means to the equipment supply sector – is that this kind of research can be invaluable to regional health and capital planners, if they are to understand the effects of capital investment decisions on local economies, and if they truly wish to promote regional development.

The Graz Policy Agenda

Policy recommendations for health sector capital investment are contained in *The Graz Agenda* available at www.healthclusternet.org and included in the final section of this report. This Agenda provides a practical response to the 'health equals wealth' challenge first set out at the European Health Policy Forum in October 2003.

The aims of the agenda are to:

1. To enable regional health systems to more positively engage with regional development through capital investment policies, planning and actions that contribute to affordable, flexible, possibly intersectoral and dynamic health care infrastructure and IT-based services.

2. To redefine 'value for money' (or national equivalent term[1]) to include outcomes that connect health sector capital investment to the achievement of intersectoral regional development priorities.

3. To enable European regional health systems to have flexible options regarding approaches to capital investment that ensure capital investment is affordable and capable of allowing health care to adapt to changes in service priorities reflecting local health and well being needs.

The Graz Agenda puts forward a range of early and longer-term capital investment policy actions for localities, regions, national governments and the European Commission. The recommendations are organised into three regional group categories that reflect progress within partner regions in terms of economic performance, Lisbon orientation and engagement of regional health systems with regional development. The Agenda has been shaped by the practical experiences, evidence and insights generated by regions from across the EU and beyond who are partners in HealthClusterNET.

[1] Other words used across partner regions that are equivalent to 'value for money' are: best value, total economic benefit, best offer.

Contents

EXECUTIVE SUMMARY **3**

Introduction *3*
Who should read this report *3*
Key messages *3*
Case study examples *4*
St. Helens, Knowsley, Halton and Warrington LIFT *4*
Health sector capital investment in Pomurje Region, Slovenia *5*
The Graz Policy Agenda *5*

CONTENTS **6**

1 INTRODUCTION **8**

2 DEFINITIONS **9**

3 THE HEALTH SECTOR AND CAPITAL INVESTMENT **12**

4 LESSONS: PARTNER CASE STUDIES AND MASTER CLASSES **15**

CASE STUDIES 15
Capital investment in hospital care in Brandenburg *15*
Healthcare capital investment in North East England *16*
Capital Investment in the South Transdanubia Region *17*
Heath sector capital investment in Pais Vasco *18*
Enabling capital investments In health care in Etela Suomi *19*
St. Helens, Knowsley, Halton and Warrington LIFT *20*
Capital Investment in Alentejo *21*
Health sector capital investment in Harghita County, Romania *21*
Health sector capital investment in Pomurje Region, Slovenia *22*
Lifecycle Partnership Model: a new approach to ensure efficient public health care in Steiermark *23*
Capital Investment in the Health Care Sector in Malopolska Region *24*
Health Issues in Sjuhärad/Västra Götaland, and Sweden *26*
Transition in the health care sector in Basilicata, Italy *27*
MASTER CLASSES 27
The Martini Hospital Health Design *27*
The UK and Scottish PFI experience (Arup International and Scottish Executive Health Dept.) *28*

5 ECONOMIC AND SOCIAL ISSUES IN CAPITAL INVESTMENT **30**

PLENARY: CAPITAL INVESTMENTS IN HEALTH CARE – EUROPEAN PERSPECTIVES AND TRENDS 30

PLENARY: THE FUTURE CHALLENGES FOR CAPITAL INVESTMENT, REGIONAL PLANNING, HEALTHCARE PRIORITIES AND VALUES 31

6 CONNECTING CAPITAL INVESTMENT TO REGIONAL ECONOMIES 33

THE NEED FOR BETTER DECISION-MAKING TOOLKITS 35

7 TOWARDS A POLICY AGENDA FOR CAPITAL INVESTMENT 39

ENSURING THE RELEVANCE OF A POLICY AGENDA 39
PURPOSE OF THE AGENDA 40
AGENDA AIMS 40
FOCUSING THE GRAZ AGENDA 41
POLICY RECOMMENDATIONS 41
Group A: Economic potential, weak Lisbon orientation, health sector starting engagement 42
Group B: Less clear economic trend, high Lisbon orientation, health sector engaged 43
Group C: Strong economic trend, high Lisbon orientation, health sector engaged 44
KEY DEVELOPMENTS FOR ALL REGIONS 45
OVERALL BENEFITS 46

1 Introduction

1.1 This report examines how, and to what extent, capital investment in health care infrastructure can affect economies and health outcomes at a regional level. It draws on the knowledge and experiences exchanged between HealthClusterNET partners at a three-day workshop in Krakow (Krakow 2006) and a policy forum in Graz (June 2006), together with further material and analysis supplied by the European Health Property Network (EuHPN – www.euhpn.org) and a number of invited commentators. The report is also to be found on the HealthClusterNET website (www.healthclusternet.org) to provide an opportunity for wider consultation on its content and recommendations.

1.2 As described by INTERREG IIIC, "HealthClusterNET is intended as a lasting interregional network of 13 regions from across the EU that will build and share knowledge and experience among regional policy makers in order to find out how they can more effectively engage their health sector within the regional development agenda". The four themes that are identified by partners as key interfaces between the health sector and regional policies on social cohesion, and economic competitiveness are: employment, procurement, capital investment, and innovation.

1.3 The purpose of knowledge sharing and development through each of these four themes is to focus on **how** the health sector can contribute to regional development and **how** other regional stakeholders can support this engagement.

1.4 In summary, the purpose of this report is to show how the health sector can contribute to the dynamism of regional and local economies and communities. The capital investment component of the HealthClusterNET programme has therefore sought to encourage:

- Understanding of the linkages between capital investment, healthcare infrastructure, and regional development.
- Promotion of examples of best practice in the interdependent relationships between healthcare infrastructure investment and employment, education, clinical practice, and sustainable economic development.
- Development of a toolkit to enable healthcare planners and managers to influence policy makers at regional, national, and European level, so that capital investment in healthcare assets becomes a central element in master planning and regional development policy.

2 Definitions[2]

2.1 **Capital investment:** Money used by an organisation to buy assets (buildings, equipment, land, etc). In the case of health care, capital investment generally refers to funds invested in hospitals, clinics, surgeries, high-tech equipment and IT systems. Capital investment is usually thought of in the long-term, and therefore requires careful planning and some acceptance and understanding of the risks involved.

2.2 **Capital models:** Different ways of obtaining and using money to pay for capital investments. For example, a government can raise taxes to pay for new hospitals, or borrow on the international market. Alternatively, government can choose to ask the private sector to assume some or all of the risk of this kind of investment. In this case the model is essentially that of repayment over a period of time. The amount of capital risk can be varied according to the balance of public and private involvement. The kind of capital model in place can greatly affect what is possible, in the short to medium perspectives, in terms of investment in assets.

2.3 **Capital planning:** The process of deciding how to apply money to the needs of a health care system, in terms of its fixed assets. Such planning may take place at a local, regional, national, or even cross-border level. Often the plans produced at different levels need to inform each other. Different models of capital planning are in use, such as:

- Top-down (governmental): where a Ministry makes the bulk of the decisions about how capital will be spent, and local officials are only involved in implementation.
- Bottom-up (regional, local): where local experts make capital planning decisions and then negotiate with central government over the available money.
- Market: where planning is left to a mix of suppliers, in competition for available 'customers'.

2.4 **Health care facilities:** Usually refers to hospitals, clinics, surgeries. However, this term can also refer to the physical parts of a healthcare system that are not normally seen by patients, so we could include administrative buildings, staff training centres, spaces for storing supplies, waste disposal units for example.

2.5 **Health care policy:** The overall structure, in terms of legislation, directives and recommendations, which sets the course for health care provision. Such policy may be set at international or national level, with implementation left to local organisations. Alternatively,

[2] Some of these definitions are adapted from Sacks J (2005) *Public Spending for Public Benefit*, New Economics Foundation – a HealthClusterNET supported publication.

government may choose to devolve policy making powers to regional or local government and therefore act in a more advisory role.

2.6 **Health care system:** The totality of means, in a society, by which health care is provided. Some definitions see this phrase as encompassing only the assets and services available for health care; other definitions put more emphasis on human resources, technology, or economics. In very general terms, most health care systems include a large public element, with some private or charitable (not-for-profit) involvement as well.

2.7 **Investment criteria:** The rules that govern where and how money should be invested (spent). In the health care setting, these criteria will include, amongst many other factors, consideration of whether it is better:

- To invest in primary care (rather than secondary care)
- To work towards prevention of disease (rather than cure)
- To encourage public education (rather than expert intervention)
- To entrust money to a 3rd party (private or charitable) organisation, rather than a state-run enterprise
- To rent buildings and services (rather than owning them).

2.8 **Local:** What is local? It is a question that troubles anyone dealing with regeneration. We all define local for ourselves. The easiest answer is whatever you consider to be your local area is your local area. For the case studies in this paper, local refers to their region and the communities within that region. We do not seek to challenge what truly constitutes local or not, but rather how to let people use whatever definition inspires them to take action.

2.9 **Master plan:** A long-term, comprehensive programme for the future provision of health care services in a particular area. As a very brief overview, such a plan will include:

- Demographic and epidemiological data
- What services will be needed
- Which organisations will provide those services
- What resources (buildings, technology, people) will be required
- How the services will be paid for
- How different elements of the service will integrate with each other
- How the proposed health care system will support other policy objectives, such as economic growth.

2.10 **Public Private Parnerships (PPP):** Public private partnerships involve some element of input from private (commercial) organisations. Essentially, some elements of a service that was originally run solely by the public sector are given over to a partnership between government and the private sector. This is not the same as privatisation, in that government (national, regional, or local) still has some involvement in running the service. There are different 'flavours' of PPP, which depend on the mix of public/private involvement.

2.11 **Regeneration** is a short word for 'improving a community'. Regeneration literally refers to the process of giving new life or energy and is commonly used with reference to disadvantaged communities. You may see words like economic development, revitalisation, or renewal. They all have the same meaning.

2.12 Definitions and discussion of terms such as 'procurement', 'sustainable development', and 'value for money' can be found in the Health ClusterNET Report 1 *How the Health Sector can contribute to regional development: the example of local procurement*.

3 The health sector and capital investment

3.1 In *The contribution of health to the economy in the European Union* (European Commission, DG Health & Consumer Protection, 2005) the authors argue that:

> *While the economic argument for investing in health in high-income countries may differ in detail from that in low-income countries, we have found considerable and convincing evidence that significant economic benefits can be achieved by improving health not only in developing, but also in developed countries.*

3.2 In economic terms, health services are clearly important because their efficiency and scope have a direct impact on population health, and thus indirectly on the productivity of the workforce and hence GDP. However, as the authors later acknowledge, it is also true that:

> *The health sector 'matters' in economic terms simply because of its size. It represents one of the most important sectors in developed countries, representing one of the largest service industries. Currently its output accounts for about 7% of GDP in the EU-15, larger than the roughly 5% accounted for by the financial services sector or the retail trade sector … Through its sheer accounting effect, trends in productivity and efficiency in the health sector will have a large impact on these performance measure in economies as a whole. Moreover, the performance of the health sector will affect the competitiveness of the overall economy via its effect on labour costs, labour market flexibility and the allocation of resources at the macroeconomic level.*

3.3 In recent years, the institutional bodies of the European Union have strongly emphasised regional development as a means of tackling economic inequality, encouraging cross-border cooperation, and targeting populations that have most need of resources. More recently the notion of 'sustainable development' (essentially, balancing current needs with those of the future), has been used to provide a framework for regional development (e.g. SUSTAINE in North East England). While the EU provides regional development and structural funds, there is a requirement and expectation that national governments will (a) recognise the importance of decision-making at regional level and (b) ensure that additional resources – financial and human – are made available to complement EU spending.

3.4 The importance of health as a fundamental component of strong, competitive economies has now appeared on the international and European agenda (DG SANCO 2005). This amounts to a recognition that health care systems can act as drivers for economic and social regeneration,

especially when considered in concert with other elements of social policy. Health sector investment therefore finds itself both affecting and affected by three principle areas of social and economic activity, as illustrated in Figure 1.

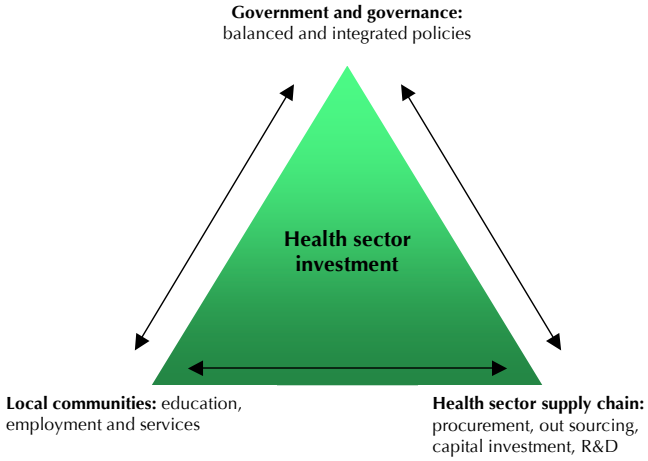


Figure 1: Links between health sector investment and three areas of economic and social policy

3.5 For regional bodies, decisions on where to find capital for health care investment, and on how best to apply these funds, are constrained by a number of factors:

- The national context of health funding:
  - Welfare ('Beveridge') taxation based
  - Social insurance ('Bismark'); personal or employer based
  - Mixed economies
  - Plural – responsibility of state and/or regions and/or municipalities
  - Transitional, as in the case of some new EU-member states, which are moving to new health funding systems.

- The local priorities accorded to the many drivers for change, which include:
  - Health equality
  - Issues of access
  - Developments in clinical technologies
  - Current and future use of ICT
  - Patient empowerment
  - Safety
  - The condition of existing assets, both physical and functional
  - Shifts towards new clinical models (e.g. towards care pathways)

- The degree to which decision-makers recognise the economic importance of health care investment.

- Health policy at regional, national and international levels:
  - The extent of the treasury's influence on health planning
  - Reliance on a particular form of capital funding (private, EU funds, co-payments, insurance, taxation)
  - The balance between preventative and curative models
  - The level of competence in understanding the value of strategic assets.

3.6 Many of the issues summarised in 3.5 were illustrated by the case studies presented at the April 2006 HealthClusterNET Krakow workshop, and by the presentations given by invited experts. However, the partner organisations also presented evidence of the means by which regional health care organisations can (a) ensure that they are making the right capital investment decisions, given local context, and (b) encourage health care investment as a driver towards a strong local economy. Summaries of the case studied are presented in section 4.

4 Lessons: partner case studies and master classes

4.1 Health ClusterNET partner organisations were asked to submit case studies of illustrative capital investment projects, intended to spotlight examples of best practice, innovative solutions to specific needs, or particular challenges faced in a region. A number of invited experts were also present at the Krakow workshop, to share their experience of the linkages between health sector capital investment and the wider economy of a region, by way of master class sessions and plenary presentations. The rest of this section summarises the key messages and themes, and concludes with a commentary. The table in Appendix 1 provides a comparative overview of context and theme(s) of the case studies.

Case studies

Capital investment in hospital care in Brandenburg

4.2 The German health system operates as a form of public private partnership (PPP), whereby the state supplies the legal framework, public institutions contribute the financing, and (quasi) private partners provide the health care. The costs of individual health care are met by the statutory insurance fund.

4.3 Under Germany's Federal system, the states have responsibility for supplying hospital services and for developing guidelines for the structure of regional health care. The funding of capital investment for hospitals comes from the states, in line with the regional 'hospital plan'. Any request for capital investment has to undergo a thorough and fairly lengthy approval process, which includes submission of evidence on patient need, development of a detailed functional and architectural plan, and consideration of the project on the urban fabric of the region. If approved, capital financing is released in staged payments.

4.4 The disadvantages of this system are as follows:

- The interplay of hospital owner, architects, and subsidising body is complex, and may involve years of negotiation.
- Public rules for construction work can be restrictive.
- The capital budget depends on the financial health of the Exchequer.
- In periods of low economic growth, the amount of capital available for investment may be reduced.

4.5 On the other hand, there are numerous advantages:

- Close cooperation between the public and private sectors can achieve a balance between business interests and patient needs.

- The length of the planning and construction phases allows time to incorporate changes in priorities, or advances in medical technology.
- Hospital development has to take account of the regional 'hospital plan', and can't proceed in isolation.

4.6 The tender process favours large projects (to keep unit costs down), and has to invite EU-wide submissions above certain threshold values. The commissioning hospital has to be inventive and quick-witted in order to give regional bidders a chance of getting their bids accepted. This is illustrated by the case of the Municipal Hospital, City of Brandenburg, which has been engaged in a three-phase modernisation and rebuilding exercise since 1999. The hospital has 11 medical departments and 520 beds, and it serves the city of Brandenburg and outlying areas. Its buildings have grown up as successive accretions, with part of the hospital (still in use) dating back to 1901. The hospital master plan has required the modernisation of the central medical functions at a cost of approx. €55 million; a new site for all hospital beds (to cost around €50 million); and the reconstruction of the old hospital to provide outpatient services. While the federal authorities have provided capital and helped with the planning phases, the construction is commissioned and overseen by the hospital itself. By means of clever tailoring of the construction phases, the hospital has been able to ensure that much of the internal construction and fittings can be supplied by regionally based firms, thus benefiting the local economy.

Healthcare capital investment in North East England

4.7 The north east of England has a population of some 2.5m people, many of whom live in three large conurbations. The region also has large rural areas with low population density. Like the rest of the UK, health care is provided by the National Health Service (NHS), financed mainly through direct taxation and free at the point of delivery. Different bodies (the primary care and hospital trusts, and the strategic health authority) have responsibility for commissioning and providing services, and for regulation and performance management.

4.8 NHS capital investment now comes from a mix of public capital (the Treasury), the PFI scheme, and an arrangement known as the Local Improvement Finance Trust (LIFT). The strategic health authorities have an annual capital allocation intended for distribution to individual projects; the trusts get an operational capital allowance to maintain assets; some funds are available at national level for specific objectives (e.g. IT infrastructure).

4.9 Public capital is normally used for smaller schemes (up to around €30m capital value) which are not attractive to private financiers, e.g. refurbishment projects or extensions to existing buildings.

Recent examples include renovation of older hospital buildings for modern clinical practices and the building of a primary care and minor injuries unit.

4.10 The PFI takes the form of a long-term contractual partnership between public and private bodies. The NHS commissions the work and provides clinical care; the private sector designs and builds the new facilities, assumes the risks inherent in the construction schedule, and leases the premises to the NHS for 25-30 years. PFI has attracted much criticism for failing to provide much in the way of clinical or architectural innovation, and for the costs to the NHS of occupying the new premises. On the other hand, the PFI schemes have meant that significant amounts of extra capital investment have entered the health care arena, and that these costs are kept 'off balance sheet'. PFI projects in the north east of England have included major new clinical blocks, large-scale extensions to existing hospitals, the complete replacement of district general hospitals, and some new community and mental health hospitals. Total investment to date is in the order of €950m.

4.11 LIFT was established to address under investment in the premises used for primary care. Like many other areas, north east England has had to cope with a historically piecemeal investment in primary care buildings, with the result that many of them are inadequate for modern needs and not sited in the areas of greatest need. LIFT projects consist of a PPP consortium, comprising local primary care trusts, the local authority, a joint venture arm of central government, and a private sector partner. This body acts as a development corporation, which stays 'in business' for 20 or more years. The intention is to provide the local community with social, economic, and environmental sustainability, such that procurement is encouraged at a local level, and training and skills remain in the community over the long term.

Capital Investment in the South Transdanubia Region

4.11 The South Transdanubia region of Hungary is a largely rural area, with a low population density of just under a million people spread across 14,169 km^2, mostly living in small villages. It has an ageing population and a low birth rate, and high incidences of cardiovascular diseases and cancer. Baranya, as the largest county in south Transdanubia, hosts the regional health care centre in the city of Pécs. The region houses 22 hospitals with a total of 7442 beds, including a university hospital, 2 church hospitals, and 2 private hospital institutions.

4.12 The capital investment climate in South Transdanubia is affected by a number of local and national factors. Operating within a system of a centralised, national insurance fund, but with responsibility for health care devolved to local government, capital costs are financed by hospital owning organisations. Decisions on which services should be provided, and where, are complicated by the fact that 90% of GPs are now private businesses, outpatient care is based on

a fee-per-service point system, and the cost of inpatient care is calculated on DRG-like Homogenous Disease Groups. While central government can (indirectly) affect health policy, it remains the case that health care institutions are interested in maximising revenue, and that this priority may clash with the aims of the newly established regional health care councils.

4.13 Despite the tensions between national, local, and private health care bodies, south Transdanubia has a clear idea of where capital investment should be concentrated, in:

- Structures and functions that are patient-focused
- Resource and distribution systems
- Informatics and communication
- Support of the R&D and health industry
- Rationalisation of the existing hospital structure, in line with the regional master plan.

4.14 Capital investment is badly needed, since many of the existing hospitals are old, pavilion-type structures, or 'block' hospitals built in the 60s and 70s – all in need or replacement or renovation. Some capital funding is available from national government (e.g. for medical hardware), some smaller amounts may come from the regional development council, with the rest having to be found from the hospital owners or from external investors.

Heath sector capital investment in Pais Vasco

4.15 Amongst the Health ClusterNET partner regions, the Basque Country is unusual in that it has full fiscal autonomy, with funding for the publicly owned health care facilities coming from general taxation. Regional level, public bodies are commissioners and providers of services. There is an agreed set of priority aims for the Basque health service, namely:

- To improve the health status of the whole population
- To encourage choice and personalised services
- To provide accessible, high quality services for the 'marginal' population
- To create an efficient health service
- To aim for decentralised services.

4.16 Management of the service-level agreements between the regional bodies, regional government, and acute or primary care providers, is often a complex business. To help to meet the priorities outlined in 4.16, and to make evidence-based health service management a reality, the Basque region has invested in an ambitious IT infrastructure project, equipping citizens with smart cards that hold the electronic patient record (EPR), and hospitals and clinics with the software to enable data collection and analysis.

4.17 The instigators of the EPR have been careful to leave the door open for local businesses to tender for the supply of software, consultancy, and training, by insisting on a minimum data set that meets EU standards but which is open-ended enough to prevent domination by a single, multinational supplier. Citizens and family doctors are now able to exercise greater choice over the site of acute inpatient care, and hospital management has more information, in a more timely fashion, about the profile of patients, the distribution of DRGs, and the costs of services.

Enabling capital investments In health care in Etela Suomi

4.18 Southern Finland has a population of around 2,125,000 inhabitants, with population growth (mostly from internal migration) projected to be running at 7% by 2020. As with other Finnish regions, responsibility for organising health and social services lies with the municipalities and with the regional bodies, with the funding coming from central government. Considerations of capital investment policy are affected by a number of issues:

- Debate on the merits of renovating existing premises Vs the merits of new build.
- An ageing population, with a projected shortage of community facilities.
- Increasing use of outsourcing of certain services.
- A large difference in the efficiency of the most and least effective primary care units.

4.19 Capital investment decisions function in the context of purchase-provider models, where public bodies have the relevant data on patient needs but the provider has the autonomy to invent solutions to meet those needs. Capital investment is coordinated through regional master plans, and in the case of EU Structural Funds, through regional councils. Procurement mainly takes place through conventional tendering and outsourcing (e.g. the Karis primary and elderly care centre), although there are also examples of PPP in practice (e.g. the Coxa Hospital for Joint Replacement). A special health-care fund has been established by Sitra (Finnish National Fund for Research and Development) to finance building the new specialized units

4.20 The Coxa Hospital is a striking example of a Design-Build-Finance-Operate PPP project. Initiated by physicians at Tampere University Hospital who wanted to improve the outcomes of patients undergoing implant joint replacement surgery, the Coxa provides Pirkanmaa hospital district with endoprosthetic surgery, and the whole country with treatment of some of the most difficult cases. The Coxa has 49 beds, 5 operating theatres, a bone bank, rehabilitation facilities, and an outpatient clinic. It is owned by a mixture of public and private shareholders, namely: Tampere University Hospital, the city of Tampere, the Finnish National Fund for Research and Development (SITRA), the Invalid Foundation Hospital, the cities of Mänttä, Valkeakoski, and Vammala, and a number of central hospital districts.

4.21 In the case of the Coxa Hospital, the traditional boundaries between public and private provision of capital (with their associated spheres of influence) have been somewhat dissolved. On the one hand, the hospital is fully integrated with the local public health care organisation, is mostly funded by public money, and governed mostly by public shareholders. On the other hand, it has some features of a private organisation, in that its employees are incentivised through their salaries, it has some economic independence, and it operates flexibly and efficiently.

4.22 To date, the Coxa Hospital has succeeded in providing better clinical outcomes for patients and greater productivity. The model used by the Coxa is part of a growth strategy which will see a further 3-5 joint replacement hospitals being built. The project has emphasised at least two features of PPP: the need to create a shared vision between public bodies and private companies, and the emerging possibility that specialised units can take some of the burden off both the primary and acute sectors.

St. Helens, Knowsley, Halton and Warrington LIFT

4.23 A Local Initiative Finance Trust (LIFT) is essentially a joint venture between the public and private sectors; a strategic partnership that has the aim of improving the provision of primary care premises in a particular location. But LIFT is not just a financial means of acquiring new buildings. It also targets:

- Inequalities between affluent and deprived areas
- A shift in care from secondary to primary settings
- Regeneration of poorer localities
- Integration of health and social care
- Flexible, adaptable, and sustainable primary care facilities.

4.24 Under LIFT, primary care services are provided by a local joint venture partnership, known as a LIFTCo. This comprises a strategic partnering board, local stakeholders (including primary care trusts and local councils), 'Parnerships for Health (a national body), and a private sector partner.

4.25 By the end of 2007 there will be almost 50 LIFT schemes in operation in the UK. The St. Helens, Knowsley, Halton and Warrington LIFT programme is one of the most complex examples, worth around €180m over 20 years. This LIFT project will see the construction of 20 new primary care facilities, integration with social, community and leisure services, and emphasis on the regeneration of the most deprived communities. Hundreds of jobs will be created as a result of this partnership, and new space will be provided not just for health care, but also for local businesses and other organisations.

Capital Investment in Alentejo

4.26 Most of the health infrastructure in the Alentejo is owned and managed by national, public bodies. The Portuguese Ministry of Health, advised by a national health council, decides health policy. Current health policy is part of a wider process of the reform of public administration, and the overall aim is to increase efficiency in the national health system. There has been strong support for elements of privatisation, the introduction of innovative management models, and a more patient-focused approach.

4.27 Key to understanding capital investment in Portuguese regions is the fact that there is little devolution of policy setting, funding, or procurement strategy. In general, the criteria for investment in strategic assets are set centrally, and normally recommend acceptance of lowest cost bids.

4,28 In line with governmental policy of encouraging a greater degree of partnership between the public and private sectors, the Ministry of Health makes use of a body known as 'Parceiras Saude' (Health Partnerships) to investigate and implement financing and management solutions for the health sector. This body has set a strategic direction for construction of new hospitals, and the proposed new hospital in Evora, Alentejo is fourth-placed in the list of priorities.

Health sector capital investment in Harghita County, Romania

4.29 Harghita County faces a number of challenges: a largely rural population with poor transport links, lower than EU-average numbers of physicians and nurses per 1000 population, and the burden of high rates of communicable diseases. The health system is under financed, poorly managed, and inefficient in its use of resources.

4.30 Central government in Romania is well aware of the problems facing the country's health system, not least in regard to capital investment in health assets. The current strategy places emphasis on decentralisation of decision-making and financial responsibility. Local authorities will be given the legal framework necessary to manage capital investment strategy at regional level, as well as (hopefully) the funds necessary to carry out reforms. The state will concentrate on public health measures, on protecting the rights of patients, and on setting policy objectives. Current priorities include:

- Equality of access to basic medical care
- Improvements in quality of life
- A move towards the health and epidemiological profile of developed countries.

4.31 While the Romania government aims to ensure health equity and quality, it is also to encourage contributions to social insurance funds and will attempt to stimulate private investment in health care facilities. Competition between suppliers of medical services, and between insurance funds, will be encouraged.

4.32 The structure of the hospital sector will be reformed, with clear demarcation between emergency centres, clinical hospitals, hospitals for treatment of chronic illness, and 'social' hospitals. All hospitals, apart from the emergency centres, will be managed locally, but there will be provision for private bids to provide services and to own hospital premises. National government will ensure standards are met and operate a system of accreditation.

Health sector capital investment in Pomurje Region, Slovenia

4.33 Slovenia's health system is funded through a mix of compulsory (80%) and voluntary (20%) insurance, with political and administrative decisions taken on both national and municipal levels. The service consists of a mix of public and private providers, in both the primary and secondary sectors. Capital investment plans for the 2004 – 2008 period concentrate on the purchase and replacement of diagnostic equipment, with responsibility for larger elements of this programme falling on the Ministry of Health.

4.34 Analysis of the Pomurje Region's health sector has identified two distinct areas in which health investment has influence on the local economy: those organisations which are directly funded by the health insurance funds, and those companies which service the health sector. A survey of commissioner and provider organisations revealed that in 2004:

- Both public-public and private commissions were placed.
- 62% of investment was in equipment; 38% in construction.
- Most of the organisations interviewed made their own, independent decisions about capital investment.
- Within the construction sector, some 61% of contracts were connected with renovation or refurbishment; 39% with new build, and contracts were awarded to local companies in 90% of cases.
- In contrast, local suppliers accounted for only 52% of equipment purchases by public organisations, 14% by private organisations.
- Local construction companies seem to have excellent market penetration, but equipment suppliers appear to be missing out on business opportunities – perhaps because they are not 'clustered' into competitive units.

4.35 The above survey is illustrated by the case of the Murska Sobota regional hospital. Of expenditure on equipment, so 95% went to non-regional suppliers, but 80% of the construction budget went to contractors in the region.

4.36 Analysis has suggested that barriers to increasing the share of capital investment awarded to local suppliers include the nature of public procurement legislation, and lack of skills in coping with procurement procedures. The regional construction sector has learned to put together competitive offers; equipment suppliers should try to cooperate to achieve the same ends.

Lifecycle Partnership Model: a new approach to ensure efficient public health care in Steiermark

4.37 Austria's public hospitals face the same problems of spiralling cost and expectation that are seen across much of Europe. In Steiermark, the VAMED group has proposed an alternative to the traditional solutions of outsourcing, privatisation, shut down, or cost cutting: a cooperative, public private partnership over the entire lifecycle of a hospital. The vision here is that PPP is about providing a service over the long term, not about owning real estate.

4.38 This integrated approach is intended to ensure:

- Co-operation in partnership over the entire lifecycle of a public hospital
- Long term, efficient operational management plus appropriate investment in technology and infrastructure
- Professional management as well as financing over the entire lifecycle of a complex health care unit
- Maximum possible efficiency and quality guarantee
- Public character of hospital is being kept
- Strengthening of competitive position.

4.39 The balance of task sharing in this kind of PPP project breaks down as follows:

- The public partner has responsibility for the medical and nursing staff, the legal framework, and health care politics.
- The private partner deals with project management; development, design, construction and financing of buildings; logistics and purchasing; maintenance.
- Both partners share: medical leadership, core clinical competencies, administrative staff, patient management.

4.40 The Steiermark Region's Schladming Hospital (123 beds, €44.6m investment) is an example of one such PPP programme, in which the private contractor is responsible for general planning, construction, project management, training, financing, start-up, and facility management. Many other such projects are either underway or in the pipeline throughout Austria, with total investment of many hundreds of millions of Euros, including one particularly interesting example of 'wellness tourism' at a spa development.

4.41 The key messages from the Austrian PPP experience are that:

- The public sector has to ensure adequate competency and know-how
- There is positive impact on the labour market and the local economy
- Public authorities maintain political influence over health
- There is evidence of cost saving and generally on-time project delivery
- Cooperation, and focus on solutions rather than problems, are encouraged by the PPP model
- The critical success factor is the lifecycle approach to investment.

Capital Investment in the Health Care Sector in Malopolska Region

4.42 Poland's Malopolska region lies in the south of the country, with a population of some 2.5m people and a well developed network of general hospitals, psychiatric hospitals, and long-term care centres. Roughly two thirds of the 66 general hospitals are in public ownership, as are 2 out of the 5 psychiatric hospitals, but only 3 of the 25 long-term care centres. Responsibility for health care, including public health, primary and secondary care, and ambulance services, is devolved to three tiers of regional competence. In common with the rest of the country, health care costs are met by the National Health Fund (NHF), which has both a central and 16 regional offices. Public and private providers have to operate within this system, with *per capita* funding for primary care, *fee-for-service* financing for specialist outpatient care, dental treatment and medical transport, and *reimbursement* for medicines and medical goods.

4.43 Local health authorities have ultimate sanction over the operation of public health care institutions, and are responsible for setting standards, supervision, and contract negotiations.

4.44 The Malopolska region is the 'founding body' (owner) of 25 health care facilities, including 17 hospitals, 2 spa institutions, 4 outpatient care centres, and 1 emergency rescue organisation. Recent statistics indicate that the region has seen significant increases in cancer treatment and cardio-vascular disease, and in the need for palliative care and rehabilitation units. There has also been a trend towards more hospitalised patients and outpatients in psychiatric care. In

terms of community health (average age at death, infant mortality) Malopolska compares favourably with other regions in the country.

4.45 The experience in Malopolska is that a regionally devolved health strategy, with decision-making powers at local level, has been mainly beneficial. The following benefits are cited:

- Cooperation between the main bodies charged with developing regional health strategy
- Ability to match service provision with defined health needs
- A decrease in the number of short-term beds, and increase in the number of long-term beds
- Development of selected specialities – cardiology, psychiatry, oncology
- Better definition of capital investment principles
- Control over the balance of public and private providers
- Dissemination of knowledge concerning regional priorities.

4.46 The breakdown of sources of capital funding is as follows:

- Regional government budget contains elements for infrastructure modernisation, preventative programmes, purchase of medical equipment
- The individual health care institutions have funds for equipment purchase, investments, and infrastructure
- The state provides funds also for equipment and infrastructure, but also for workforce restructuring and ambulance services.

4.47 The current priorities for long term investment are the oncology centre at Saint Lucas Hospital in Tarnow, the modernisation and development of the thoracic surgery department at the John Paul II Hospital in Cracow, and the dependency therapy centre at Babinski Hospital, Cracow. All three of these projects have been undertaken with public funds, in response to (a) analysis of regional health care needs, now and in the future, and (b) a desire to bring these important services up-to-date with modern clinical requirements.

4.48 The burden of capital investment in current plans up to 2008 falls mainly on regional government, with some funds also provided by the state. However, in view of the need to continuously increase the capital value of health care institutions, a search is now underway to find other stakeholders within public-private partnership arrangements. Interestingly, one option that may make this kind of investment attractive to the private sector is a proposal to attract health tourists to the region.

Health Issues in Sjuhärad/Västra Götaland, and Sweden

4.49 The Sjuhärad association for local authorities, which is part of Sweden's Västra Götaland county, works on mutually agreed programmes to increase inter-municipal cooperation, make better use of available resources, and develop the local economy. The programme for economic growth prioritises new enterprises, infrastructure projects, sustainable development, social cohesion, and an internationalist outlook. Making improvements in health care is seen as a key element in all of the above.

4.50 Public private partnerships have become a preferred means of enabling finance, finding creative solutions, and creating a balance between entrepreneurial energy and a need for public sector stability. Although living standards are high in Sweden compared with many other European countries, the country does face some challenges to health provision, including a rapidly ageing population and the migration of clinicians to neighbouring Scandinavian countries, together with an influx of physicians from German and Hungary. Almost all health funding comes from direct taxation, with only 1% from private insurance.

4.51 Responsibility for health and medical care is divided between the state, the county councils, and the municipalities. The state looks after overall health policy and questions of accessibility. The Medical Services Act is administered by the county councils, and support to the elderly and disabled provided by the municipalities.

4.52 In line with the demographics of the region, care of the elderly has been identified as a priority, with some SEK 600m allocated for 2006, rising to SEK 1750m yearly thereafter. At the same time there is consensus that a large proportion of capital investment should be directed towards IT infrastructure. The IT priorities are to create a comprehensive patient record, to make the systems user friendly (for clinicians, social services, and patients),l and to improve communication between patient and health care providers. These priorities call for new legislation, a common data and communication structure, and interoperability between systems. The region's 'Action' project bridges the needs of investment elderly care and IT infrastructure, by giving:

- The elderly access to nursing advice from home
- A direct citizen link to medical records
- Patient empowerment
- Transparency in decision-making.

Transition in the health care sector in Basilicata, Italy

4.53 The Italian health system is to some extent in flux. In recent times the regional authorities have had responsibility and financing devolved to them by central government. However, this situation is under review, with a national referendum to be held on the best means manage health care: at national, regional, or local level.

4.54 Basilicata region sees the current capital investment challenges as follows:

- The development of networking between public institutions and the private sector.
- To stimulate the not-for-profit sector, and to make its role more significant.
- To ensure that funds allocated for capital expenditure are spent.
- To deliver essential health services without increasing taxation or the need for private insurance.
- To guarantee the quality of both assets and services.

4.55 The specific priorities in the health sector are to reinforce 'care at home', especially for the elderly; to develop ICT and telemedicine applications; and to carry forward preventative programmes in the areas of cardiovascular disease, oncology, public health & safety, and drug dependency. To these ends, Basilicata has proposed a model of health care that places less emphasis on hospitalisation and more on integrated home assistance (IHA). The IHA structure will be part of a network of services which will include monitoring of patients after discharge from hospital. This will integrate with nursing homes for the elderly and with hospices for patients with terminal illnesses.

Master classes

The Martini Hospital Health Design

4.56 The trend in the Netherlands is for hospitals to use fewer beds, but to treat more patients for shorter periods. Naturally this trend is accompanied by more day care, optimisation of admission and discharge procedures, and more intensive cooperation with other care partners. In the case of the new Martini hospital, management has set up close cooperative arrangements with four nursing homes and a care centre, to deal with palliative, intermediate, and joint care, Parkinsonian patients, and geriatric advice.

4.57 The Martini hospital's vision is that capital investment should fund a hospital that is flexible and adaptable, because whatever solutions are found to today's problems, it is almost certain that new challenges will arise in the medium to long term. The Martini's capital investment concept emphasises:

- Care logistics
- Master plan → structure plan
- Industrial, flexible and demountable (IFD) construction
- Planning
- Long-term site development, with a building life cycle of 20-40 years.

The UK and Scottish PFI experience (Arup International and Scottish Executive Health Dept.)

4.58 In the late 1990s the UK embarked on a very large programme of capital investment in health care facilities. The early emphasis was on finding a means of getting private investors to supply the funding, so that (a) the risks inherent in planning and construction were not borne by the public sector, and (b) the costs remained 'off balance sheet' for the purposes of the Treasury. The model chosen to achieve these aims is known as the Private Finance Initiative (PFI). The following sections concentrate on some of the lessons learned over the last decade, rather than the debate over the efficacy of PFI, and whether it has proved to give value for money, since these issues are comprehensively discussed in other arenas.

4.59 Some basic observations regarding PFI in the UK are not controversial:

- The PFI procurement process is considerably more complex, lengthier, and often more expensive, than the equivalent public procurement process.
- PFI designs can draw on a wider range of private sector solutions, but at greater cost.
- While the PFI construction contracts assume price and completion date risks, this also comes at a cost.
- Private finance costs more (up to 25-40% more) than direct government borrowing over a 25 year concession, but there is greater discipline in project execution.
- In terms of operational issues, PFI removes public sector flexibility to use maintenance budgets to cover short-term budget difficulties.

4.60 Some commentators have argued that, despite criticism, PFI does confer certain advantages, namely:

- Better definition of public sector requirements
- Better risk management by the private sector
- Greater scope for innovation.

4.61 With over 500 PFI projects currently in operation, and with many more in the pipeline, it is clear that performance to date has been patchy, and that questions remain over whether or not PFI can respond to a rapidly changing health care market, and whether the NHS can afford the long-term financial commitments that have been put in place.

4.62 Circumstances in Scotland, however, make for interesting comparison with PFI in England. Scotland has traditionally had a very different health system from that in operation in England, and since the formation of the Scottish Parliament in 1999, responsibility for capital investment in health has been part of the remit of the devolved Scottish Executive Health Department. PFI has certainly been embraced, largely to enable the rebuild or refurbishment of outmoded and inadequate building stock. However, government in Scotland has encouraged a much more partnership-oriented approach to PFI contracts, typically involving community consultation and a commitment to regeneration of the urban fabric. To obtain PFI contracts offer value for money and correspond to genuine clinical need, the responsible authorities have made great efforts to ensure the stability of public service procurement teams, such that their accumulated skills and knowledge are brought to bear on successive projects. This contrasts sharply with circumstances in England, where public servants are often confronted with the complexities of PFI without the benefit of extensive training or experience.

5 Economic and social issues in capital investment

5.1 In this chapter, two plenary presentations given by Peter Pazitny (Partner, Health Policy Institute, Slovakia) and Simona Aggar (Evaluation of Investments Group, Ministry of Health, Italy and a former Professor of Urban Planning) are summarised. The first, drawing on experience in Slovakia focuses especially on economic efficiency aspects of capital investment. The second, based on extensive experience in Italy, gives particular attention to social values and community integrity in decision-making.

Plenary: Capital Investments in Health Care – European Perspectives and Trends

5.2 Slovakia has recently taken the step of privatising health care, moving from a system which was based on multiple social health insurance funds and (mostly) government owned hospitals, to a new arrangement whereby for-profit insurance funds negotiate premiums with citizens and employers, and payments with privately operating doctors, pharmacists, distributors, and hospitals.

5.3 The background to this very significant change in health service funding is a belief that the market and private capital, are better able to solve the many difficulties faced by health services everywhere. In particular, it has been argues that for-profit orientation in social health insurance:

- Improves motivation among health professionals
- Imposes much-needed budgetary constraints
- Takes pressure off public finances
- Makes purchasing more efficient
- Removes risk from the public sector
- Avoids unnecessary political influence.

5.4 The argument here is that, while employing private capital to achieve desired health outcomes requires very different structures and stewardship from those required by a publicly funded system, there is a trend towards private, for-profit insurance and medical care, and that this trend represents the most efficient use of resources and capital. The subtext is that economic development at national and regional level can be achieved through a mix of direct application of public funds, the creation of appropriate legal and regulatory frameworks, and local incentive schemes.

Plenary: The future challenges for capital investment, regional planning, healthcare priorities and values

5.5 By way of contrast with the Slovakian approach, this plenary presentation outlined an argument for keeping health care assets in public hands. Italy has a national health service that is largely funded by general taxation, but which faces many problems in common with other European neighbours: significant health inequalities between regions, an urgent need to re-organise hospital networks, lack of investment in improved facilities and medical technology, and a clear requirement to place more emphasis on preventative medicine. Like many other nations, Italy needs fewer acute beds and many more facilities for care of the elderly and patients with chronic illnesses.

5.6 In the 1990s the Italian government drew up ambitious plans for reorganisation of primary and secondary care. The first phase of this meta-project concluded in 1997, but with questionable results. On analysis, the emerging critical factors were:

- Resistance to change
- Not enough administrative and technical capacity in the health agencies
- Lack of health planning tools and models.

5.7 However, from 1999 there were significant changes to the regulatory framework: regions were given much greater responsibility for the planning of health services, a new law on public capital investments was passed, and the Investment Evaluation Group was established at national level. New goals were established, giving priority to the creation of regional networks of health facilities and hospital rationalisation. National government was made the guarantor of equality of access and quality; the Ministry of Health was given a monitoring and evaluation role (especially with regard to the use of national funds for capital investment, and the regions were granted autonomy to plan and implement regional health services. In addition, procedures were put in place to improve coordination of health policy at different levels and to share experiences of excellence. The Evaluation of Investments Group produced a methodology, based on international standards and tools, to guide infrastructure planning.

5.8 The experience of the Tuscany region is an example of the benefits of the above approach. Tuscany has created a regional health plan, based on rigorous capacity mapping and demographic data, which has been used to radically reconfigure the local health care system. Hospitals have been reduced in number from 93 to 41; bed numbers have almost halved; the functions of hospitals are now clearly defined and matched to patient need across the region.

5.9 It is interesting that Tuscany's reconfiguration of the health service has been achieved through investment of public funds, and with an overriding philosophy that hospitals have social value and should remain in public hands. The aim has been to create modern, efficient services in buildings that preserve their architectural values and firmly remain part of the existing urban fabric.

6 Connecting capital investment to regional economies

6.1 The case study presentations and discussion at the Health ClusterNET Krakow workshop illustrated a number of factors that can promote or hinder the effectiveness of health care capital investment in improving regional economies. These are summarised below.

Decision-making and financial authority

6.2 The degree to which regions enjoy responsibility for health care, as opposed to central government, varies greatly from country to country. In Sweden, for example, many aspects of the health system are in the hands of municipalities, whereas in Portugal it is still the case that agencies of central government are involved in local decisions. A key message from the Krakow workshop was that, where regions have been given responsibility for decisions in any of the basic elements of health care - public health, primary care, rehabilitation services, acute hospitals, mental health – it is vital that they also have the autonomy to plan, finance, and implement solutions to health care needs. The Basque country took the decision that ICT development was central to a progressive health care system, and has been able to follow effectively this route because regional authorities have the capital and decision-making powers to do so.

Capital models

6.3 There is a changing financial climate in health care infrastructure investment across the whole of Europe. Governments are increasingly looking to sources of finance other than central treasury funds earmarked for health care, whether this involves the private sector, not-for-profit organisations, or a re-appraisal of how other public funds can be put to use. Regions have to be aware of the shifting ground, and prepared, through staff with relevant competencies, to propose solutions that will benefit their local economies. The research from Pomurje Region, Slovenia, for example, suggests that capital projects can make use of local suppliers if they have successfully organised themselves into 'clusters' which can achieve economies of scale and offer the same levels of service as the multinational operators.

Using ICT to shift resources into the community

6.4 If the demographic profile of a region suggests that, for instance, an ageing population would benefit from increased levels of high-quality home care, then it may be appropriate to embark on ICT projects that reduce levels of hospitalisation; as is the case in Sjuhärad/Västra Götaland, Sweden, and as is proposed by Basilicata, Italy. Regions with low population density, or with widely dispersed communities, may find ICT solutions more cost effective that the traditional hub and spoke hospital model.

Risk and opportunity management

6.5 This area addresses the competencies and skill set of regional health care policy makers and planners. Do they understand the risks and opportunities inherent in:

- Advances in medical technology?
- Development of care models?
- Management of demand, now and in the future?
- Shifts in public opinion?
- Adopting new financial models?

Arguing the case for the economic value of health infrastructure investment

6.6 Regional health organisations should be familiar with, and able to speak, the language of the Treasury/Finance Ministry, to show that the benefits of rational planning of health infrastructure extend far beyond the immediate needs of treating patients. There may be a case here for education and training of senior policy makers and planners. The experience of PFI and LIFT in the UK has shown that best value for communities is obtained when local personnel have the significant knowledge and experience of new capital models.

Sustainable development

6.7 Although it is tempting to solve only today's problems (and sometimes only yesterday's), there is widespread recognition that this does not amount to an effective application of capital investment. Health care buildings should be built, renovated, or reconfigured to meet future needs – as far as this is possible. In the interests of sustainability, is it possible to consider joint capital investment projects with other sectors in order to reduce the overall capital burden? The UK's St. Helens, Knowsley, Halton and Warrington LIFT project could be seen as an exemplar of this kind of approach.

Societal values

6.8 The closing presentation in Krakow argued that in focusing too closely on capital, and in how it interacts with economic development, we run a risk of losing sight of the social, human values bound up in health care buildings. This echoes one of the themes of the Lisbon Agenda: health care is about people. Regional authorities should bear in mind that the services they are responsible for, or at least have influence over, need to reflect the aspirations and needs of local populations. This is especially true in the case of health care facilities that have become part of the fabric of a locality, such as Brandenburg's Municipal Hospital.

The value of master planning

6.9 Master planning is increasingly emerging as an element of regional development that promotes an integrated approach to urban regeneration, stimulation of local economies, private care and the positioning of hospitals. It provides a clear vision of what people are collectively aiming for. The question, however, is whether health is ready to become part of the regional development agenda, especially in the new EU member states and the pre-accession countries. In some cases - South Transdanubia, Hungary, for example – it clearly has, to the extent that health infrastructure improvement is seen as key in developing R&D businesses in the health field.

The need for better decision-making toolkits

6.10 The primary purpose of investing in capital assets for health care is to improve the quality and outcomes of the services provided within them. This may seem to be stating the obvious but surprisingly there is little evidence to help policy makers and managers faced with making investment decisions. The connectivity between capital asset input and clinical outcomes, and improvement in the health status of populations, is tenuous. For those concerned with health care decision-making at any level, the following hierarchy of questions is a useful self-examination:

- To what measurable degree will quality be improved by capital invested?
- To what measurable degree will clinical outcomes improve?
- To what measurable degree will the health status of the population be improved?

6.11 For regional authorities, it is useful to add one further question to those above:

- To what measurable degree will the regional economy benefit?

6.12 As an initial starting point, consider the use of care pathways, which are increasingly in use across many European health systems. The care pathway principle operates in two complementary and interlinked forms:

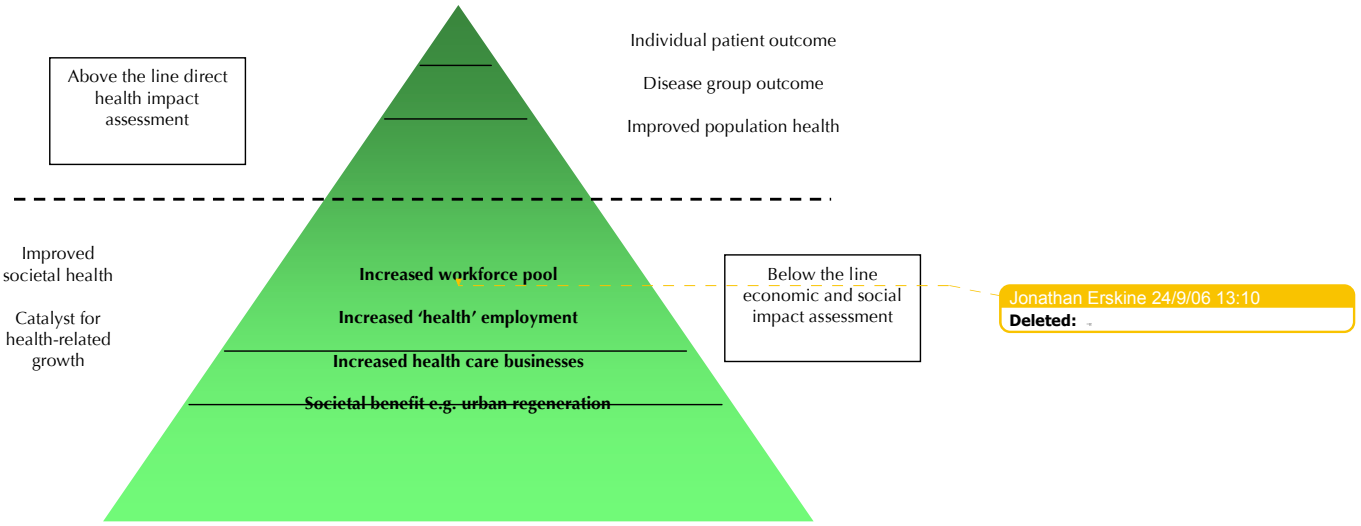
- The whole systems pathway that describes the planned trajectory of care across all the agencies involved, from initial diagnosis to predicted outcome.
- Internal pathways, contained within the overall pathway that describe how episodes of care will be provided by hospitals and other agencies.

6.13 In both instances the pathway describes the type and level of clinical and resource usage against predictions and allocations. This is a crucial first step in giving policy makers the first transparent

view of the connectivities (a to d) described above. Having the means of comparing resource effectiveness between different elements of the programme creates the potential of evidence-based allocative distribution (and redistribution) of resource – both service and capital.

6.14 The above process may pave the way for a more structured decision process that can bring the wider economic benefits of capital investment into play. The lack of measurable co-related economic benefit of healthcare capital investment has seriously inhibited assessment of the wider perspective - a perspective that public health, and urban planners have argued for, for some time. What is required is a means of providing:

- The discipline of measuring resource input, and usage
- The basis of relating resources to specific elements of care
- The means of measuring effectiveness – outcomes against predictions
- An option appraisal toolkit to assess the effects of changing resource investment patterns
- The means of handling comple, interrelated service and capital connectivities
- The basis of comparing 'above the line' health-specific resource investment against 'below the line' economic impact assessment.



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6.15 The level of complexity should not be underestimated. The chart above shows the manner in which complexity increases as the analysis moves from individual outcome impact assessment to the wider economic agenda. In the chart shown complexity increases from top to bottom, and is proportionate to the relative volume of each section. *Above the line* – describes the direct impact on healthcare outcomes of specific health system related resource investment. *Below the line* -

relates to wider economic benefit of healthcare expenditure (capital and service), much of which will have some impact in improving health status of populations.

6.16 Whilst this approach provides a logic system for decision making, in practice there are barriers which can get in the way of implementing this approach, implementation, for example:

- Many public service capital systems are generic in nature and do not fit well within the complexity of health systems. Capital models are often directed by government Treasury departments which may be more concerned that the model fits within macro economic strategy e.g. meeting national and/or European debt management principles, than its ease and effectiveness of implementation within the service concerned. Recent publicity over the UK's PFI model suggests that it may be satisfactory for simple investments such as roads or bridges, but not sufficiently flexible to meet the needs of healthcare investment. In other words, there needs to be consistency between the capital model, the planning system and the outcomes desired.

- Many governments lack overarching systems or agencies that can span across spending departments e.g. health, education or transport. Lack of coherence and cohesion in planning is a major factor inhibiting the wider view. Furthermore the timing and processes for accessing capital may not coincide, creating further dissonance. Many Governments have now identified the need for 'joined up government' as a priority but so far results in many countries have proved disappointing in practical terms.

- In many instances (for example, countries with insurance based systems) capital spending lies outside the direct control of public service agencies. Hospitals in these circumstances tend to be autonomous, and capital provision is a provider led exercise. The level and disposition of capital investment can (and in many instances is) subject to some for of regulation this is usually to:

    - Ensure equity of distribution of services
    - Avoid overcrowding in the marketplace
    - Avoid the risk of monopolies
    - Ensure adequate quality and safety standards

6.17 There seem to be few regulatory measures that are aimed at stimulating capital investment to create wider economic gain. This is not surprising, the private sector, or charitable trust hospitals are primarily concerned with their own bottom line – sustainability and profitability.

6.18 What is needed in all these cases is greater recognition of the mutual dependency of healthcare and the economy. If this is to develop it will require a stronger evidence base that demonstrates the value of capital in more tangible and measurable terms. The outline matrix approach described above may create a useful framework for the development of more effective planning and decision systems for the future.

7 Towards a policy agenda for capital investment

7.1 The costs of publicly funded health services are pushing at the limits of affordability. This is a challenge shared by all European regional health systems. In this financial climate, health organisations need to be able to demonstrate the added value of investment and expenditure decisions.

7.2 Within partner regions, spending by health services on staff, goods & services, buildings, IT and equipment ranges from 6 to 9% of regional GDP. This is a significant level of economic activity. But it is not optimised to positively contribute to regional development agendas. Nor is it used to maximise the population health benefit of health care expenditure.

7.3 Capital investment in refurbishing or building new health care infrastructure and IT are one way of achieving these contributions. They should: help create dynamic local businesses that are competitive in wider markets; boost local employment; widen the skills base; improve workplace & population health; and strengthen social cohesion. These are the kinds of added value that we should expect from public organisations spending public money.

Ensuring the relevance of a policy agenda

7.4 There are five main audiences for an agenda on health sector procurement:

- For **health service decision makers** this agenda shows understanding that capital investment decisions need to address the move from acute illness to chronic preventable conditions as the third 'age' of health care across European regions. This shift will need (i) cross-sectoral service delivery designed around the needs of patients, carers and families (ii) investment in technologies that minimise hospitalisation. It also supports the development of the corporate social responsibility role of your organisations and also shows your commitment to the health inequalities and health improvement agenda.

- For **local health organisations** such as acute hospitals and primary care organisations, this agenda helps show your commitment to joint working with local government and other partnerships to develop fully engaged communities at both individual and organisational levels in service delivery and quality of preventable and minimised affordable care.

- For **regional governments**, evidence suggests that capital investment in health care assets is best managed where there is considerable local autonomy in decision making, coupled with tightly-knit accountability to a region's population. Overall, the partner case studies indicate that regional health bodies should develop and maintain expertise in anticipating future

health demands, understand how to manage relations with other private or public sector providers, and become proficient in speaking the language of the central Finance Ministry.

- For SMEs, the adoption of this agenda in your region or community, offers a clear basis for lobbying for simpler, more transparent procurement processes with less bureaucracy and the development of an enterprise aware culture in health service organisations.

- For relevant directorates within the European Commission (DG Enterprise, DG Research, DG Regional Policy, DG Health & Consumer Protection), this agenda offers a platform for an approach that cuts across individual DG competencies in order to achieve European added value.

Purpose of the Agenda

7.5 This Agenda provide a practical response to the 'health equals wealth' challenge first set out at the European Health Policy Forum in October 2003.The Graz Agenda puts forward a range of capital investment policy actions for localities, regions, and the European Commission. The Agenda has been shaped by the practical experiences, evidence and insights generated by regions from across the EU and beyond who are partners in Health ClusterNET. Importantly, it also reflects how partner regions are currently progressing in terms of economic performance and Lisbon Agenda orientation.

Agenda aims

7.6 To enable regional health systems to more positively engage with regional development through capital investment policies, planning and actions that contribute to affordable, flexible, possibly intersectoral and dynamic health care infrastructure and IT-based services.

7.7 To redefine 'value for money' (or national equivalent term[3]) to include outcomes that connect health sector capital investment to the achievement of intersectoral regional development priorities.

7.8 To enable European regional health systems to have flexible options regarding approaches to capital investment that ensure capital investment is affordable and capable of allowing health care to adapt to changes in service priorities reflecting local health and well being needs.

[3] Other words used across partner regions that are equivalent to 'value for money' are: best value, total economic benefit, best offer.

Focusing the Graz Agenda

Factors that promote or block the effectiveness of health care capital investment in improving regional economies and communities

Decision-making and financial authority – Regions with responsibility for decision-making should also have freedom to plan, finance and implement capital investment programmes and projects

Capital models – regions should understand that financial climates change and should develop and maintain the expertise and insights to propose solutions that benefit regional and local economies and communities

ICT – Regions with ageing populations, low population density or widely spread communities may find ICT solutions more cost effective than the traditional 'hub and spoke' hospital model

Risks and opportunity management – Do regional health care policy makers and planners understand risks and opportunities involved in decision-making e.g. advances in medical technology that can reduce hospitalisation; changes in care models that reflect transition to preventative chronic illness in health care populations; shifting demands now and in the future; changes in public opinion about what is acceptable; being able to adopt flexible financial models

Economic value of health care infrastructure investment – the need to show that the benefits of rational and innovative planning extend far beyond the immediate needs of treating patients. The best value for local communities is achieved when local health sector policy makers and planners have key knowledge and experience of new capital models

Sustainable development - A regional focus on solving today's problems is not effective capital investment. There is a need to consider joint or intersectoral shared capital projects in order to reduce the overall capital burden

Societal values – If we focus to much on how capital interacts with economic development then we risk not seeing and ensuring that health care is about people. This is a key theme of the Lisbon Agenda. Services need to reflect the needs and priorities of local communities

The value of regional masterplanning – Promotes an integrated approach to urban regeneration, stimulation of local economies, mixed and third sector care and positioning of hospitals. But is health care policy ready to become part of the regional development agenda in all regions?

Policy recommendations

7.9 The following policy recommendations are organised into three regional categories. These categories reflect how two objective indicators and 1 self-assessed indicator define partner regions. The two objective indicators are Lisbon Orientation and Economic Performance and were developed and reported by the European Spatial Planning Observatory Network (ESPON). The self-assessed indicator reflects how partners assessed the extent to which health sector investment in their own regions is contributing to regional development. This self-assessment used agreed criteria to place each partner region into one of three development stages (early development, solid progress, fully engaged).

Group A: Economic potential, weak Lisbon orientation, health sector starting engagement

7.10 Group A includes regions (i) where the health sector is at an early stage of development in ensuring that health sector investment and assets contribute to regional development for regions (ii) that have economic potential but weak Lisbon orientation. In Health ClusterNET the following regions are in this group: *Harghita, South Transdanubia, Malapolska, Alentejo, Basilicata, Slovenia*.

7.11 This group of partner regions identified the following policy recommendations as a 'route map' to enable them to make progress in ensuring that health care capital investment contributes best to regional development:

- Ensure that health care capital investment opportunities from EC Structural Funds are available especially in regions in new member states and objective 2 regions in other member states There is a need to make available to regional decision-makers and planners scientific research findings that identify the investment effects of different capital investment models
- These regions should not be required to use only one fixed capital investment model if this is likely to reduce the flexibility of regional health systems and health care organisations to adapt to and address changing service needs and opportunities
- Goals for capital investment programmes should be based on a clear understanding of the complex nature of social health determinants in the third age of health care with the focus on managing preventable chronic illness conditions through intersectoral care pathways
- Explore EC policies, strategies, action plans (e.g. Amsterdam Treaty) and programme information documents to clarify if they will support the development of regional decision-making on the factors identified above that promote the effectiveness of health care capital investment in improving regional economies and communities
-
- Develop and invest in training and development of key decision-makers and planners in regional health systems and regional government regarding the strengths and weaknesses of different capital models and how investment decisions should contribute significantly to social cohesion within regions
- Identify and make available tools for intersectoral planning in regions
- Develop and invest in expertise that enables regional health systems and other regional stakeholders to assess capital investment opportunities in terms of economic, social and health impact.
- Develop processes for decision-making on capital investment that allows all key stakeholders to contribute to and inform decision making

- In tackling regional population needs (e.g. ageing, wide spread and rural populations) for health care, allow regions to explore the appropriateness of and allow capital investment projects to use ICT and high technology rather than single hospitals to improve care pathways across regions.

Group B: Less clear economic trend, high Lisbon orientation, health sector engaged

7.11 Group B includes regions (i) where the health sector is making solid progress or is fully engaged in ensuring that health sector investment and assets contribute to regional development (ii) that have less clear economic trend but with high Lisbon orientation. The regions in this group are: *Västsverige, Brandenburg and North West*.

7.12 This group of partner regions identified the following policy recommendations as a basis for enabling them to maintain progress in ensuring that health care capital investment contributes best to regional development. This route map is presented in Table 1 below:

Table 1: Success factor and policy level actions needed

SUCCESS FACTORS	POLICY LEVEL ACTIONS	LEVEL OF POLICY ACTION
Health strategies that will achieve optimum health gain	The use of evidence-based care pathways for capital planning and objective measures from outside the health sector	Regional
Professional culture change	Consider appropriate incentive schemes (financial, reputational, educational)	Regional and national
Aligning health outcomes with financing	Introduce incentives	Regional and national
Local/regional planning and legal obligations	Educate decision makers and reinforce regulation	Regional
Master planning and legal obligations	Combine decision making of different sectors	Regional, national and EU
Master planning taking place across sectors	Combine decision making of different sectors	Regional, national and EU
Clear lines of accountability and responsibility	Identify who takes overall responsibility	Regional and national

7.13 Beyond these policy level actions the following three recommendations are central if regions are to maintain progress:

- Write a communications plan tailored to each stakeholders expressed needs
- Ensure a continuing focus on sustainability when bidding for Structural Funds

- Integrated master planning is essential. Sectors need to get out of their policy and planning silos and work together if regions are to develop further.

7.14 Essential outcomes that should be part of this reoriented capital investment approach are: societal benefits, improved health, increased workforce pool, increased "health" employment, increased healthcare businesses, community regeneration.

Group C: Strong economic trend, high Lisbon orientation, health sector engaged

7.15 Group C includes regions (i) where the health sector is making solid progress in ensuring that health sector investment and assets contribute to regional development (ii) that have strong economic trends with high Lisbon orientation. The regions in this group are: *Steiermark, Etela Suomi, North East, Pais Vasco*.

7.16 This group of partner regions identified the following policy recommendations as a 'route map' to enable them to continue progress in ensuring that health care capital investment contributes best to regional development:

7.17 In these partner regions there is already (i) good and strengthening level of intersectoral collaboration between key organisations (ii) reasonable quality of capital stock and access to capital funds for further development (iii) a good level of citizen satisfaction. However at policy level there is understanding of the need for structural and related policy changes.

7.18 The weaknesses in these regions are identified as: (i) lack of total stakeholder agreement but there are means to obtain reasonable levels of consensus (ii) questions about affordability of existing approaches to health care capital investment in terms of sustainability of current care systems, technology growth and the need to disinvest to reinvest (iii) a degree of short-termism and lack of future scope in policy making (iv) inadequate risk assessment and management strategies (v) differing planning cycles among relevant contributing organisations (vi) lack of good evidence about the strengths and weaknesses of different capital models among decision-makers. In this self-assessed context, a number of recommendations are made:

- The need to develop among key stakeholders a consensus belief on the desired regional economic value of capital investments. In particular, there is a need to maximise population-wide health status from societal investment (public funds, partnership options and stakeholder commitment leading to economic value and societal value. This will need prioritisation of future investments and assessment tools and techniques to improve the quality and relevance of intersectoral prioritisation and planning

- Ensuring the adoption of integrated care models and pathways across the regions communities
- Using evidence about demographic profiles and epidemiological changes s criteria to prioritise economic value of capital investment decisions
- Ensuring widespread stakeholder commitment to decision making i.e. political, clinical and citizens
- The need to further ensure information transparency through better considered ICT development across sectors and that this should inform longer planning time frames
- The need to (i) remove inappropriate financial and other 'reward systems' among policy and decision makers (ii) be clearer about how to deal with professional cultures and politics that can act as barriers to improved decision-making.

7.19 Regions in this group identified the following **important policy opportunities** to ensure that health care capital investment is better orientated to delivering the Lisbon Agenda:

- Shift health policy towards prevention of chronic conditions and promoting well being (this should be done by health care policy makers)
- Develop cross-government and cross-ministry commitments to intersectoral planning, funding and implementation at regional levels (national governments need to address this)
- Approaches to capital investment within regions should be linked to and support merging best practice care models e.g. enabling integrated care pathways (Health and Finance Ministries at regional and national level)
- Information on and access to diverse capital models should be made available to regional decision-makers with clear evidence about relevant strengths and weaknesses of the different models (Finance Ministries)
- Responsibility for decision making on health care capital investments should be clearly devolved to regions and appropriate service organisations (National Ministries with responsibility for Regional Development and Finance Ministries)
- Identify incentives to encourage partnership working between cross-sectoral agencies e.g. through the development and use of integrated performance management frameworks and processes (Finance and Health Ministries, regional health systems)
- Enable the better development of integrated information systems to improve intersectoral decision-making about how to supply and improve better managed care pathways (local, - regional and national information experts and agencies).

Key developments for all regions

7.20 The following two key developments would enable regions to effectively improve the contribution of health care capital investments to regional development:

- **Adopt master planning within each region** – this would make it difficult to isolate individual policy makers. Everyone has a contribution to make
- **Advocate Structural Fund reform –** there is a lack of accountability once a bid is won on outcomes but not enough flexibility to adjust outcomes where appropriate.

Overall benefits

7.21 In conclusion, the following benefits will emerge if regions are able to address the relevant group recommendations:

- Models of capital investment that enable health care organisations to stay flexible across time will significantly enable regional health systems to adapt to developments in medicine and demands on care and prevention that are emerging in future years. In the shorter term, approaches to capital investment by health service organisations has the potential to stimulate the development of capable local businesses, strengthening their competitiveness in wider markets and so supporting a positive drive to achieve the goals of the Lisbon Agenda (growth, competition, employment)

- Capital investment in refurbishing or building new health care infrastructure can be done in ways that: help create dynamic local businesses that are competitive in wider markets; boost local employment; widen the skills base; improve workplace & population health; and strengthen social cohesion. These are the kinds of added value that we should expect from public organisations spending public money.

Appendix 1: Summary table of case study themes

Country	Region	Funding	Division of responsibilityand/or Locus of decision making	Regional Priorities	Health Priorities and Future Trends	Challenges
Sweden	Sjuhärad/Västra Götaland	Direct taxation; social insurance model	State: policy making and guarantee of access; County: Medical Services Act Municipality: health and medical care	* Improved infrastructure * Education, job market * New enterprises * Culture and tourism * Support for municipal autonomy	* Care of the elderly * Child and youth mental health * Dental care reform * IT strategy for the health market	Clinical workforce migration Ageing population Common standards for IT Legal framework for IT that preserves privacy
Slovenia	Pomurje	Insurance (80% compulsory; 20% voluntary)	Political and administrative decisions taken at both state and municipal levels Place of decision making depends on where funding comes from	* Freedom of access to healthcare * Employment * Development of local market to supply skills and labour for CI in health care	* Purchase and replacement of medical equipment (ministry of health) * Legal framework for PPP * Clustering of local providers to improve their competitive position * Local construction sector	High unemployment Public procurement legislation
Spain	Basque country	General taxation	Region has full fiscal autonomy	* Articulation of relations between the health dept. (finance) and the Basque Health Service (provider) * Equality and accessibility of health services	* Universality, equity * Patient centred * Efficiency of delivery * Decentralisation * Evidence-based management	* Portfolio of new services * New clinical channels * Medium/long stay and mental health
UK	North East England	Direct taxation; PFI; LIFT	State (Dept. of Health) provides policy, standards, funding. Strategic Health Authority (regional) is the local DH representative. Primary Care Trusts (local) commission services from hospital, GPs, etc	* Regeneration * Transformation from 'old' industries to new * Social, economic, environmental sustainability	* Refurbishment of existing health facilities (public capital) * New hospital building (PFI) * Community health buildings (PPP – LIFT) * Reform of the NHS at local and regional level	* Regional health policy linkage to economic development

Poland	Malopolska	Insurance (National Health Fund)	State influences employment policy, overall strategy, funding for equipment. Region has control of the long-term investment program, including construction	* High quality interaction between the various bodies involved in health care at national, regional, municipal levels	* Restructuring of acute sector * Improved treatment for cancer and cardiovascular disease * Psychiatric care	* Alcohol-related illnesses * Tobacco usage * Continuing restructuring of health care facilities.
Finland	Etela Suomi	Direct Taxation	Municipalities and regions have to organise services, with the municipalities providing funds to regional service providers	* Coping with rapid population growth through internal migration * Regional master plans * Coordination of EU structural funds	* New hospital building * Renovation of old buildings * Shortage of community facilities * Ensuring that capital spending corresponds to service needs	*Outsourcing of services, via purchaser-provider models * PPP(?) – e.g. Coxa; collaboration with tertiary teaching centres
Hungary	South Transdan-ubia	Insurance (central, national fund)	Local govt responsible for health service provision; except for university hospitals Central govt has only indirect control to enact health policy	* Health care development strategy * Coping with a rural, dispersed population	* Patient-focused health system * Development of informatics, telecoms, distribution systems, human resources, R&D	* High incidence of cancer and cardiovascular disease * Ageing population *Low birth rate * Increase in rehabilitation of chronic disease patients * Move to fewer, but more modern hospitals * Need for renovation and reconstruction
Germany	Branden-burg	Insurance, within a 'PPP' model	Federal States have responsibility for supply of hospital services, and fund the investment costs for hospitals in the 'hospital plan'. Hospital services function like private institutions.		* Linkage of capital investment with demonstrable patient care needs * Close public scrutiny of functional and architectural plans * Strong public control of financing * Good outcome for patients * New technology can be integrated late in the process	* Complex relationships between hospital owner, designer, and the financing institution * Restrictive rules for spending public money * Finance depends on the strength of the Treasury – low economic growth can slow projects.
Portugal	Alentejo	For infrastructu	Central govt. sets the policy	*Tackling depopulation	*Integrated health services	*Improvements in the quality of

		re, funding is public, through general taxation	agenda; local and regional bodies are responsible for implementation.	*Socio-economic issues	*Closer working relationships between public and private sectors *Continuing development of telemedicine	healthcare *Better access *Ageing pop. *Relatively high mortality rate
Nether-lands (External to the Cluster-NET partners)	Sittard Hospital	Insurance funds – public and private - competitive market recently introduced	Govt (MH) sets standards and oversees quality and access. Municipalities responsible for primary and public health. Hospitals are mostly private + non profit, except for university hospitals.	*Adapting to the new environment of the competitive tariff environment of the insurance funds.	*Adaptability and flexibility of design. *Reconfiguring the hospital environment to meet changing service models, now and the future.	*Coping with a more dynamic, fluid health system. *Risk factors inherent in capital invest-ment in a tariff-based market. *Keeping 'ahead of the game' in terms of technology.
Italy	Basilicata	1. Regional quota of the National Govt Health Funds 2. Regional Funds assigned to Local Health Authorities 3. Share by the Citizens the costs of each exam	A major part of health care responsibility has been given to Italian regions. A referendum will decide the balance of decision making between national, regional, and local govt.	* Improve roads and railroad connections * Develop tourism as an important economic resource * Create conditions for the return of young people especially with graduate and graduate University degrees * Increase support for elderly and the weakest segments of the population	* Reinforce the "at home" health care and assistance especially for the elderly; * Develop ICT, e-health and telemedicine * Develop prevention in the most risky health areas such as cardiovascular problems, oncology, and in social areas concerned with car and domestic accidents, work injuries, drug dependency.	* Develop a strong network between main public institutions the private sector, especially non profit organisations, to achieve more efficient and effective use of the financial and human resources * Stimulate the non profit sector to make its role more significant, building professionally and social entrepreneurial methods. * Invest to the planning and related timing the funds granted for capital investments in health infrastructures * Deliver the health services recognised as "essentials" to all the population but without increasing expenses and general taxation, and without creating the need for the complementarity of private insurances. * Guarantee quality of the structures as well as the services